THE U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2010

HEARING

BEFORE THE

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

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

MARCH 10, 2009

Serial No. 111–6

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THE U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2010

TUESDAY, MARCH 10, 2009

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

The Committee met, pursuant to notice, at 2:33 p.m., in Room 345, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Snyder, Michaud, Herseth Sandlin, Hall, Perriello, Teague, Donnelly, Space, Walz, Buyer, Moran, Boozman, Bilbray, Bilirakis, and Roe.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Well, everybody is quiet for an Army General. I have never seen it like this, Mr. Secretary. I want to wait for some of our colleagues to show up. We apologize for keeping you waiting, we had a series of votes just at the time the hearing was scheduled to start. I will wait for some of my Republican colleagues and then we will get started. Mr. Buyer is here now so we will begin this hearing.

Mr. Secretary, we thank you for joining us. I know you are used to going to battle alone, and I see you have nobody on your wings here today, so good luck.

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

Today's hearing is on the preliminary budget submission from the U.S. Department of Veterans Affairs (VA) for our next fiscal year.

A few weeks ago the Administration submitted a preliminary budget, and it is a document that provides what they call "top line" budget numbers and brief discussions regarding Administration priorities.

I must say, Mr. Secretary, we are pleased to see that, even with this summary you had about a 10-percent increase in discretionary funding, and about a 20-percent increase in the mandatory accounts, for a 15-percent increase over all.

I will say to you, sir, that since *The Independent Budget (IB)* was first put out, a budget put together by our veterans service organizations (VSOs), yours is the first Administration budget to exceed *The Independent Budget*, and we are very happy that has occurred. I hope you can be proud of that. I have been using *The Independent*

Budget as my bible for the last 17 years. We know that the budget request calls for $25 billion increase over the next 5 years. We haven't had an Administration budget like that for a long, long time, so thank you, sir, and it looks like you understand, and the Administration understands, the importance of veterans in the budget.

We know these out-year numbers are not binding figures, but they are a good start. You put some interesting things in there, and I think the Committee shares your policy formulations.

For example, the decision to bring in the Priority 8 veterans, 500,000 as I understand it, is what many of us have wanted for a long time.

I think you also expand concurrent receipt, and again, many Members on this Committee have been working on this issue for a long, long time, so we thank you for that. We are looking forward to meeting the needs of our veterans in the coming year.

From looking at your Senate testimony and the testimony of some of the veterans' organizations, there is a controversial policy recommendation in the budget concerning collections—third-party collections.

We believe, Mr. Secretary, that you can meet your numbers for revenue, income, and third-party collections, without any policy changes, that is, by using existing authorities. We believe we can do that with the numbers you have created, without having to get into policy recommendations on third-party collections, and still meet the revenue needs that you have forecast in your budget.

In fact, both Mr. Buyer and I have been talking over the last several years with people who think that we are leaving hundreds of millions, if not billions, on the table from third-party collections, and we are both committed to seeing that you realize that without going into any policy shifts with regard to service-connected veterans.

Again, thank you for being here, thank you for the leadership that you have shown in your short time on the job. We are looking forward to working with you over the next 4 years, and I will now yield to the Ranking Member, Mr. Buyer.

[The prepared statement of Chairman Filner appears on p. 57.]

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Chairman, and good afternoon. It is my pleasure once again to welcome Secretary Shinseki back to the Committee, and thank you for appearing here today. I look forward to your testimony. I also look forward to hearing from the second panel of witnesses from the veteran service organizations.

Mr. Secretary, the funding increases outlined in your budget is welcomed. Overall, it is also a move in the right direction.

I do have some concerns, particularly with regard to the out-year numbers, and that is the gamesmanship that occurs in this town. And so when all is put together, the budget views and estimates, I will also try to make these projections with regard to the out-years.

It is a gamesmanship that is occurring through the Office of Management and Budget (OMB), and not that you haven't lived with this when you were over at U.S. Department of Defense

(DoD), but if we are going to put together a budget, we want to be realistic with regard to those out-years, we really need to prepare for them. And kind of what is happening is, there is so much lumped on the front end it is trying to make it look as though they are more fiscally responsible in the out-years.

I want to die in the out-years, okay? That way I will live forever. That is just the way we do budgets in this town.

The CHAIRMAN. I want to make an amendment to that.

Mr. BUYER. So I can live forever?

[Laughter.]

Mr. BUYER. Well, maybe you will be right there with me and we will create a lot of energy for a lot of years for somebody.

A number of factors, I believe, are going to place great demand, Mr. Secretary, on the VA, and so when I am talking about the out-years I think we have to prepare to handle it.

President Obama announced the draw down of the combat troops in Iraq, which will contribute to an increase in veterans seeking VA benefits and services over the next 2 to 3 years, the Priority 8's being enrolled, and I know we are moving incrementally what type of political pressures are there going to be from the veterans service organizations to even make—to accelerate that, especially at a time when we have the economic circumstances that we do. You couple that with medical inflation, that tells me that the out-line—the out-year numbers are too low in the budget that you have submitted to us.

Regardless of what the numbers are, it will require, I believe, bold action to ensure that the VA's health and disability systems are effective in delivering timely and quality service to our veterans.

I am also concerned about a proposal, and I have spoken to you about it, reportedly considering the billing of third-party insurers for the treatment of service-connected disabilities.

I told you in private, which I will also say public, I will be a good listener to your proposal; however, I believe that the proposal is contrary to our basic national obligation, and that is just how I feel. But that is my opinion, and I want to be a good listener to what you are proposing to us, and we will have it properly vetted.

So we will treat your proposal with respect, and we will figure out where it lies.

I also have a growing concern about the VA's ability to handle the thousands of claims it will receive next fall for the new GI Bill benefits.

As you know, I requested the VA Office of Inspector General assessment of the system being implemented to administer the new program. We must have a candid view of any problems as far in advance as possible, to ensure the VA is ready and capable when the new delivery system comes online.

The men and women of our Armed Forces do not hesitate when called upon to defend our Nation, and I think we, as the government, owe them the timely delivery of the benefits that they have earned.

Veterans will be relying on the VA to make timely GI Bill payments to them and their schools next fall, and it is incumbent on

Congress and the VA to make sure the program works as it was intended.

Also, when you appeared here last month, I expressed my concern over varying quality of care standards with regard to veterans' grave sites.

The Battle Monuments Commission sets, I believe, the gold standard. It is followed closely by the National Cemetery Administration. But I am not pleased, however, by the appearance of two cemeteries that are maintained by the National Park Service. Andersonville in Georgia and Andrew Johnson Cemetery in Greenville, Tennessee.

They have improved—they have improved it, and I have shared the pictures with you, but it is still—we should not have three tiers of standards with regard to how we honor those who came before us.

So I am close to the conclusion that the best solution would be to transfer the jurisdiction of these two open cemeteries to the VA, and I welcome your thoughts on that idea.

You had told me that you were going to be speaking with the Secretary of the Interior, so I anticipate if you could share that with the Committee, I would appreciate it.

I do want to note my particular agreement with the provision in the budget summary that states that the highly disabled veterans who are medically retired will be eligible for concurrent receipt.

When I served on the Armed Services Committee and chaired Personnel, I had $25 million and I took that and I popped the lid off the issue of concurrent receipt, and did it for the 100 percent disabled combat veterans. And that was the beginning of what you are now bringing to us, a budget for full concurrent receipt and it has taken about 10 years for this to happen.

So I agree with your proposal, in fact it is similar to a provision I have that is in one of the Noble Warrior Initiatives I have introduced. I also introduced the Armed Forces Disability Retirement Enhancement Act to simplify the military disability retirement and ensure that those found unable to serve will automatically receive retirement benefits based on rank and years in service. This is another issue we have discussed.

The Chairman has his ideas, I have mine, Danny Akaka has his, everybody has got a lot of ideas on how to do this one. We welcome your input.

And with that Mr. Secretary, I appreciate you being here, there are a lot of issues to discuss today.

[Ron Walters, Director of Finance and Planning, National Cemetery Administration, Department of Veterans Affairs, provided the requested technical assistance by telephone to Committee staff on March 30, 2009.]

The CHAIRMAN. Again, welcome Mr. Secretary. We are all, I think, knowledgeable of your outstanding record of service and personal sacrifice to our Nation having served with honor and dignity for 38 years in the United States Army, in Vietnam, in Bosnia, Afghanistan, Iraq, before your retirement as the 34th Chief of Staff of the Army.

You have been called a "soldier's soldier." We are looking forward to you being the "veterans' veteran."

We welcome you today and the floor is yours.

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

Secretary SHINSEKI. Chairman Filner, thank you, and Ranking Member Buyer, thank you for having me here today, and other Members—distinguished Members of this Committee.

Thank you for this opportunity to present an overview of the 2010 Budget for the Department of Veterans Affairs.

I appreciate also the opportunity I have had to speak with a number of the Committee Members in preparation for testimony during what has been a very busy legislative session, but regret that I was not able to get to everyone, but that is something I will correct in the future.

Let me also acknowledge and thank the leaders of our veteran service organizations who are here today sitting in our audience.

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

I have been conducting that comprehensive and fundamental review for about 7 weeks now, and would like to offer a quick status about what I have learned since my last appearance before this Committee.

New GI Bill. An outside consultant was hired to conduct a quick-look study to validate our plans and procedures for executing this large new program of educational benefits. The quick look was completed on 27 February, and it validated what we are doing and provided—validated the procedures and processes that we have in place and are executing, but provided us eight additional risk factors to consider. I have accepted them all except for one, which I accommodated internally.

I am satisfied that we will get veterans who apply in time into schools this fall. It remains high risk because of the compressed timelines we have faced since legislation was passed, but we have mitigated that risk responsibly, and at this point I consider the risk an acceptable one.

The 2009 plan for the new GI Bill will be a computer-assisted manual system. Computer assisted, but manual exercise. We hope to move to a fully automated system in 2010. We are just not able to get all the pieces in place this year.

But for 2009, user testing of the interim information technology (IT) solution was completed, phase one training for our newly hired 530 employees began yesterday, and I get updates on how we are progressing there.

The final regulation is at OMB, the contingency plan is finished, and final coordination is under way.

In my opinion all is in order to meet the August 2009 implementation date.

We still have multiple milestones to meet before then, and I will continue to keep the Committee updated as we achieve them.

Paperless. Our goal is to re-engineer the claims process into a fully paperless environment by 2012.

A leads system integrator has been on board since October 2008 reviewing our business processes and beginning key design deliverables, which we expect by August of this year.

Application developers will begin building specific components in early fiscal year 2010, capitalizing on recent successes with VETSNET and leveraging funding that should be available in next year's budget.

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

In conjunction with this paperless initiative DoD and VA have met three times now to address the potential for automatically enrolling all military personnel into the VA upon entry into the armed forces. We call this initiative uniform registration. We are in agreement about the goodness of such a system and have people working toward making it a reality.

Uniform registration will push both of us, both DoD and VA, to create a single electronic record that would govern how we each acknowledge, identify, track, and manage each of our clients, active and reserve component, who populate both of our departments, from the moment they first take the oath of allegiance in uniform.

Our management decisions will be better, faster, more consistent and fair, and less subject to lost files or destroyed claims. Such electronic records would have a personnel component and a medical component.

We have benefited from the insights and experience and advice of Secretary Gates and Deputy Secretary Lynn about not trying to build a single large database, so we are committed to doing this smartly and differently from some of our past hard lessons learned.

Electronic health record. In the VA's experience the EHR, electronic health record, has figured prominently in the growth and quality of medical services.

In 1997, we rolled out an enterprise-wide update to our EHR. We have been in EHR for about 20 years, but in 1997 we rolled out this enterprise-wide update.

Two years later, by 1999, that update provided a clinical data repository, including privacy protection, with real-time data flow across the entire system with clinical decision support and clinical alert templates, notification systems, and disease management features.

Today it has an imaging capability, EKGs, any test that has ever been taken as part of this, studies, procedures, endoscopies, scan documents are—can be part of this file.

International observers have called it—I will say some international observers have called it the gold standard in clinical informatics.

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

Now some would suggest that the VA's lower costs of treatment were as much a function of its lean budget in some of those years as they were of efficiencies and delivered services, and I think that is fair. But lean budgets were not just visited on the VA in those years, but at Medicare and other institutions as well, where costs rose 26 percent. So there is a variance between what our performance has been.

On the backlog. I have not made much headway in understanding or solving this dilemma, other than to acknowledge that it is a significant obstacle to building trust with veterans and the organizations that represent them.

I am not sure that I have a valid working definition for the backlog, but I am working personally to develop that valid definition. Not to define myself out of a problem, but if a claim is initiated today and I ask is it part of the backlog tomorrow and the answer is yes, there is no way for me to fix that. I have to define the backlog in a way that gives me an opportunity to measure it and then to set about correcting it.

So this is what I am about. And unless I can validly define and measure the backlog I would have a hard time fixing it, and I am about fixing it.

Our efforts to institute uniform registration and create a single electronic record will lay a foundation for eventually controlling the inputs to the backlog dilemma, but I must find ways to control and reduce the backlog as it exists today, and for the time being it is a brute force exercise. I put more people into handing these claims, because that is the only way to get measurable process. I am not sure that is the solution for the long term, and paperless becomes important to this consideration.

So having provided you this quick update, let me now report that our proposed 2010 budget is critical of realizing both the President's vision for the 21st Century VA, and also my opportunity to set about correcting some of these issues that I have described for you.

The proposal would increase VA's budget. As the Chairman as pointed out, $112.8 billion, up $15 billion, or a 15 percent-increase from the 2009 enacted budget. This is the largest dollar and percentage increase ever requested by a President for veterans.

Nearly two-thirds of the increase, $9.7 billion, would go to mandatory programs, which would increase it by 20 percent. The remaining third, $5.6 billion, would be discretionary funding and would increase that account by 11 percent.

The total budget would be almost evenly split between mandatory funding, $56.9 billion, and discretionary funding, $55.9 billion.

The 2010 budget funds the new GI Bill, and would allow a gradual expansion of health care eligibility to Priority Group 8 veterans who have been excluded from VA care since 2003. An expansion of up to 550,000 new enrollees by 2012. Further, it contains sufficient resources to ensure that we will maintain our quality of health care for veterans, which today sets a national standard in my opinion, with no adverse impact on wait times for those—or quality for those already enrolled.

The 2010 budget provides greater benefits for veterans who are medically retired from active duty by phasing in an expansion of concurrent receipt eligibility to military disability retirees.

The proposal allows highly disabled veterans to receive both their military retired pay and VA disability compensation benefits.

The budget provides resources to effectively implement the Post-9/11 GI Bill and streamline the disability claims process.

It supports additional specialty care in such areas as aging, women's health, mental health, homelessness, prosthetics, vision and spinal cord injury, and it helps extend VA services to rural communities, which lack access to care today.

The details of the President's budget are still being finalized and should be available in April, at which time I am happy to come back and address this Committee again.

So while I lack budgetary detail on specific programs and activities today, I do however look forward to answering your questions and am prepared to take those questions now.

Thank you, Mr. Chairman.

[The prepared statement of Secretary Shinseki appears on p. 57.]

The CHAIRMAN. Thank you, Mr. Secretary.

When I think about some of the issues that have been brought up over the last decade, issues that were thrown on the table and nobody listened to them, it is sort of scary to hear you come back with all them—so we are really glad to have you here today.

Mr. Michaud, I will recognize you for 5 minutes, please.

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

First, I also want to thank you, Mr. Secretary, for coming here, and look forward to working with you as we move forward over the next couple of years to make sure that we provide adequate funding in a timely manner for our veterans.

I do have one question, but I also have a comment. I want to follow up on Congressmen Buyer's remark.

You mentioned the backlog and building trust with veterans organizations and with veterans. Having not seen the budget language, I have heard the same rumors that I am sure a lot of Members here have heard, about the Administration, whether it is OMB, whether it is the President, whoever it is, I don't know, want to have third-party payment on service-connected disability.

If that is in the budget, I will not be supporting the budget. It is unconscionable, and it is an insult to our veterans who have been hurt overseas.

So hopefully you will give that message to OMB as it relates to third-party collections for the disabled veterans. It is just unbelievable that anyone would ever think of doing that in this budget.

So hopefully it will not be in the budget, but that is what the rumor is out there. Hopefully you will do everything you can do to persuade those who are pushing this, if fact they are, not to include it.

My comment is that I would like to commend everything that you had mentioned about the budget outline that focuses on access and services for post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and our rural veterans.

As you know, Maine is a very rural state. We have a large number of veterans in Maine, and I look forward to working with you to provide our veterans with greater access to PTSD services.

Can you offer the Committee your ideas on how VA plans to make these services available to rural veterans? And could you offer the Committee your assurance that the VA will work with Congress to ensure that these priorities will be enacted into law to take care of our veterans?

Secretary SHINSEKI. Certainly, Congressman.

I will tell you that I have been engaged in discussions about the rural health issues with a number of Members of this Committee, as well as other Committees, and I am sensitive when I look at a map about how much of the country is either rural or highly rural, and that provides challenges.

I think for us the movement in the VA away from singular hospitals as the only measure of health care deliverability to other options that included community-based outpatient centers (CBOCs), outreach clinics, mobile clinics, and so forth is the right move, and it has been under way for some time now, we are just building more capacity here. But it does reach not only the veterans who can't get to the hospital, but gets to those areas where there are no hospitals, and I will continue to treat this as a priority.

I think you know that we are implementing a rural health pilot project involving mobile clinics at four of our Veterans Integrated Network Services (VISNs), and we will look to the goodness that comes out of that to inform us on how much faster and what else we can do in that area, but I am sensitive to the issue and this will continue to be a priority.

Mr. MICHAUD. Well, I want to thank you very much for making it a priority, because those are a lot of the complaints that we hear. For those of us who are from rural areas it is that whole access issue, so I really appreciate your making that a priority, look forward to working with you, and really appreciate your willingness to meet with Members of Congress on both sides of the aisle to get our concerns and hear them in advance before you move forward with policy. I really appreciate that.

And I realize that you have a boss as well, and you have to deal with OMB, so hopefully you will deliver that message, and when we meet—or when I meet with the OMB director I will be delivering that message personally as it relates to collections for soldiers who are injured on the battle field.

So thank you once again, Mr. Secretary, for coming here today, appreciate it.

Secretary SHINSEKI. May I just add a point here? That is a consideration. It is not in the budget, but it is a consideration, and I will be sure that your concerns are delivered.

And again, we are talking in health care the two aspects of this are delivery of health care and the financing of it, and this is about the financing.

I want to assure you that there should be no concern about the delivery, that we will provide the best quality health care we can to our veterans. That is not discussable.

Mr. MICHAUD. Thank you.

The CHAIRMAN. Thank you, Mr. Michaud.

Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you very much.

General, thank you for joining us today, and thank you for the opportunity I had to visit with you in my office earlier this year.

There are a couple of bills that are being implemented, or should be implemented, by the Department of Veterans Affairs in this current year.

One, you mentioned in your testimony, the GI Bill, and I look forward to working with you on this bill. I hope you will spend a lot of time with veterans and with financial aid officers at universities and technical colleges trying to make certain that we do this in a very effective manner.

Second is the implementation of a bill that I introduced that became law last November.

You mentioned four VISNs in an implementation of mobile vans in rural areas. There is also another rural program that we created in the last Congress that you will be implementing, and I want to stress that how it is implemented is so important, because I want this program to succeed.

And that is that if there is no outpatient clinic or VA hospital within a certain distance of our veterans, that in four VISNs you are to implement a pilot program in which you contract with local providers to provide those services to veterans.

One of those VISNs is, in fact, the two VISNs that I represent in the state of Kansas, are included in that pilot program, and I would love to have the opportunity to visit with the appropriate staff, personnel at the Department of Veterans Affairs about this implementation if you could make that possible.

In addition to those two implementations, I would be delighted to hear your thoughts about health care provider recruitment and retention.

As I listen to my VISN directors and hospital administrators within the part of the VA that I represent or the geography that I represent, the Department of Veterans Affairs is no different than the private sector in many ways regarding to the inability to attract and retain the necessary health care professional. It is particularly true I think in specialties, but specialties dealing with mental health, mental illness, at a time in which the need seems to be a priority of ours.

And finally, I would like your comments on advanced appropriations. My understanding, from comments that you made and that President Obama made, is that the Administration would be supportive of legislation allowing for advanced appropriations.

It is my understanding that there is some belief that you are now talking about a timely funding as compared to advanced appropriations, and I was interested in knowing the difference between those two phrases. And I thank you, sir.

Secretary SHINSEKI. I am not sure I can answer the last question there, but let me start with the beginning.

We need to be better at recruiting and retaining health care professionals and workers for rural areas.

The VA is working with the National Rural Recruitment Retention Network to one, to be linked in with them, but also to get bet-

ter at the business of training our people, our recruiters on how to do this. So we are taking that on.

There are incentives for recruitments such as the Education Debt Reduction Program. And besides that, we also look at the opportunity to employ an outreach clinic, which is not a full-time clinic in a given area, but we will go for a period of time, set up a clinic, bring in all the health care professionals we need, and conduct the clinic for a regular, but limited time, and see as many patients as need to be seen.

The patient load is not enough to keep that clinic open full-time, but it gives us an opportunity to one, see what the needs are, and also address some of these issues.

Regarding advance appropriations. I believe a couple testimonies ago I indicated that I think even then that I said my preference was for timely budgets.

My experience with continuing resolutions always pointed up some difficulties for those of us that had missions to execute, especially where health care and other services were concerned, and if timely budgets were not available, then advanced appropriations may be an appropriate alternate way of looking at this.

I now understand that timely budgets are what we are going to do, and so that is what I am going to go to work on, my piece of it.

Mr. MORAN. Mr. Secretary, thank you.

It is pleasing to me that you are able to speak on behalf of Congress, that we are going to do our work in a timely fashion and avoid continuing resolutions. I hope your optimism is founded.

The CHAIRMAN. Thank you, Mr. Moran.

Ms. Herseth Sandlin.

Ms. HERSETH SANDLIN. Thank you, Mr. Chairman.

Secretary Shinseki, thank you for being here today, thank you for your testimony. We had a chance to visit again earlier this week, and I look forward to continuing to work with you to strengthen and transform the VA to meet the needs of our Nation's veterans.

Thank you for helping craft the largest ever increase in VA funding. I appreciate the VA's commitment to assuring that it has the resources it needs to meet a very long list of challenges; however, Congress must also conduct proper oversight to ensure that taxpayer dollars are spent wisely and that programs are implemented effectively, and more funding can't alone guarantee better services, aggressive oversight is also needed.

Now as you know I serve as the Chairwoman of the Economic Opportunity Subcommittee, and along with the distinguished Ranking Member, Mr. Boozman, we have been working closely in our oversight capacity with Keith Wilson, Director of the Education Service, and Stephen Warren, the Principal Deputy Assistant Secretary for the Office of Information and Technology. And just recently on February 26 we held yet another oversight hearing to review the VA's process in implementing in Post-9/11 GI Bill, which you addressed in your opening remarks.

Now at that hearing, Mr. Wilson and Mr. Warren indicated what you have indicated today, that the VA remains on schedule to implement this new benefit by the August 1st, 2009 deadline. And

while we remain cautiously optimistic that the program will continue to move ahead on schedule, we also know that any disruptions to the plan will likely cause the VA to miss that deadline.

Now in your opening statement, you indicated that the fiscal year 2010 VA budget will fully implement both the short-term and long-term goals of the Post-9/11 Veterans Education Act, and I appreciate your continued support for the program, and I encourage you to be up front and open with the Committee if any problems arise or if any additional resources are needed.

Could you perhaps address or share your thoughts on the concerns that have been recently expressed regarding the variance of the benefit by schools, by states, and how we can go about addressing those concerns without disrupting the August 1st deadline?

Secretary SHINSEKI. I understand there has been some concern expressed. I am not totally familiar with all of them. I am told they are not a single concern, but I am on a timeline right now that is fairly precise.

New forms are going to be available on 28 April. Veterans apply for certificates of eligibility, 1 May. VA processes enrollment information from schools and authorizes payment, 8 July. Tuition fee payments are issued to schools beginning first week in August. Housing allowance, books, supplies, stipends, et cetera, 2 September.

It is a very tight timeline. I am willing to work these issues. I am just concerned that if I have to pull back the regulation that it has taken us 8 to 9 months to put in place to adjust them and to undo some of the programs that we have already put in place and have begun training on, that it risks this timeline.

So I am happy to take on the concerns. I am not sure that I can do it this year and also meet the August start dates.

Ms. HERSETH SANDLIN. I appreciate your thoughts.

Secretary SHINSEKI. I will analyze that.

Ms. HERSETH SANDLIN. Mr. Secretary, we look forward to working with you on that.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Boozman.

Mr. BOOZMAN. Thank you very much.

Again, we appreciate your service, and I really look forward to working with you in the future, and we appreciate you being here.

The forward budgeting, again, that seems to me like it—I know you have been in a situation where because of continuing resolutions and things like that you start having to juggle money around, but it does seem like if that were done correctly, and I don't really have the answer to it, but it does seem like something that we really ought to look to in the sense that when you start juggling funds around like that when we put the agencies in those situations, and Congress is the one that is doing that, and I think, you know, if you look at past Presidents, it is not a partisan thing, you know, it happens on both sides regardless of who is in the White House, regardless of who is controlling Congress, but it does seem like that is a way to actually save some money. That, you know, you would be in a situation where you could better look at your budget and then again actually save some money from not juggling around.

So that is something that is going to be coming up again. I would just encourage you to really look at that and then give us some good ideas and some good guidance as to, you know, if that is possible to implement.

The other thing is—you know, I am excited about hearing that we have the potential to increase our Category 8s as far as serving them.

One of the concerns though, that we have had is that we have worked really hard to get our times down and things, is that we do that and then we don't put the resources in place, the added personnel, the added infrastructure and things like that, and so then we go back to the waiting times that we have worked so hard.

I understand the importance of that. My dad was in the Air Force for 20 years and was a recruiter, and a lot of these individuals, you know, were told that they were going to get health care and things, and so I think it is an important commitment, something we need to do.

Can you comment on that? I guess at some point in time we are going to have 525,000 additional Category 8s, so half a million people. Can you talk to us a little bit how you are prepared to do that?

Secretary SHINSEKI. Yes. The timeframe of establishing this program, beginning in June of this year out to 2013 and hitting that 550,000 potential enrollee mark is designed to let us get it started, and then adjust as we go. I mean, if it is possible to go faster then certainly we can do that, if not then we need to slow things down.

The issue here is to ensure that we don't put at risk any of the programs or any of the quality of services being provided to enrollees today, to veterans who enroll today, and so that—your question is appropriate. I will have to look at this as we start and increase the program.

As I indicated, the first year up to 266,000, which is a significant number. We think we can handle that.

Mr. MORAN. I thank the gentleman from Arkansas for yielding.

Mr. Secretary, is your philosophy or your belief that all veterans should be covered? All Category 8 veterans should be included in the health care delivery system, and it is just a matter of getting us to that point in an orderly fashion that doesn't cause a detriment to the rest of the system? Or do you believe that under a certain set of criteria those veterans should be served?

And I thank the gentleman for yielding.

Secretary SHINSEKI. Priority Group 8 veterans are veterans. What distinguishes their entitlements right now is circumstances that have to do with economics or location, but they are veterans.

If it is within my ability to reach them, I don't know how to not include them in the consideration.

Whether I can find ways to reach the affordability factor here, I don't know, but this is why this program is phased in over a period out to 2013. That will give us an opportunity to assess how we are doing and ensure that we are maintaining the quality standards I am describing here, and then make decisions at some point down the road.

To answer your question, whether all Priority 8 Group veterans should be included, today I can't tell you how many are in the Pri-

ority Group 8. I need to come to some way of estimating that before I can fully answer your question.

Mr. MORAN. Thank you, Mr. Secretary, thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman and Ranking Member Buyer, and thank you Mr. Secretary for your service, and for the President and you showing the overwhelming support of veterans that you have shown in this budget. The first time I believe in our history where an Administration has proposed a budget that exceeded the recommendation of *The Independent Budget*.

And I also want, as the representative from New York's 19th District, home of your alma mater, West Point, to say that the veterans in my district are especially proud of you and supportive of your service now as Secretary.

In regards to the budget, I understand you can't go into specifics, but I would like to ask you about PTSD in particular.

As you know, I have a bill introduced in this Congress that would establish service in the theater of combat as a presumptive stressor for the occurrence of PTSD.

For too long, I believe veterans have had to leap through hoops or over hurdles to prove specific events that caused their trauma, and my bill would remove this burden if they served in the uniform of this country in a war zone.

Can you tell us your thoughts on how the VA could facilitate such treatment and compensation for PTSD and how the budget would play a role in this?

Secretary SHINSEKI. Are you referring here to the determination of precursor for PTSD based on——

Mr. HALL. A presumptive stressor being established in this legislation.

Secretary SHINSEKI. I would start out by first pointing out that I am not a clinician here, and so I rely on those experts who help me understand what might be the precursors for validating PTSD as a condition.

I do know firsthand that you don't have to be in combat to go through trauma that could result in PTSD. I think there are ample cases of assaults on women that give us an understanding that that is enough of a traumatic experience to create the conditions for PTSD.

So my sense here is this is an area that requires a clinicians determination, but I would—I would also say that I have been in operational zones where servicemembers have been exposed to conditions that were horrific enough, they were not involving combat, and PTSD determinations were made on those individuals being in an operational environment.

I am willing to work with you in trying to understand how we best address this issue, PTSD, and TBI issues, which we are trying to put our arms around with regard to mental health as an area for us to spend more effort in.

Mr. HALL. Thank you, sir.

And the legislation does require diagnosis of the symptom, so it is not just having been there, and I appreciate your comments on

different people handling different experiences in a different way, but I thank you and look forward to working with you on developing and refining that legislation.

Regarding the IT progress that is being made in response to legislation this Committee passed, can you tell us—give us an update as to where the Department's efforts are in this area and how confident you are that when the IT account level is established it will be sufficient to meet the requirements mandated by Congress?

Secretary SHINSEKI. You are looking for where we are going to put our priorities?

Mr. HALL. Well and just sort of an update to tell us somewhat about the paperless—moving toward a paperless claims system.

You also talked about, you and the Secretary of Defense, which I think is a terrific idea, having single enrollment so that starting with new servicemen and women that record would then hopefully continue and already be in the system, and that will obviously help future cases. But in terms of our existing veterans population, how is it being approached and what kind of progress are you making so far in moving toward paperless claims in particular I am concerned with?

Secretary SHINSEKI. In terms of just the IT arena, we are strengthening our network security operation in terms of tools, standardizing desktop systems and components, and beginning to put into place our process for determining how to attack the backlog.

Based on our experience with what the electronic health record did for us in terms of health care between 1997 and 2004, we are looking to have the same kind of effect by smartly introducing IT into this area of adjudication.

As I think I have mentioned before, 11,100 adjudicators today—actually it is 11,300 since the last time I was here to testify. That is a leadership issue, that is a training issue, but it is still a brute force solution that right now the way I get faster at this is to hire more people.

I am not sure that that is the solution, and I am looking for a way to address this quickly, and IT is very much a part of this.

Mr. HALL. Thank you, sir.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Bilbray.

OPENING STATEMENT OF HON. BRIAN P. BILBRAY

Mr. BILBRAY. Let me start all over again by saying I want to thank you for your fresh approach.

But actually, Mr. Secretary, I want to say sincerely I appreciate your fresh approach. There is a lot of people that have had your hot seat, and believe me it will be tough, and I just want to say that I think that we are starting off on a good footing. I think it is something that both sides can really hope for your success, pray for your success, but more importantly work together for your success. And as son of a veteran both of deceased veterans and a mother who still are getting benefits from your organization, your department, I appreciate your approach to this.

My only warning to you is that 2 years from now, let us just hope we have that much of a positive, and that is a challenge of all of us working together.

And I just have to tell you personally being a personal friend of the Chairman, believe me, he can be a tough overseer. He can be one of the toughest guys I have ever worked with, especially when you are at your end of the dais, so I look forward to your success. I look forward in a few years being able to look the Chairman in the eye and matching him success for success. So good luck, okay?

Secretary SHINSEKI. Thank you.

The CHAIRMAN. Thank you, I guess, Mr. Bilbray.

Mr. Perriello.

Mr. PERRIELLO. Good afternoon.

Let me begin by thanking Chairman Filner and Ranking Member Buyer for convening this important hearing on the Department of Veterans Affairs. Let me also thank everyone on the Committee for their prayers and thoughts for my family during my absence over the last couple of weeks due to the loss of my father, who was proud to have worn the uniform of the U.S. Army.

Secretary Shinseki, I want to echo the sentiments of my colleagues in welcoming you back to the Committee, and for all of your service to this country when you wore the uniform and in your current capacity.

It is indeed exciting to see such an unprecedented commitment to veterans, and it is a timely moment for this leadership surge as we see the unprecedented convergence of some very severe challenges. Veterans returning home to a very bleak job market, returning home to a bleak housing market, and dealing with the unprecedented mental health challenges of PTSD and TBI.

It is a great time to have your leadership and a very challenging time in terms of living up to the pledge we have made to our veterans.

I would also like to recognize the VSOs present here today for their work in preparing *The Independent Budget*, which has been met, matched and exceeded. Thanks also for increasing intergenerational cooperation between veterans past and present. It has been very helpful to all of our offices to be able to share your breath of wisdom.

As a representative of a rural district, I just wanted to ask you two questions. One, specifically what commitments we are ready to make to ensure we are taking care of those veterans returning to rural areas? And two, the strategies for addressing the specific challenges of the current economic environment into which our veterans are returning.

Secretary SHINSEKI. Congressman, I think I will quote President Obama here when he says, "That veterans lead in lost jobs, homelessness, substance abuse, and a tendency toward being part of that suicide discussion."

And so, my sense is that if we are able to help up front, first order of things here matter. If veterans come home and we have a good way to identify who they are, get them into our programs. For those who are injured, get them safely and completely through the vocational rehab process.

I know that right now we are not doing very well at that. Many of them indicate interest, lesser numbers show up, and even fewer complete the program. Some of that has to do with economics, and I need to get inside of that. But we show that if they will complete that program the opportunity for placement and successfully getting a job is much higher.

Both Secretary Donovan from the U.S. Department of Housing and Urban Development (HUD) and I have appeared before the Coalition for Homeless Veterans to hear them primarily, but then for the both of us to commit to working on the homeless veteran issue in this country. It used to be about 240,000, today it is 154,000.

I would like to tell you that there are some programs out that there that we have found to have been successful in reducing by 40 percent that number. And again, these are estimates, so I am a little reluctant to put a hard pencil on it, but I am told that we have reduced those numbers significantly.

If we can get these veterans back and keep them from going homeless I think we have a much better chance with our programs. If it is substance, abuse to get them off of it. If it is educational initiatives, to get them engaged in vocational rehab training, and get them situated for turning a page and being successful in the next phase of their lives.

These are all successful people, they were successful in uniform, and our responsibility here is to get them back on that track again.

If we can do that up front, and that requires the VA working with DoD to get this transition into our programs, working with education for those issues, working with the U.S. Department of Health and Human Services (HHS) for the health care issues, working with labor on jobs, and HUD for housing, we have a much better opportunity to reduce the 154,000 homeless veterans today to something significantly less.

Mr. PERRIELLO. Well, I just want to commend you for your support of vocational and on-the-job training programs. For many of the veterans in my district this is a top priority. The GI Bill, expansion in education has been great.

I have authored a bill, which would expand on-the-job training. Vocational and skills training programs are really a lifeline to living wage jobs in my area, so I commend your support of this and look forward to working with you on it.

The CHAIRMAN. Thank you.

Mr. Roe.

Mr. ROE. Thank you, Mr. Chairman, and thank you General for coming by the other day and visiting my office.

And it just, as I was sitting here I remember when I was in college when the entire budget of the United States was $100 billion, and now the VA budget is over $100 billion this year.

Just a couple of comments. One, on the Category 8 veterans. I was glad to hear you say in your testimony, or your answer I should say, that veterans are veterans.

And we may have talked, I think, last week in my office about a veteran that I know that is a sheriff in a county, and the county is so poor that they can't provide health benefits for their county employees. No county employee has health insurance. This veteran makes a little bit more money as a sheriff of the county than is al-

lowed apparently, and I am not sure what that number is, and I don't know whether this 10 percent-boost will help him or not, but he should be able to go to the VA medical center in his district, which is close by, and I am glad to hear you say that, and I would like to work with you to make that—and this Committee, to make that happen for all veterans.

On the backlog. I was just wondering if you know any of the—or do you know the demographics of our veterans population now that they are currently using the VA?

And the reason I bring that up is because just looking at this budget going forward it doesn't seem like that it is realistic. If we raise it 10 percent this year and then look at a 2 percent basically, which is not going to be inflation for the next several years, that doesn't seem to be adequate to me to do that.

Would you comment on that?

Secretary SHINSEKI. Well, I would just offer that timely budgets allow us to work the budget that is being considered, just as we did this one. And I think I would share the concern looking out that more work needs to be done as we get to those budget years to get resource levels where the priorities that I think we will be facing will be appropriately addressed.

It also touches, I won't say directly, but it also touches on the issue of advanced appropriations. Because sitting here looking out several years and trying to figure out how to put that in place I think is the reason that timely budgets become discussable.

And I will accept Mr. Moran's caution here. I was not suggesting that I could do this, I was just suggesting that I will do my part.

Mr. ROE. I guess the question I am asking is, as we look at the veterans that are currently using our facilities, 1,500 or so World War II veterans are dying every day. And what percent of the VA budget is going to caring for them and then the other Vietnam veterans and so forth that we know are going to be around a while longer?

Secretary SHINSEKI. I am sure there is a number, Mr. Roe. I will try to go figure it out, but I don't have that detail today.

Mr. ROE. Yeah, that is very important in going forward in to know whether your resources are going to be—whether you may have less demand, who would know.

Secretary SHINSEKI. Yes, our Vietnam veterans are today the largest population of our veterans.

Mr. ROE. So that obligation is going to be going on for a while.

Secretary SHINSEKI. Right.

[An April 20, 2009, follow-up letter from Secretary Shinseki to Congressman Roe, regarding the percentage of the budget going to care for World War II, Vietnam Veterans and other veterans of other eras, appears on p. 143.]

Mr. ROE. I guess the other question we talked about we are changing this electronic medical record. And to answer Mr. Hall, it is going to be more money than you think it is going to be. We did that in our own office and changing our medical records to electronic medical records was a very expensive undertaking and a lot more laborious than we thought it was going to be, but I think it is essential that we do that.

And what I would recommend you looking at doing, it worked for us, is any new veteran that comes in enter them into the EHR system. And exactly what we were talking about, when a soldier is signed up today enter them into the system. And then as you have an active file open up do that person. One that is working along just fine get to them later. And I think you will find that works pretty—and of course the archive files, I wouldn't fool with them unless something came up.

Mr. BILBRAY. Would the gentleman yield on that point?

Mr. ROE. Yes, the gentleman yields.

Mr. BILBRAY. Yes, I would have to echo that strongly. Rather than having to go back and recapture old information, actually phasing it in is by far a much more effective way to be able to implement the program, and I just have to really reinforce what the doctor is pointing out here, and I yield back.

Mr. ROE. Thank you. Yes, that is the method we used and it worked fairly well. It will be hard, it will be difficult any way to do, but I look forward to getting that started and getting done, because I think that is going to be part of being able to get that information out there and handling it appropriately to get this backlog of 900,000 people. And I agree with you, are you a backlog when you just—are you 900,001 if you sign up today then you will be part of the backlog.

So thank you.

Secretary SHINSEKI. If I might. Electronic health records have other benefits, and I know there is cost associated with it. But for example, in 1996 patient records were available to the doctors about 60 percent of the time, today with our electronic health records, 100 percent of the time a doctor has a record with a patient, and not just the form, but every chest x-ray, every brain scan, every blood test for the history of this patient is available so that the doctor can make some longitudinal decisions based on what has happened here.

In 1996, the VA lagged industry in terms of pneumonia vaccinations for patients over age 65 at about 28 percent. Today we are at 94 percent, and all of this is information available to health care providers to make the right decisions.

And I think that this increases the quality of health care and reduces the cost, because it is preventative. It also allows us to do our part in reducing that figure that is out there about 100,000 patients falling victim to medical errors or poor decisions because of lack of current records. So there are other returns here.

The CHAIRMAN. Thank you.

Mr. Walz.

Mr. WALZ. Well thank you, Mr. Chairman, and thank you Mr. Secretary once again for being here.

The Chairman mentioned it might be a little lonely there, but you know there are plenty of people that have your back. I see some friendly faces. I see Paul Rieckhoff and Rick Weidman and Steve Robertson and others, they are always there for you. They are always there and they speak for millions of veterans, and we are all in this together.

So I really appreciate your assessment on the GI Bill, your very candid assessment of this claims backlog. I think that is refreshing

to let us get at it. I think your assessment that it is going to take brute force might be the only way to do it right now, but it gets us back to how do we make sure that start to reduce that and we start to get smart in the future?

I agree with you, and this electronic medical record is a big one.

And I will throw one in on top of that, that you said that there are people that believe that is the best. I represent the Mayo Clinic, and they always echo that, that the way that the VA handles their medical records is the best in the world, and they pioneered the procedure, and they have done it on a massive scale themselves too.

And so Dr. Roe's cautions about this, it is very—it is much more difficult than creating a database, and it is much more than just putting things into the computer, it is how we use them and the ease of use to not only save money but to improve patient care.

I just have one question. I am very excited too about your opening comments. When you were here last time you talked about a uniform approach to registering folks—when they raise their hand to defend this Nation they have also raised their hand to be part of the VA system—and a way to get to that.

So my question deals with seamless transition. I brought it up before. The Chairman has been very proactive on this and has allowed me to ask some of these questions, then to move forward.

My question deals with how are we going to get to that? Because the one thing I always know whenever I am in this Committee room, nobody from DoD is ever here, and that poses quite a problem. It is very difficult on interoperability, and this is one of the questions I want to ask.

I, too, am very pleased with the budgeting and all that, but I am also concerned, many of these issues do need the funding, but it is more than just the funding, it is intelligent funding, it is how we use them, it is how we force that seamless transition in interoperability.

So I just want to ask maybe a generalized question on this. How do we go about that?

In the National Defense Authorization Act last year, and the year before, there were some initiatives in there to get going on this. There was one very specific one on the Eye Care Center of Excellence. And the VA, under Secretary Peake, I think, took a very proactive forward-leaning approach and got after it. DoD, I have a hard time getting phone calls returned, and it takes a story in *USA Today* to start pushing, okay, we are going to get going on this. I think they do a very good job. You have been there; I have been there. They see themselves as war fighters. They also have to understand with a little bit of front help on this we can also take care of these warriors during their lifetime.

So I would just like to ask, I know it is a bit subjective and a general question. How do we bridge that gap? How do we get interoperability? How do we—those of us in this room—make sure that Chairman Skelton's Committee is ready to sit down with Chairman Filner's Committee to figure this seamless transition out once and for all? So please.

Secretary SHINSEKI. Well, the way I have approached this is to take this on at Secretary Gate's and my level, and he is been more

than forthcoming. I have met with him personally three times. We have discussed this issue. And I will tell you not everybody in the room was necessarily in agreement on whether to do this, but with his leadership and his determination, we are moving forward on uniform registration, and that will become the forcing function. If we agree to that, then the electronic record becomes a by-product of that decision.

Mr. WALZ. And the timeline on that? You were looking at 2012, or did I hear that correctly? That is kind of the——

Secretary SHINSEKI. Well, that is for going paperless inside our claims adjudication process.

Mr. WALZ. Okay.

Secretary SHINSEKI. I don't know how soon. 2012 would be well off the timeline.

Mr. WALZ. How is that funding mechanism going to work? When we fund for the VA and the DoD how do we ensure these—this seamless part, this compatibility, these joint operations? How do we ensure that funding is steady, and as I said, intelligent, and we are not duplicating, we are not creating our own silos and the things that we have done for years and years and year? Do you have any vision on that?

Secretary SHINSEKI. Well, there is always the tendency for that to happen.

This will require leadership on both of our parts to agree on a single electronic record, and force the people that are going to be the users of that record.

If it is our medical personnel, bring doctors and nurses from both sides into a room, a small room, and have them define for us what that electronic record ought to look like.

We each have one today. The problem is they are not identical, and while you can extract information from each other's systems, it is not fully open architecture where you can pass the entire record, which is the problem we have today. We can't take the record when an individual transitions.

So we need to get at that, but it is going—that is a leadership issue here. And we both left our own systems with probably design and upgrade to our current system, and that is what we are against.

We want to come up with a system that is going to serve both of us, and whatever it looks like that is the requirement we should be building to.

Mr. WALZ. Well, I appreciate that, and I feel great confidence in the two leaders we have there, and so that is comforting as a first start.

Thank you. I yield back.

The CHAIRMAN. Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. Appreciate it very much, and thank you for your service, General.

I have one question regarding concurrent receipt. I understand that the budget will expend funding for concurrent receipt. Can you elaborate a little bit?

Thank you.

Secretary SHINSEKI. Concurrent retirement disability compensation is going to be put into place over the next 4 or 5 years, but it begins 2010 with the highest disability categories, and then incrementally, so that in the 2013, 2014 timeframe we are looking at the 10 and 20 percent military disability retiree having that entitlement in place.

Mr. Bilirakis. As far as medical retirees, my understanding is that if you have less than 20 years you will receive up to 50 percent of the VA rating; is that correct, General?

Secretary SHINSEKI. I don't have the details exactly of what less than 20 years in this category, but I would be happy to provide you the details that will address the entitlements in 2010, and then each there after.

Mr. Bilirakis. Thank you. Thank you very much, we would like that.

Secretary SHINSEKI. It is a cascading set of military disability retiree from the highest categories down to 10 and 20 percent in the 2013, 2014 timeframe.

Mr. Bilirakis. Okay, I would like those details. Thank you, sir.

Secretary SHINSEKI. Okay.

[The VA subsequently provided the following information:]

CONCURRENT RETIREMENT AND DISABILITY PAY

- CRDP is a "phased-in" restoration of military retired pay first authorized by the Defense Authorization Act of 2004, effective January 1, 2004-retroactive payments started in September 2006.
- The Defense Authorization Act of 2005 eliminated the phase-in of veterans entitled to a schedular 100 percent-evaluation.
- The Defense Authorization Act of 2008 eliminated the phase-in requirement for individual unemployability recipients, retroactive to January 1, 2005.
- Retiree must have 20 years of service and be evaluated at 50 percent or more.
- CRDP *is* retired pay, *is* taxable and enrollment *is* automatic.
- VA computes the CRDP amount based upon Base Rate and Phase-in schedule.

2004 Base Rate	
Combined Disability Evaluation	**CRDP Payable**
100%	$750
90%	$500
80%	$350
70%	$250
60%	$125
50%	$100

Phase-in Schedule	
Year	**Waived compensation payable in addition to base year amount**
2005	10%
2006	28%

Phase-in Schedule	
Year	**Waived compensation payable in addition to base year amount**
2007	49.60%
2008	69.76%
2009	84.88%
2010	93.95%
2011	98.18%
2012	99.64%
2013	99.96%

- VA has released over 100,272 CRSC and CRDP retroactive payments totaling over $286 million.
- As of May 1, 2009, 256,329 military retirees are receiving CRDP.

CRDP NEW CHAPTER 61 COHORT

- 2010 budget expands benefits to include chapter 61 disability retirees with less than 20 years of service at all disability levels, not just 50 percent and above.
- 2010 budget for CRDP totals $47 million.
- New chapter 61 cohort has separate phase-in schedule based on combined degree of disability.

Phase-in Schedule	
Year	**Combined Degree of Disability**
2010	100% & 90%
2011	80% & 70%
2012	60% & 50%
2013	40% & 30%
2014	All Ratings

- **Key point:** The amount available for either CRSC or CRDP is the amount of retired pay earned (2.5 percent × years served × base pay).

The CHAIRMAN. Thank you.

Mr. Snyder.

Secretary SHINSEKI. Once the budget is completed.

Mr. SNYDER. Thank you, Mr. Secretary. I am sorry I was not here for your opening statement.

I wanted to just make one comment, and then give you your softball question for the day so that—the only comment I want to make is we are waiting on the details of the budget is, one of the issues that has come up through the years is in a way, I think, it has been a double counting of Federal research dollars. And by that I mean, I will just use some numbers that are not realistic, but let us suppose you have a pool of money at National Institutes of Health (NIH) of $50 million and the Veterans Health Administration is able to get $10 million of that to help with their VA research, and then we see a budget number that says oh, we have—they put $40 million, they have $50 million of research dollars, and

you add those numbers up and you say we have $100 million of research going on, when in fact we only have $90 million of research because the money gets, you know, the NIH folks and the Congress that look at it say oh, we have a good number here, and we look at this number and say oh, it is a good number here, but in fact, it is a double counting of money. And I would encourage you to sort those numbers out in a way that is transparent.

I hope that the VA will be competitive, that VA researchers will be competitive for other sources of funds, but let us not try to fool anyone into thinking that somehow we have this great plussed up number, if in fact what we are doing is counting on good researchers to get dollars from other sources.

I think we need a good healthy number that involves your dollars, and that is one of those issues that several of us have been following along through the years, and have been pleased with the quality of research that can come out of the VA system.

My softball question is this. You are a guy who came out of a system, a fairly dramatically different system, that you have committed almost all of your adult life to and you are now into a new system. You have had several months to get up to speed and look at the culture that you are in and all the details.

What have been your biggest surprises, either good ones or bad ones as you have spent the last several months getting up to speed on the VA system?

Secretary SHINSEKI. I guess surprises, I guess would be the number of reports I sign and send to Congress. I was surprised at the number of reports I submit daily. And I think in time I hope to earn the trust of the Committee that I am on a good track and doing the right things, and where it meets your needs I will provide every report, and where it is less useful I would look for an opportunity to come to an agreement on how we harmonize those requirements, because they are pretty significant.

There are other surprises, but that was the one that stood out.

Mr. SNYDER. I think that is something that probably a lot of us would be interested in working on. It is really easy for us to include in some bill we need a report on this without—we probably should have a requirement that they have a number on it. You know, this is the 102nd report that is required by the Secretary, but I think that is certainly something that a lot of us would be interested in looking at to make the reporting information more streamline.

Thank you, Mr. Secretary.

The CHAIRMAN. Mr. Buyer.

Mr. BUYER. We are going to have different interpretations here, since Mr. Bilirakis asked his question. It is a very complex issue, because we have multiple disability systems, and trying the figure out who is in and who is going to be left out of this type of proposal and their different interpretations by what is out there. So I am at a little disadvantage.

Dr. Snyder is right, we don't have the details and it is hard for us. Even this Friday, it is truly Friday the 13th for us, because we have to deliver our budget views and estimates without any details. And I am not picking on you, it is just even when we changed Ad-

ministrations in 2001, the same thing happened. We just didn't have the details.

So I just want you to know we are going to come and do some real questions for the record on the concurrent receipt so we can better understand how you are going to implement this.

One of the other questions I have. The status of the VA report on—the VA economic recovery report. Do you know what the status is on that report?

Secretary SHINSEKI. I don't, but I will get you that.

Mr. BUYER. You have 30 days to get it to Congress when the President signed it into law. Has it left your desk and gone to OMB?

Secretary SHINSEKI. I don't know. I mean, it is not to your——

Mr. BUYER. Well you would know if you have signed it, so it is not to your——

Secretary SHINSEKI. I don't recall, but I will get you an answer today.

[The *VA Reports on the American Recovery and Reinvestment Act* were provided to the Committee and appear on p. 164.]

Mr. BUYER. Okay.

With regard to several initiatives, this—I have had a couple discussions, and you know it is one of my pet peeves now, is this multiple standards for cemeteries. And I would love for the leadership of the VSOs to take on these kinds of issues. I think they are important. And have you had a discussion with the Secretary of Interior?

Secretary SHINSEKI. I have not had that opportunity as of yet, but I do intend to do so. I have had my staff look into the background of these two cemeteries that you have mentioned, and others.

Mr. BUYER. Okay.

Secretary SHINSEKI. There is a difference in management and a difference in standards. We are trying to assess what it would cost if we were asked to assume responsibility for these two cemeteries and what capabilities it would require at this time.

Mr. BUYER. Okay.

Secretary SHINSEKI. And what it would take.

Mr. BUYER. Thank you for doing that, and I will wait for your response.

[Ron Walters, Director of Finance and Planning, National Cemetery Administration, Department of Veterans Affairs, provided the requested technical assistance by telephone to Committee staff on March 30, 2009.]

Mr. BUYER. With regard to the Priority 8s. We received a briefing in a report from the VA. It is titled, "Analysis of the Requirements to Reopen Enrollment of Priority 8 Veterans." So this was dated January 1st, and they do—excuse me—of last year, so this would be January 1st of 2008. And there was an analysis done based off of—hold on—VA's actuarial model. "The enrollee health care projection model projects that reopening enrollment to Priority 8s will increase enrollment in 2013 by 1.4 million and patients by approximately 750,000 over the current enrollment policy."

So when I read your budget, you are going to do a target opening up to 550,000. So when I look at this, when I compare the VA's ac-

tuarial model to the target that is being projected that it would be false then for anyone to infer that you are planning on opening up the enrollment to everyone. Would that be accurate?

Secretary SHINSEKI. At this point the enrollment target is up to 550,000.

Mr. BUYER. All right. Well then all I can rely on, Mr. Secretary, is the VA's actuarial model that shows that patients would be enrolled potentially 750,000. And I just bring that up as a point to make sure that no one believes that it is going to be opened up to all the 8s.

The great caution has been is the issue on building capacity.

Secretary SHINSEKI. Right.

Mr. BUYER. And even some of the VSOs have now been able to voice concern for us to watch this and be very careful as the 8s come in.

The 8s are individuals who have 91 percent, who have access to other forms of health care and so we want to make sure that we do not diminish that timely and accurate high quality health care that you have shared with all of us.

Secretary SHINSEKI. You have my assurance, I think I have said that several times. The quality that we provide and access we provide today is something we won't jeopardize.

Mr. BUYER. The last thing I wanted to make you aware of. The Energy and Commerce Committee passed out legislation last week dealing with tobacco. And because the Congress recently passed an S–Chip Bill that increased taxes on cigarettes, in order to pay for this new tobacco legislation by Mr. Waxman, there is a hole in his bill. So he has come up now with a quote, a pay-for. And one of the pay-fors is mandating Federal employees enrollment in the Thrift Savings Plan.

So I just want to make you aware that Congress is considering the mandating of all Federal employees in the Thrift Savings Plan, and that is going to have an impact upon your Department.

It will have a tremendous impact upon DoD, because I authored the Thrift Savings Plan for DoD. And when I did that I didn't have sufficient budget room and I made it an option for members of the military, and there isn't a match.

So if Congress is about to do this, I have now alerted the Armed Services Committee, they have joint referral here because we are about to mandate on Federal, you know, the personnel pension benefits of the military as a pay-for on smoking.

But I just want to make you aware of something that is moving through Congress, because it is going to impact your employees.

Secretary SHINSEKI. Thank you.

Mr. BUYER. I yield back.

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

I just want to make a few points. The first one is on the GI Bill. We understand the pressures on you to do this on time and the problem with any changes.

As Ms. Herseth Sandlin said, some inequities have come to our attention. For example, if you live in the bay area of California, and go to Stanford, the VA will pay $30,000; if you go to Berkeley it will pay $10,000, if you go to San Francisco State it will pay

$4,000. It is a function of our system, but there are some unfairness. If you live in a state that has purposely kept tuition at public universities low as a way to make sure that all of our young people do get education, they are going to be reimbursed at a level that really does not match their actual costs.

When the Senate passed the GI Bill, Senator Warner put in a provision called the Yellow Ribbon provision, which essentially gives an additional subsidy to high tuition, mainly private, schools. Nobody thought, at the time, about a provision to help those low-tuition schools who might be under funded.

I hope that we can get a recommended change very, very quickly. If we can't we will have to wait until the following year. This is an issue that is coming to the attention of many of the Members, because their universities are now figuring out how they will be affected.

If you live in Georgia, by your figures, the maximum public grant is about $1,200. Not only is that probably too low for real education costs since they are subsidizing it, but it would be hard to get the full payment for any college in Georgia under the formulas that we are using. This can be multiplied all across the Nation.

I am not sure whether we have to have a major change in terms of a standard fee that we are going to pay, or a floor, or a reverse Yellow Ribbon provision for the low tuition states. I think we are heading into a real problem that we have to fix fast. As I have told you, we need to work to get a quick formula to make it more equitable and maybe work on a long-term fix later. That is one thing that I think we have to try to do quickly.

On the claims backlog, I think you put it very elegantly, when you said, "right now I am using brute force, I am not sure whether that is the actual way to go."

If you want to use the word transformative for this system, I think you have to have a whole different approach. I have suggested a couple that can get us pretty far down the road.

Number one, our Vietnam veterans who are suffering from Agent Orange disabilities have suffered for three decades or more. First, we said Agent Orange didn't do anything to you. Then we said well maybe, and maybe if you stepped a foot in this province, and now there is a whole, you know, bureaucratic presumptive thing about which diseases are covered. So if you were in the blue waters off the shore and the blue skies above are on the boarder of Laos, and you know, Cambodia or even in Guam handling cargo, you are ineligible.

I think we have to breakthrough that and say, "if you were there we should care." Maybe define the field of action and just honor those claims. Get them off our books and off the shoulders of these veterans. People walk around for decades fighting the VA. They think the VA means "veterans adversary," and we have to say thank you for your service, stop fighting us, we are going to honor those claims. Because we know too much about Agent Orange now and how much damage it causes to start going through all the bureaucratic procedures. You don't have to comment on this now, sir, but at some point I would like to hear your thoughts on this.

Additionally, however we count those backlog claims and I would refer you to the so-called Linda Bilmes proposal based on the IRS

model, the Internal Revenue Service (IRS) which used to be one of the most dysfunctional agencies in America. When you file your 1040, and you have a refund coming, you get your check in weeks. That is amazing, 3 weeks. Subject to audit. So they will look at it at some time in the future. Why not have VA do the same thing? If a veteran submits a claim with the required medical documentation and aided by a certified veterans service officer, let VA accept the claim, subject to audit.

You could get all those claims off the books very quickly and change the function of thousands of workers who appear that their sole job is to call veterans a liar once they submit their claim. They are looking for problems. Let us have them look for answers.

I think there is a whole transformative, if I may steal your word, sir, way of looking at the backlog of claims and starting a new system.

On the subject of PTSD, I ask that when you meet with Secretary Gates, you let him know that the quickest thing DoD can do to help us do our job is a mandatory physical evaluation before they leave the service for PTSD and TBI. It is simple to say, but it doesn't happen. There are different rules if you are in the Guard and Reserves or active duty.

Right now they claim they have mandatory screening, and the VA does when a veteran comes into the hospital, but it is a do-it-yourself questionnaire. There is no real discussion with competent medical personnel. And, if they are in denial or they don't want to be bothered and they want to get home, they know which boxes to check no and yes to get out of there quickly.

So a do-it-yourself form does not do the job for us. I think Secretary Gates can order it pretty quickly, because it varies widely and some are getting it done, but most are not. That is a disservice to all of these young men and women when they leave the Armed Forces.

One last thing if I may, sir. You mentioned to Mr. Snyder, when he asked you about surprises in your new role, and you said one of the things you want to do is work cooperatively with the Committee with regards to reporting requirements. We are very grateful for that and what that means.

It is one of those issues that I think many of us get frustrated about in Congress. It is important that the VA and the Committee work together to find solutions.

I think you have to see us as a good source of expertise and help. The VSOs are on the frontline every day, and when they report things, we can take it to the bank. We know that is what is happening.

We are out there in the same way. We get information from the VSOs, but we are out at the hospitals, we are at the clinics, we are talking to our constituents all the time, and people come to us—we are a magnet.

When talking about interoperability of the electronic records, for example, we have been in discussions with Microsoft and other companies that know how to solve this problem, and yet the VA has not been very open to their suggestions.

On the subject of third-party collections, we have vendors who have showed us simple systems at no cost to the VA which could

increase our collections dramatically. Unfortunately, when we get this information, the VA tends to close itself off from these ideas, but we believe they are good ideas.

We know how to separate the chaff from the wheat too, even though we are not in your organization.

I, and every one of my Committee Members, get presentations of new technologies to deal with the problems your organization faces every day—our organization, I should say. For example, we have seen a non-invasive procedure for veterans who have had TBI or other problems with vision, to expand their field 50 percent and allow them to read, and yet they can't get the VA to talk to them.

I just had a visit today from a company whose products are used all around the Nation, but they can't get into the VA to share their product for early detection of oral cancer. If you can detect oral cancer, and a doctor knows more than I do, right away or in its early stages, it is going to be far cheaper and far more effective to treat than if you have to wait and see it only by visual inspection. This company has a method of dealing with it that can give very early detection. The company can't even get in the front door with the VA.

So we come with a lot of this information, and I hope that you will be very open. I know you have visited us personally, you have shown that you will listen, and I just want to say again, use us as a resource.

We are not here to beat you over the head, we are not here just to oversee, we are part of a group that can help. Our constituents are on the line every day and we come committed to the service of our veterans. I hope you will look at those as helpful suggestions some time, not political interference.

Thank you. I will give you the last word or as much time as you would like for your conclusion. We appreciate your candor and your willingness to listen and your effectiveness in the future.

Secretary SHINSEKI. Thanks, Mr. Chairman.

Again, as I said in the beginning, thank you for this opportunity to be here. I always look at this as an opportunity to establish a good dialog and solve some of the issues that we are both wrestling with that are focused on just one thing and that is our veterans and what more and better we can do for them.

For the comments about the backlog. Advocacy training, you know, as small as that might be does make a difference. I mean if the approach to performing that responsibility is favoring the veteran, it will make a lot of difference on how people see the outcomes. So I will take that on.

[An April 20, 2009, follow-up letter from Secretary Shinseki, regarding advocacy training appears on p. 143.]

Secretary SHINSEKI. And I would ask you not to misconstrue my response to Mr. Snyder as any kind of complaining about the reports I submit. I am happy to submit reports if they are useful. I was just surprised at the volume of reports, some of them going back a long time that I wondered whether we were addressing current issues. That was the point of my observation.

But again, I thank you for this opportunity to appear before the Committee, and my opportunity to work with each of you, and then all of you collectively in helping me with this mission.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you. And I think Secretary Rumsfeld heard you say that and he called up President Bush and—oh, that was your last testimony.

Thank you, sir. It was great to have you here.

We will start with our second panel right away. Thank you.

We are very pleased to have our second panel here today. I don't think you have heard testimony where you got so many compliments as the VSOs who have helped us, so we thank you for being here, and thank you for continuing to do your jobs.

We have representatives from the Paralyzed Veterans of America (PVA), Disabled American Veterans (DAV), the Veterans of Foreign Wars (VFW), and American Veterans (AMVETS). Carl Blake is the National Legislative Director for PVA.

Welcome, Carl. You have the floor.

STATEMENTS OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; KERRY BAKER, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND RAYMOND C. KELLEY, NATIONAL LEGISLATIVE DIRECTOR, AMERICAN VETERANS (AMVETS)

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you, Mr. Chairman.

On behalf of the co-authors of *The Independent Budget* seated here I would like to thank you for the opportunity to present our views regarding the funding requirements for the Department of Veterans Affairs Health care System for fiscal year 2010.

We are pleased to see that the initial information provided by the Administration suggests a very good budget for the fiscal year 2010.

The discretionary funding levels provide for a truly significant increase.

I find it a little amusing that you say we got so much praise, because I felt like *The Independent Budget* got beat up a little bit there.

A number of people made the comment that the Administration's budget actually came out above *The Independent Budget*, which is great, I am not down playing that at all, but given my interest in budget matters, I would be interested in having the opportunity to dig a little deeper into the details and make up the one single number that we have from the VA right now and see where we are actually at when we get to April and May and June and on down the line in the budget process, but we certainly look forward to the opportunity.

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

The *IB* recommends approximately $36.6 billion for medical services. This recommendation includes approximately $34.6 billion for current services, $1.2 billion for the projected increase in patient

workload, and $800 million for policy initiatives. And I won't explain those in much detail because they are laid out in more detail in the full *IB*.

For medical support and compliance the *IB* recommends approximately $4.6 billion, and for medical facilities approximately $5.4 billion.

The amount for medical facilities includes an additional $150 million for non-recurring maintenance (NRM) for the VA to begin addressing the massive backlog of infrastructure needs beyond those addressed through the recently passed stimulus bill. And again, we appreciate Congress providing that additional funding. It is a known fact that the infrastructure needs in the VA are probably one of the biggest needs that there are.

The IBVSO's contend that despite the recent increases in VA health care funding, VA does not have the resources necessary to completely remove the prohibition on enrollment of Priority Group 8 veterans who have been blocked from enrolling in VA since January 2003 at this time.

However, we believe that it is time for the VA and the Congress, with our assistance, and with the Committee's assistance, to develop a workable solution to allow all eligible Priority Group 8 veterans to begin enrolling in the system.

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

We are particularly pleased that Congress has recognized this critical need for funding in the medical and prosthetic research account in the last couple of years.

Research is a vital part of veterans health care and an essential mission for our national health care system.

Mr. Chairman, we would like to express our sincere thanks for your instruction of H.R. 1016, the "Veterans Health Care Budget Reform and Transparency Act of 2009."

Moreover we would like to extend our thanks to the Members of the Committee who have agreed to cosponsor this important legislation. I look forward to working with the Committee to move this legislation forward.

This funding mechanism will provide an option that the IBVSOs believe is politically more viable than mandatory funding and is unquestionably better than the current process.

Finally, Mr. Chairman, I would like to express our serious concerns that we have regarding the policy proposal that has been discussed here today, elegantly referred to as third-party reimbursement for veterans with service-connected conditions.

I think the Secretary's testimony before the Senate this morning sort of affirmed our worst fears that this is something that the Administration is seriously considering, and I am not so certain that the overall budget number that has been presented thus far does not include, or does include, the funding, which the Secretary testified is soon to be about $500 million in that additional budget for fiscal year 2010.

We just simply find it unacceptable that a veteran would have his third-party insurance billed for conditions and disabilities and injuries that were incurred while in service of this Nation.

We understand the fiscal difficulties that this country faces right, I think we all understand that, but placing the burden of those fiscal problems on the men and women who have already served and sacrificed a great deal for this country is, as I believe Dr. Snyder or Mr. Michaud put, unconscionable.

We strongly urge Congress to investigate whether such proposal is actually moving forward, I get the sense that it is, and to forcefully reject it if it is brought before you.

With that, Mr. Chairman, I would be happy to answer any questions.

Thank you for the opportunity to testify.

[The prepared statement of Mr. Blake appears on p. 61.]

The CHAIRMAN. Thank you.

Kerry Baker is the Assistant National Legislative Director for the DAV.

Welcome Mr. Baker.

STATEMENT OF KERRY BAKER

Mr. BAKER. Mr. Chairman, Ranking Member, and Members of the Committee.

It is a pleasure to be here today on behalf of *The Independent Budget*. Today I will focus on issues affecting the Veterans Benefits Administration (VBA).

On behalf of VBA, we have come before you for many years requesting additional funding to reverse its chronic history of under staffing. You have answered that call.

In just the past few years VA has hired over three thousand additional claims processors and more continue to be hired as we speak.

This year the IBVSOs recommend that Congress adopt both short and long-term strategies for improvements. Strategies focused on VBA's IT infrastructure, as well as the claims and appeals process.

We are also seeking improvements in training, accountability, and quality assurance.

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

Despite growing problems with the claims process, Congress has steadily reduced funding for IT initiatives over the past several years.

In fiscal year 2001, Congress provided $82 million for IT initiative. By 2006, that funding had fallen to $23 million.

Congress has however noticed the disconnect between IT and improvements in claims processing.

Section 227 of the Veterans Benefits Improvement Act of 2008 places new requirements on VA to closely examine all uses of current IT and comparable outside IT systems with respect to claims processing.

Following that examination, VA is required to develop a new plan to use these and other relevant technologies to reduce subjectivity, avoid remands, and reduce variances in VA Regional Office disability ratings.

Section 227 will require VBA to examine IT systems that it has been attempting to implement and improve for years.

We believe this examination will reveal the progress that has been impeded due to lack of direct funding to underwrite IT development.

The IBVSOs believe a conservative increase of at least 5 percent annually in IT initiatives is warranted.

VA should give the highest priority to the review required by the Benefits Improvement Act of 2008, and double its efforts to ensure these ongoing initiatives are fully funded and establish their goals.

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

Additionally, as long stated by the IBVSOs, VA must invest more in training adjudicators and decisionmakers. It should also hold them accountable for higher standards of accuracy.

The VBA's problems, caused by a lack of accountability, do not begin in the claims and development process nor the rating process, they begin in the training program.

A lack of accountability during training reduces, or even eliminates, employee motivation to excel.

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

In addition to training, accountability is the key to quality, however, there is a gap in quality assurance for purposes of individual accountability and decision making.

In the STAR Program, the sample drawn each month from a Regional Office workload is simply too inadequate to determine individual quality.

The Veterans Benefits Improvement Act of 2008 requires VA to conduct a study on the effectiveness of the current employee work credit system and work management system. The legislation requires VA to submit a report to Congress which must explain how to implement a system for evaluating VBA employees no later than October 31st, 2009.

This is a historic opportunity for VA to implement a new methodology, a new philosophy by developing a system with primary focus on quality through accountability. Probably undertaking the outcome would result in a new institutional mindset across VBA, one that achieves excellence and changes a mind set focused on quantity to one focused on quality.

The IBVSOs believe the VA's upcoming report must concentrate on how the VA will establish a quality assurance and accountability program that will detect, track, and hold responsible those employees who commit errors.

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

That concludes my statement. It has been an honor to testify before you today.

[The prepared statement of Mr. Baker appears on p. 63.]

The CHAIRMAN. Thank you, sir.

Dennis Cullinan, is the National Legislative Director of the VFW. Welcome, Mr. Cullinan

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman. Distinguished Members of the Committee, it is certainly a pleasure to be here today, and I want to extend a thanks of the men and women of the Veterans of Foreign Wars in including us in today's most important discussion.

As you are aware, the VFW handles the construction portion of the *IB* budget, and I will limit my remarks to that.

VA's most recent asset management plan provides an update of the state of Capital Asset Realignment for Enhanced Services (CARES) projects, including those only in the planning or acquisition process. It shows a need of future appropriations to complete these projects of $2.195 billion.

Meanwhile VA continues to identify and re-prioritize potential major construction projects. In a November 17, 2008, letter to the Senate Veterans' Affairs Committee, Secretary Peak said that the Department estimates that the total funding requirement for major medical facility projects over the next 5 years would be in excess of $6.5 billion.

One thing that is clear, the VA needs a significant infusion of cash for its construction priorities. VA's own studies validate this.

In light of these things, the *IB* recommendations for fiscal year 2010, major construction, is $1.123 billion. With respect to minor construction we recommend $827 million. We need to increase spending on non-recurring maintenance. For years the IBVSOs have highlighted the need for increased funding for the non-recurring maintenance account. Projects in this area are essential because if left undone it can really take their toll on a facility, leading to more costly repairs in the future, and the potential of a need for a minor construction project, perhaps even major.

Beyond the fiscal aspects, facilities that fall into disrepair can create access difficulties and impair patient and staff health and safety. And if things do develop into a larger construction projection, because their repairs were never done, it creates an even larger inconvenience and safety issues for veterans and staff.

VA must dramatically increase funding for non-recurring maintenance in line with a two to 4 percent-total that is industry standard so as to maintain clean, safe, and sufficient facilities.

VA needs an NRM budget of at least $1.7 billion. Portions of NRM accounts should continue to be funded outside of the bureau formula so that funding is allocated to facilities that actually have the greatest maintenance needs.

Congress should also consider the strengths of allowing VA to carryover some maintenance funds from one fiscal year to another so as to reduce the temptation some VA hospital managers have of inefficiently spending their NRM money at the end of the fiscal year.

It has come to our attention that something like 60 percent of NRM funding is expended in the final quarter of the fiscal year. That just is not good management.

VA must protect the deterioration of its infrastructure and declining capital asset value. The last decade of under funded construction budgets has meant that the VA has not adequately recapitalized its facilities. Recapitalization is necessary to protect the value of VA's capital assets through the renewal of physical infrastructure. This ensures safe and fully functional facilities long into the future.

VA's facilities have an average of over 55 years and it is essential that funding be increased to renovate, repair, and replace these aging structures and physical systems.

Accordingly, using the five to 8 percent-industry standard, VA's capital budget should be between $4.24 and $6.8 billion per year in order to maintain its infrastructure.

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

I would add here that the IBVSOs and the VFW are very appreciative of Congress' actions in the additional funding they have provided over at the past several fiscal years to tend to VA's physical infrastructure needs.

The last thing I want to mention here is the IBVSOs are concerned with VA's recent attempts to back away from the capital infrastructure blueprints laid out by CARES.

To put it briefly, there has been an increased interest on privatization in providing contract care. The IBVSO support contract care were necessary; however, we wish that the Congress would guard jealously against over excessive use of private facilities. VA's capital infrastructure and its own resources must be protected.

Thank you Mr. Chairman, that concludes my statement.

[The prepared statement of Mr. Cullinan appears on p. 70.]

The CHAIRMAN. Thank you.

Raymond Kelley is the Legislative Director for AMVETS. Thank you for being here, sir.

STATEMENT OF RAYMOND C. KELLEY

Mr. KELLEY. Thank you, Mr. Chairman, thank you for holding this hearing today and inviting AMVETS to testify on behalf of *The Independent Budget*.

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

In fiscal year 2008, $195 million was appropriated for the operations and maintenance of NCA, $28.2 million over the Administration's request, with only $220,000 in carryover. NCA awarded 39 of 42 minor construction projects that were in the operating plan. The state cemetery grant service awarded $37.3 million of the $39.5 million dollars that was appropriated. Additionally, $25 million was invested in the National Shrine Commitment.

NCA has done an exceptional job of providing burial options for 88 percent of all veterans who fall within the 170,000 veteran within 75-mile radius threshold model. However, under this model no

new geographical area will become eligible for a national cemetery until 2015.

An analysis shows that five areas with the highest veteran population will not become eligible for national cemeteries because they will not reach the 170,000 person threshold.

Lowering the population threshold to 100,000 veterans would immediately make several areas eligible for a national cemetery, regardless of any change in the mile radius threshold.

A new threshold model must be implemented so more of our veterans will have access to this earned benefit.

The *Independent Budget* recommends an operations budget of $241.5 million for NCA for fiscal year 2010 so it can meet the increasing demands of interment, grave site maintenance, and related essential elements of cemetery operations.

Congress should include as part of NCA's appropriations $50 million for a first stage of a $250 million 5-year program to restore and improve the condition and character of existing NCA cemeteries.

The *Independent Budget* recommends that Congress appropriates $52 million for the State Cemetery Grant Program. This funding level would allow the program to establish six new cemeteries that will provide burial options for 179,000 veterans who live in regions that currently have no reasonable access to state or national cemeteries.

The national average cost for funeral and burial in private cemeteries has reached $8,555, and the cost of a burial plot is $2,133.

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

For veterans who live inside the threshold the service-connected burial benefit should be increased to $6,160. Non-service connected veterans burial benefit should be increased to $1,918. And the plot allowance should increase to $1,150 to match the original value of the benefit. For veterans who live inside the threshold the benefits for service connected burial should be $2,793. The amount provided for non-service connected burial will be $854, and the plot allowance will be $1,150.

This will provide a burial benefit at equal percentages, but based on the average cost of a VA funeral and not on a private funeral cost that will be provided for those veterans who do not have access to state or national cemeteries.

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

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

This concludes my testimony, and I am happy to answer any questions at this time.

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

The CHAIRMAN. Thank you, Mr. Kelley.

Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman. The panel, can you guys talk—first of all, thank you all for being here and thank you for your testimony.

Can you talk to us a little bit about how you feel like—we have heard the plans to significantly increase the Category 8s, Priority 8s, which is a very good thing. Can you tell us, though, any concerns about perhaps by what you feel like we need to do as far as capacity, concerns about maybe unwanted consequences that we don't realize it might have on some of your membership?

The CHAIRMAN. Mr. Cullinan.

Mr. CULLINAN. Mr. Boozman, if I might first.

A big concern of ours is that VA not be inundated with Category 8 veterans. We want to see them flow into the system, we want to make sure that the quality and timeliness of care is maintained, and we also view it as essential that this be a cooperative venture between the Department and the Congress.

And it is funny, Chairman Filner, you mentioned that earlier, that at times it seems that the executive branch views the Legislative Branch's expertise as being somehow different than theirs, and I suppose it is different, but it is essential as well, so that is what got to be—we need close oversight of what is going on, and a cooperative venture with the Secretary and VA.

Mr. BLAKE. Mr. Boozman, can I add something?

Let me say that I think just at first glance the Administration's plan as it relates to this roll out of $500,000 additional through the next I think 5 fiscal years essential is how it is laid out without any real details seems like a doable solution budget wise, because I think it can be much easier managed that way.

Interestingly, as we were developing *The Independent Budget* one of the troubles we had is sort of pinning down this Priority 8 Group number, because I don't think anybody really knows what the number may actually be. But from what we have been told by some officials at the VA, the actual number of folks who have been turned away from the VA physically since this enrollment ban went into place is pretty close to the $550,000 that is apparently the target for the next 5 fiscal years.

So I can easily see where the idea that this is where the initial target would come from, but going forward I think there are a lot of dynamics that by rolling it out will allow us to better judge this going forward. Because I am not sure that the utilization patterns, at least in the short term, would be like what Priority Group 8 may have been in the past, and we just don't know what the current economic state of the country might have.

I mean, there are so many factors, but I think that without a lot of information the Administration has at least outlined a good plan that seems reasonable, and if managed correctly, and as Dennis mentioned with that adequate oversight, could be done.

Mr. BOOZMAN. Okay. Again, I guess the only thing I think we have to be careful, it just doesn't seem like the out-year budget numbers really seem to—are a little bit questionable, you know, when you start.

Again, you know, it is good news that we are in the process of moving forward, but I would agree with you all in a sense that it is just something that we need to work together to make sure that

it is done in a way such that, you know, we have worked so hard to get ourselves in a much better situation where we were a few years ago with everyone working together, and I would hope that we would continue in that regard.

Let me just ask one other thing real quick. The VA budget request assumes a 33 percent-increase in the medical care collections fund for a total of $3.4 billion. VA estimates only about $2.5 billion in collections for fiscal year 2009 and 2010. That seems a little bit optimistic.

Did you all notice that in regard to the budget?

Mr. BLAKE. I would say it definitely stands out, which I think is relevant as it relates to the discussion we had about third-party reimbursements for service-connected veterans.

Now again, the devil is in the details, we don't know what makes up that estimate. It is a significant jump, given what we have seen sort of the recent history as we have gotten into this area of the $2 billion dollar realm for collections. There have been sort of marginal increases in estimates year after year, and it seems like a pretty significant jump.

But again, I go back to my point from my testimony that what the Secretary said this morning was that they have estimated that under this third-party billing for service connected they could generate as much as $500 million. Now whether that is actually in, that $3.4 billion or not is unclear. I think the Secretary sort of said it wasn't, but I find it hard to believe with that significant of an increase that it would not be. So it is sort of remains to be seen.

Mr. CULLINAN. Mr. Boozman and Mr. Chairman, we were startled too in reviewing the numbers when we saw this. It was over $1 billion increase, and that is before we heard the rumors about the possible inclusion of this abhorrent idea of charging insurance companies for service-connected care.

And I would have to say too, that in recent fiscal years, VA has been doing very well with respect to collections, so a 33 percent-increase is inexplicable without something pretty extraordinary.

Mr. BOOZMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Well thank you all again for everything you do and for coming here. And as I have said, the last 2 years and I need to say it again and I also will as long as I am in this job, a Presidential budget is a suggestion. Article 1 of the Constitution puts it here. So I share your concern too.

The third-party billing thing does not fly, and I am not deaf to the need to make sure we use every dollar wisely, making sure we are cutting down on waste and getting efficiencies, but as I have said it, and I will continue to say it, we are not going to balance this fiscal mess on the backs of veterans, so this is a bad idea at a bad time. It would be bad at any time.

But with that being said, here is a conundrum I want you to help me with a little bit. I too share your concerns of making sure this issue on private contracting and some of those types of things.

The thing I hear about coming from a rural district is that it is easier access to care, and I literally have veterans who say I live in the shadow of the Mayo Clinic, but I've got to get on the bus to go to Minneapolis.

Now my concern is making sure, just like you and you have stressed it very clearly, keeping the core issues of the VA funded and working. We have expanded some CBOCs. We are going to get one in my district, another one which I think is on the right track.

I would like to ask you, how do we go back and talk to those veterans about it?

And I want to thank each and every one of your organizations for bringing this out there, because you can see from a veteran's perspective where they are saying heck, I just wish I had a card and could walk in the Mayo and get everything done.

That is the way they see it. They don't realize, well, that is maybe because you could walk in the Mayo and do it, you are not one of our veterans who has the core issues that need to be cared for at the VA, the research dollars and everything else.

So I just want to hear from each of you maybe on that, if you have some—just some ideas on what you think and how do we talk about that.

Mr. CULLINAN. Mr. Walz, I would say, first of all right now VA has authority to provide contract care in certain rural areas, and we think they should use it more, and we would ask this Committee and the Congress to ensure that they do.

There is a pilot program going on now that was just initiated. We think there could be some valuable results coming out of that. That remains to be seem, what ideas come out of that. And of course in certain parts of the country, while a mobile clinic and that kind of thing isn't the equivalent of a CBOC, we are certainly not a hospital, it is a lot better than nothing, and greater utilization of these should be made as well.

With respect to the Mayo Clinic that is a tough one.

Mr. BLAKE. Mr. Walz, one thing I would suggest too is we have all sorts of advocated for supporting the Office of Rural Health and the VA, and yet I am not sure that that office has been really given a fighting chance. It has had a very small budget, a very small staff, and yet from my perspective the rural health care issue, while maybe not targeting the biggest population of veterans, is dealing with what is maybe one of the biggest—maybe the biggest access related issue.

And so I think there needs to be some focus on plussing up the operations of the Office of Rural Health and giving them the ability to sort of manage this. That is not the say that they force things into the VA, but figure out the best ways to work about these problems.

I agree with Dennis entirely, the VA has the authority as it relates to fee basis for contract care in rural setting, and for years since I have been here we have batted around the idea of what constitutes rural and that sort of thing.

As far as getting at the veterans themselves, Dennis mentioned mobile clinics. Another thing, some of this is an outreach effort to these folks out there, and particularly in the extremely rural areas.

I would say we have been pleased to see how the VA has rolled out their mobile Vet Centers, and what the capabilities of those are, and I believe there may be a desire to expand that program further, but you get at these folks and figure out where the needs

are and you can kind of use that as an arm to adjust its access and the delivery of care going forward also.

Mr. WALZ. And I just had one final thing if I could, just that I am really focused on this seamless transition thing.

It sounds like to me that maybe we are getting close. I know many of you have said yeah, I have heard that for 20 years. It seems different this time, and I have watched this for a long time too.

Do you see any concerns or areas that you think need to be addressed first, or are you optimistic after you heard what the Secretary had to say today? From each of you as far as seamless transition goes and making sure that we see that as a way to cut down some of the systemic problems.

Mr. KELLEY. Mr. Walz, Ray Kelly from AMVETS.

There has been a continuation of we are 2 years away from having an IT solution or a transition solution. I will believe it when I see it. I take it to heart that he says he is going to do it, I believe that he is going to put every effort into making that happen, but again, I will believe it when I see it.

Mr. BAKER. There are a lot of things that sound promising to us. I don't believe we have had the chance to discuss the idea about enrolling somebody in VA as soon as they come into the military. That is something I would like to discuss with everybody. I know the Benefits Delivery at Discharge program has become paperless. I know that assisted in the seamless transition. The VONAP system, while not necessarily restricted to people coming off of active duty, it is paperless.

You know, the key thing is right now transferability with the medical files between the VA and the DoD. If that could become seamless—somebody mentioned the DoD is never in this room—you need them here for that. But if you could accomplish that, then you have just taken a very large step.

Mr. BLAKE. Mr. Walz, I would say that through the Senior Oversight Committee I think we have seen at least the biggest stab at trying to fix seamless transition since I have been here. I mean, I feel like there is a real commitment to addressing this now because of that entity and the level of focus being placed on it, but again, I go back to what my colleagues have said about seeing it and believing it, so.

Mr. WALZ. We can quote President Reagan on this one, "We will trust but verify." That needs to be our manta around here.

Well thank you all, thank you Mr. Chairman.

The CHAIRMAN. Thank you, and again, we thank you for being here.

My sense is, and this is just from my political understanding, the message that you have been sending out about the third-party issue has been received at the White House. I don't think, frankly, that you should spend too much time worrying about it. That is my sense. You have other more important things to do.

You were wondering where the money is coming from, for example, if they didn't have a policy change. I think I mentioned several times in the earlier hearing that we believe there are systems available to the VA that will dramatically increase their collection

rate, but they have just not taken them up. I hope the new Secretary will look at it differently.

Both Mr. Buyer and I have been involved with this issue together. We think there are hundreds of millions of dollars on the table, if not more, and that we hope to really dramatically increase that without the kind of policy change you were worried about.

Just one last question. I mentioned within the context of the GI Bill, the situation of the inequity of low tuition states. Have you all been in contact about this? Has that been expressed by anybody? Any of the colleges? Do you see it as a real problem that we need to correct right away?

Mr. CULLINAN. Mr. Chairman, we are aware of the problem. And the real issue comes down, there are certain states where this instate tuition is low, but since the money for the GI Bill tuition flows directly to the university it doesn't impact the veteran directly. However, if a veteran wants to go to a private institution in that state he or she are out of luck, unless the Yellow Ribbon Program, which is an opt in if the university cuts in, it still represents an inequity.

We would like to see some kind of—this addressed somehow. I mean, one approach may be to establish a different floor for those veterans in those particular states that are going to private institutions.

So I am not saying that an institution that charges $1,200, I think that was the sum that was cited earlier, should get more than that. However, if a veteran wants to go to a pricier and private institution that say costs $1,200 a year, that difference should somehow be accommodated.

The CHAIRMAN. I mean, you have two big problems. One, some of the high tuition established rates are not really the rates.

Mr. CULLINAN. Yeah.

The CHAIRMAN. I mean, it is artificial. There is tuition discounting in there that we have to be careful of.

On the other hand, California is one state that I know very well, the tuition rates are artificially low. As you said, they shouldn't get more than their public tuition, but it costs more to educate a student in those states than the public published tuition.

We have to watch for abuse at one end, but I think we have to help the universities at the other end.

Mr. CULLINAN. And the veterans they serve, sir.

The CHAIRMAN. Yes, sir.

Thank you very much, we appreciate your testimony, and as always, we will continue to keep in touch.

We will now hear from the third panel. Please come forward. Mr. Sullivan, the Executive Director of Veterans for Common Sense (VCS) will be the first to testify. We look forward to your testimony.

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

STATEMENT OF PAUL SULLIVAN

Mr. SULLIVAN. Veterans for Common Sense thanks the Chairman and the Ranking Member for inviting Veterans for Common Sense to testify here today about the 2010 VA budget. Last month, President Barack Obama and VA Secretary Eric Shinseki announced they would increase VA's budget to a new record high of $113 billion. This $15 billion increase far exceeds or highest expectations.

With that money, Veterans for Common Sense urges Congress to focus on five key measures to monitor VA during 2010. Maybe cut down some of those reports.

Those five areas are health care mental health care suicide prevention, reducing homelessness, and eliminating the disability benefit claim backlog.

VCS asks you to focus on three budget questions when dealing with the VA.

First, we ask you to ask VA, does VA have enough funding, staffing, and legislative guidance to accurately process all disability claims within 30 days?

Second, does VA have enough funding, staffing, and legislative guidance to provide all patients with quality physical and mental health care within 30 days?

And the third question, does VA have enough information to answer both of those two questions.

This is bottom up budgeting that we support. We want VA to say yes, we can provide this information. And asking these questions is essential because of VA's past history of failing to plan properly and VA's continual underestimation of the number of Iraq and Afghanistan war veterans seeking care.

In February 2008, VA told this Committee it expected to treat about 333,000 Iraq and Afghanistan War veterans in 2009; however, by September 2008 VA had already treated more than 400,000.

Based on the current rate of more than 10,000 first time patients flooding into VA each month, VA may expect a total of 520,000 Iraq and Afghanistan War veteran patients by September 2009.

In contrast, Secretary Shinseki's testimony a little while ago said that the VA expects 419,000 patients this year.

Summarized from our written statement, VCS recommends five priorities for VA's 2010 budget.

First, VCS urges Congress to streamline VA's claim system and quickly pass Chairman Hall's Combat PTSD Act, H.R. 952. There are more than 105,000 Iraq and Afghanistan war veterans already diagnosed by VA with PTSD; however, only 42,000 receive service-connected disability compensation for PTSD.

In 2008, the Institute of Medicine concluded there is a link between deployment to a war zone and PTSD. With a new law or a

regulation based on science, VA can improve the lives of 1910s of thousands of disabled veterans with PTSD during an economic crisis when their needs are most acute.

Second, in a manner similar to PTSD, VCS urges Congress to streamline claims for TBI.

Third, we urge you to improve seamless transition and bring VA to our veterans by expanding VBA.

VA should open permanent offices at military bases and at more cities so veterans can meet face to face with VA staff about claims, including their new GI Bill benefits.

Fourth, Congress needs to expand research to better understand Gulf War illnesses.

In 2008, the Research Advisory Committee on Gulf War veterans' illnesses confirmed up to 210,000 Gulf War veterans remain ill.

We ask you to please support $30 million for competitive research in the Congressionally directed medical research program to search for treatments, which is what the Gulf War veterans want.

Fifth and finally, VCS would like Congress to insist that veterans play a key role in any proposed truth commission suggested by Senator Leahy investigating Administration actions between 2001 and 2008.

In 2008, the *Houston Chronicle* editorialized that servicemembers and veterans bore the brunt of the enormous policy failures of the last Administration.

If we are to truly understand the mental health needs of our war veterans, then we must make sure our history books accurately reflect the fact that the Vietnam War, the Gulf War, and the Iraq War were each initiated by the executive branch using misleading statements and without preparing a plan to care for veterans when they came home, and this is a betrayal of our veterans who are serving our country and our Constitution.

Thank you.

[The prepared statement of Mr. Sullivan appears on p. 83.]

The CHAIRMAN. Mr. Paul Rieckhoff is from the Iraqi and Afghanistan Veterans of America (IAVA). Mr. Reickhoff?

STATEMENT OF PAUL RIECKHOFF

Mr. RIECKHOFF. Thank you, sir.

On behalf of IAVA and our more than 125,000 members and supporters, I want to thank you for inviting Iraq and Afghanistan Veterans of America to testify today regarding the VA budget for fiscal year 2010.

I would also like to thank you for your commitment to our Nation's veterans. From the passage of the new GI Bill to the dramatic increases in veterans health care funding, the remarkable legislative victories we have seen for veterans in the last 3 years would not have been possible without your leadership.

At IAVA we are committed to making sure that no servicemember and/or veteran is ever left behind. Our mission is to improve the lives of the more than 1.8 million Iraq and Afghanistan veterans and their families. And as veterans are coming home from Iraq and Afghanistan to the worst economy in decades, we need to show real support for our troops and veterans.

Over all, we are pleased with the limited information currently available about the 2010 budget. The top line numbers for veterans discretionary funding is about $1.2 billion higher than the amount recommended by the leading veterans services organizations, including IAVA in *The Independent Budget*.

The budget plans increases funding by $25 billion over 5 years, and this funding will be critical if we are to provide proper care and support for the surge of new veterans who will be coming home from combat in the coming years.

We are also pleased to see the renewed focus on mental health care in the DoD budget, including comprehensive TBI registry and the roll back of concurrent receipt limitations that unfairly cut benefits available to disabled military retirees.

We are also pleased to see the Administration's plan to expand VA health care access to about 500,000 moderate income veterans. It is a good first step, although we would like to see it happen faster.

About 1.8 million veterans lack health insurance, and over 500,000 have been denied VA health care because their income level was too high. IAVA believes that every single veteran should be eligible for VA health care.

From what we have seen the budget looks strong, but the devil is in the details. Until we have had the opportunity to go through this budget line by line in April we cannot entirely endorse the plan.

Above all, we must ensure that this budget does not rest on increased co-pays, premiums, and fees for veterans.

Our biggest disappointment about the current budget is that the President has not opted to include advance appropriations to the VA in this proposal.

Advanced appropriations doesn't cost any additional money. It gives VA hospitals and clinics advance notice of the funding they will receive for the following year. Right now VA hospitals have no way of knowing what their budget will be next year, and when the budget is passed late, and it usually is, they often have to ration the care they give to veterans.

The bottom line is that VA budget delays hurt veterans, veterans of all generations. And I want to tell you about one of those veterans that would definitely benefit from advanced appropriations.

Ray Leal served as a marine in Fallujah during some of the heaviest fighting earning a bronze star with valor as a private first class almost unheard of for a troop of that rank. When he returned to southern Texas his VA hospital was over 5 hours away. He is a tough marine and he is a boxer, but he shouldn't have to fight to get care at a veteran's hospital.

At his nearest outpatient clinic there is just one psychologist taking appointments only 2 days a week. The psychologist only works 2 days because that Texas clinic, like many VA clinics and hospitals, has to stretch its funding to make sure the money lasts the whole year. They don't know how much funding they will have next year because the VA budget is routinely passed late. For the millions of veterans like Ray we must fix this broken funding system.

Advanced appropriations is a common sense solution that President Obama supported as a candidate, and it is something we would have liked to have seen in the budget.

If the Obama Administration is not going to lead on the fight for advanced appropriations, we need Congress to step in.

A number of Members on this Committee, including of course Chairman Filner, have already proven to be key allies in the fight for advanced appropriations, and we thank them for their leadership and support.

IAVA is proud to endorse H.R. 1016 and S. 423.

We will work with Committees in any way we can to move this legislation forward. With your help we can ensure that veterans are not kept waiting, as they have been in the 19 of the last 22 years while Congress plays politics with the budget.

Last month President Obama traveled to Camp Lejeune to announce the eventual draw down of combat troops in Iraq. And no matter what you think about this plan, one thing is clear, the new strategy in Iraq will create a surge of new veterans coming home in 2009 and 2010.

America needs to be ready, and the 2010 veterans budget will be a crucial first step.

Thank you for your time, and we look forward to working with you.

[The prepared statement of Mr. Rieckhoff appears on p. 89.]

The CHAIRMAN. Thank you, Mr. Rieckhoff, and thank you for representing our newer veterans when they come back.

Richard Weidman, Executive Director for Policy and government Affairs of Vietnam Veterans of America (VVA). Welcome.

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Thank you, Mr. Chairman, and thank you to your distinguished colleagues on both sides of the aisle for the opportunity for us to represent our views here today. Over all, first let me say that we endorse *The Independent Budget* and associate ourselves with their figures, particularly when it comes to construction, which needs to be speeded up and not slowed down. And those within VHA who take the attitude that we will never again build a free-standing hospital need to be—find another way to contribute to the good of the world and be replaced with people who understand what the core mission of the VA is.

We looked at, as we do every year, the Center for Medicare and Medicaid services and the inflation rate that they are projecting for medical inflation, and they are upping theirs by 3.6 percent. And so we use that in calculating that we need a $1.4 billion, assuming that there were no more people that came into the VA and that VA had adequate staff to meet the full needs of people at this point, which in fact they don't.

So we recommend another $2 billion on top of that just for just VHA in order to expand organizational capability and front load the staff needed to take care of the new veterans coming through the door. Not just those who serve in Iraq and Afghanistan and elsewhere within the world, but of new registrants who are qualified with moving forward with restoration of ability of Category 8—so-called Category 8s to be about to use this system.

We had asked VA repeatedly for 4 years now to do a migration study about people who were refused treatment who were Category 8s, how many of those ended up either being led into the VA hospital eventually because they became service connected but were much sicker and, therefore, more expensive to treat when they came in, and how many of those people ended up indigent because they couldn't work and therefore gained admission that way? And they continue to come up with excuses, and perhaps when the Committee asks you will get the answer to that question looking back to January of 2003.

We recommend a significant increase in research and development to $750 million for the next fiscal year for 2010, and moving up in increments to bring that research total to well over a billion dollars by the end of 5 years on an annualized basis with ordinary inflation increases from that point forward.

NIH does not do veteran health research. They flat won't do it. Even the grants they give to VA they do not take a person's military history as a variable and a possible confounder in the studies that they conduct at the VA. And therefore we know DoD is not going to do it because they always want to continue to have deniability, particularly about the environmental wounds; therefore, all we have left is the VA.

For the first time in many years, VA has not—VVA has not signed on to the Friends of VA Medical Research and Health Care. And the reason is they pledge not to ask for any earmarks.

It would be irresponsible of us not to ask for earmarks in a changing of the course of the leadership of research and development when they are not funding a single study related to the long-term health care of Agent Orange at the moment, nor I might add, except for those earmarked items and studies are they funding—looking at the long-term health care effects of environmental hazards in the first Gulf War.

So we have a real problem with the way in which they are going, and ask that you again ask Mr. Edwards to include an earmark in the budget legislation requiring the VA to obey the law and complete the National Vietnam Veteran Readjustment Study replication, thereby making it a robust mortality, morbidity study of Vietnam veterans, and that they set aside $20 million additionally out of R&D funds, specifically for study of long-term consequences of Agent Orange, and in addition to that $15 million to go to MFUA or the Medical Follow-up Agency of the Institute of Medicine of the National Academy of Sciences, which is the repository for all of the wealth of data of the ranch hand study, which has now ended, but all that data needs to be put into modern computerized format in order to make it accessible for research.

Mr. Chairman, I am over time, and I appreciate your indulgence. I would just add two things if I may.

One is the idea of having a specific line item for outreach is important.

We just started and launched last month the Veterans Health Council initiative working with the private sector to inform providers and through providers to inform veterans, 80 percent of whom don't go anywhere near the VA, of their rights and benefits, and more importantly, what are the health care dangers that they

should be looking for in themselves, and what their family should be looking for in their health based on when and where they serve? But if it is everybody's responsibility, it is nobody's responsibility, and outreach continues to be very haphazard from VA.

Last but not least, we appreciate all of your leadership on getting the advanced funding, Advanced Appropriations Act through, and we look forward to working with you on that, and hope that this year you will, despite the fact of having new leadership at the very top of VA, look to his own words, that what is wrong with the VA at almost every level is leadership and accountability, and we need to have much more stringent and much more in-depth oversight of VA's function in the coming year.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Weidman appears on p. 90.]

The CHAIRMAN. Thank you.

Steve Robertson is Director of National Legislative Commission for the American Legion.

Welcome, Mr. Robertson.

STATEMENT OF STEVE ROBERTSON

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

The American Legion appreciates the opportunity to be able to participant in this hearing on President Obama's top line budget request, and in fact the American Legion has sent a letter to the White House telling them that we support the top line numbers that they have recommended.

I would be remiss if we too did not express our appreciation to you and your colleagues for passing the fiscal year 2009 budget on time at the start of the fiscal year.

I am sure when Secretary Shinseki sits around the cabinet table he realizes what an advantage he has in this transition period with having a budget, while many of his colleagues at that table are still waiting on theirs. We have been there before and we understand the situation.

Speaking of the budget, we too want to thank you Mr. Chairman for your leadership on the Advanced Appropriation Legislation, and I assure you we will do everything we can in our power to make that a reality.

We also want to thank you for the stimulus package and the many provisions that were in there that specifically related to veterans. But one particular thing I would like to highlight is the money that was set aside for construction within the VA, a lot of the non-recurring maintenance, and we would hope that service of veteran-owned businesses and especially those businesses owned by disabled veterans would be given some consideration in awarding a lot of the contracts that will be done in VA facilities.

With the President's budget outline that we have of two pages, which is a lot easier to read than the five or six volumes that we normally get, looking at the highlights the American Legion supports all of the highlighted items based upon seeing the final details.

The area that is dealing with Priority Group 8 veterans. The American Legion has always advocated that every veteran be enti-

tled to their earned benefit. And a lot of people don't realize it, but there has been continuous flow of Priority 8 veterans into the system even though the prohibition is in place.

Veterans that are Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) veterans initially show up as a Priority Group 6, and then as their 5 years expires they are reassigned to whatever priority group that they are supposed to go to, so many of them will wind up into 8s, which brings up an interesting point.

If an OEF or OIF veteran does not enroll in the VA during this 5-year period, has a seamless transition that is the smooth transition, and at some point later on down the road decides that they want to come to the VA under the prohibition if they made a successful transition, they probably wouldn't be allowed into the VA system because they would be a Priority 8 veteran. So we are basically punishing them for a seamless transition.

The other area that we are really concerned about is the homelessness of our veterans. We keep talking about the homelessness of your veterans and we are forgetting about the families, especially the children.

We have a lot of single parents that are now in the military, and when they become homeless they have children, and I am not sure that the VA is adequately prepared to deal with a family—a homeless family situation.

The GI Bill, the exchange we have had about the equity and the inequity. I am having problems grasping what the situation is. As long as the tuition is going straight to the university, if I decide to go to Louisiana Tech or Louisiana College or LSU or Tulane that is my decision. The goal is to get a college education. And I am not worried about somebody going to Stanford and getting more money sent to their university, that does not bother me, I want to get a degree. And I think that is what we need to stay focused on.

The original GI Bill paid the university full tuition wherever you got accepted. So if you went to Louisiana Tech, yeah you got a little less money than if you went to Harvard.

The CHAIRMAN. But Steve, the way the system is set up, let us assume you have no money. If the cap in a state is low, you may not be able to go to any of the higher tuition colleges you want to, because it doesn't pay enough based on the formula. You are limited to the cap and the addition from the Yellow Ribbon provision. You can't necessarily go to the college you want if it has a high tuition. If you are going to a lower tuition school, the services provided may be more than you are paying, which hurts that university.

Mr. ROBERTSON. Well, I am not worried about the university, sir, I am worried about the student.

The CHAIRMAN. Well, it hurts the services. If they are not getting the money that it really costs to educate they are not going to provide the services, whether it is rapid movement in the admissions department or counseling services, they just may not be able to provide it. I think it affects the quality to the veteran of how we are going to reverse the institution.

Mr. ROBERTSON. Well, we will look into it more, sir, but I would rather get this thing done on time than trying to tinker with it, and possibly——

The CHAIRMAN. It may be the situation for the first year, but I don't think we should neglect these inequities.

Mr. ROBERTSON. Yes, sir.

The third-party reimbursement rumor concerning service-connected disabilities, we are adamantly against that. We signed the letter along with many of the other organizations to the White House expressing our deep concerns about that concept.

We have been asked many, many times if there is a short fall where is the money going to come from? And the American Legion still believes that when the whole concept of eligibility reform was passed in 1996 many of the veteran service organizations believed that the concept was to bring veterans in along with their health insurance.

Right now over half of the VA patient populations, if you asked them who is your primary health care provider, the answer is Medicare. I have Part A, I have Part B, why can't I bring my dollars to the VA?

Right now the VA is subsidizing Medicare in the billions of dollars. Medicare is not a health care provider. Medicare is an insurance company, and I do not understand why VA cannot be reimbursed for treatment of non-service connected medical conditions that are allowable under the VA—I mean, under the Medicare reimbursement. And it just seems that we are just giving Medicare a windfall.

The CHAIRMAN. I agree with you, Steve. Should we take on this issue right now?

Mr. ROBERTSON. If you are bringing in Priority Group 8 veterans and you are trying to figure out how to pay for them and you are trying to figure out to have the resources to hire extra doctors, nurses, providers, et cetera, that is a logical revenue train.

The CHAIRMAN. If you all are willing to work with us we will take that on, I will agree with you.

There is the argument from the average American, that we are just taking it from one pocket and putting in the other, because they are both government programs. But, as you know, we are hurting the Department of Veterans Affairs in that situation.

Mr. ROBERTSON. Sir, I have been paying Medicare since the day I started working. That is a benefit that I am entitled to. If I don't go to the VA and I go down the street it works, the reimbursements are going to be made. That is when I become Medicare eligible. But I can go down the street and use my benefits.

If I choose to go to a VA, I should be able to take my health care dollars with me. And if I have a supplemental, then VA should be allowed to bill the supplemental, as it currently does.

So I believe that this——

The CHAIRMAN. I think that we have to take on that fight.

Mr. ROBERTSON. Well, I would prefer that over charging a triple amputee for his medical costs. And a lot of insurance companies have caps, and once you have reached that cap, what is his family going to do if they have a medical condition and the veterans' services are so severe that——

The CHAIRMAN. I understand. Again, I think that is off the table, but I believe we still have to figure out how we are going to bring in those dollars.

Mr. ROBERTSON. Yes, sir. Well again, we look forward to working with you and your staff—your capable staff on addressing these problems.

The CHAIRMAN. Were you familiar with the previous bills that we did on this so-called Medicare Subvention? Was that inadequate or do we have to re-look at that?

Mr. ROBERTSON. Sir, the problem was that it was a false assumption. They said that before you could collect money you had to render the services that you would have rendered any way.

There is nothing in the entire title 38 that you qualify for VA because you are Medicare eligible. That is not a criteria. Somebody in OMB or Congressional Budget Office or some puzzle palace came up with this idea that it was an obligation of the VA to treat Medicare eligible patients. There is nothing.

What qualifies you for treatment in the VA is honorable military service. I don't care if you are 21 or 121, there shouldn't be any veteran ever turned away from a VA hospital if that is their best choice.

The CHAIRMAN. Yes, I agree. I was just wondering when there was previous legislation on Medicare Subvention if it was adequate, or do we have to re-look at that too?

Mr. ROBERTSON. You have to re-look at it because of the way that it was—the assumption was that VA would have to treat all of the patients that they are currently treating that are Medicare eligible before they could bill anybody else, and that is just a false—somebody made the law, somebody can change it.

The CHAIRMAN. All right, we look forward to working with you on that, because as you know, it is a win-win for America. The cost is cheaper in the VA than it is for private care.

Mr. ROBERTSON. I will be making another bet with you, Mr. Chairman, it would probably reduce the amount of fraud, waste, and abuse in Medicare billing, because VA has no incentive to try to falsely bill Medicare for services. It is a government to government agency.

The Indian Health Services has been doing it for years. It is the principal behind TRICARE For Life.

So for somebody to tell me one government agency can't bill another government agency, that is false, and I am sure the Public Health Service probably does it as well.

The CHAIRMAN. Thank you, sir.

Mr. ROBERTSON. Yes, sir.

[The prepared statement of Mr. Robertson appears on p. 96.]

The CHAIRMAN. Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman, and again we appreciate you all being here and the testimony today was excellent.

I think that the good news I am hearing from today is that it seems like there is starting to get real consensus that we have to do something about the budgeting process. And as I told the Secretary, I think that is something that doesn't cost us anything, we are actually going to save a lot of money in doing that and reap the savings. And again, it doesn't matter whichever party is in power, that has just been a real problem for many, many years.

As you know we are, Ms. Herseth Sandlin and I, really are working hard to try and get, with your all's help and everybody else's

help, trying to get things implemented. We have some things arises, you know, like we have been discussing today. I think the key though is we have to get the thing on plan, you know, without tinkering too much. It is too much to ask as they go forward.

So I guess my thing is, you know, we need to help and go forward. I can say that because I was a supporter of Ms. Herseth Sandlin's bill that I think was much easier, and we wouldn't have, you know, the complexity that we are in now, and yet, you know, this is just a very difficult thing to implement, and it really is going to take all of us working together, and yet the good news is it is a tremendous benefit and it is going to make a real difference in the lives of lots of veterans.

You mentioned, Mr. Robertson, about homeless children, you know, in the—are you aware of H.R. 293? It is the homeless women veterans and homeless veterans—I am sorry—H.R. 293, but it addresses homeless. Are you aware of that bill at all?

Mr. ROBERTSON. My concern is that VA, it is going to take legislation to prompt them to start focusing on the homeless family as opposed to the homeless veteran. And sometimes, you know, my guess, it is my military background, I believe you lead rather than follow, and I think that that is the mindset that the VA needs to take is how do we address the problem that exists? Not, you know, ignore it until somebody tells us to do it.

Mr. BOOZMAN. No, I agree, and I think again, I have not—we are in the process, you know, of really looking hard at that bill. I was wondering if any of you all had any—if you feel like that bill would help address that particular problem.

Mr. ROBERTSON. I believe it would push the VA in that direction. But again, a lot of what I am hearing is that a lot of the homeless veterans with families are winding up in grandma and grandpa's house, and they are not showing up in homeless shelters per se. But I think it is something that needs to be addressed, and I am not sure it is being properly addressed at the right level.

Mr. BOOZMAN. Okay, thank you all.

Yes, sir.

Mr. RIECKHOFF. We are seeing Iraq and Afghanistan vets walk into our office, and it is hard to get a grasp on the numbers. But the numbers at this point are manageable and there is a definite shortage of transitional housing. There is definitely a lack of a comprehensive understanding of what these folks are facing as a family. We are seeing single parents, sometimes both parents deployed, which is really unprecedented.

But I also want to address the issue of the GI Bill oversight if I could, sir, for a second.

I think we have two issues. One we have the execution piece, and I think Mr. Chairman, you were right to focus on that and Ms. Herseth Sandlin was as well. Your questions were dead on, and we have to work out this issue of the fee and tuition disparity, and we have to have a fair, simple way of addressing this, but there is a larger problem, and it is a communications problem. And I think all of us here are kind of at the tip of the spear facing veterans who have serious questions about where this legislation stands, where this benefit stands. Is it going to be ready by August? How

is it going to be implemented? And the VA's got an opportunity here to get ahead of the curve.

When August hits we are preparing for a boatload of phone calls and e-mails from vets who don't understand this benefit. So we have a communications problem, and I think that that is an area where the VA could sort of reframe the way they look at technology.

The conversation here today focusing on technology was outstanding, but it is largely focused on the backlog and internal operations. If the VA has an opportunity now to utilize technology to look at it as an outreach opportunity and a communications tool, and that is how your generation looks at it. So you know, General Shinseki's got some new folks coming in that have an understanding of that element, and that may be an opportunity for them to really break some ground.

Our generation is going to look to the GI Bill, for some of them as their only point of contact with the VA. It is going to make or break I think the VA's relationship with huge percentages of my population, guys and women who served in Iraq and Afghanistan. And if they mess it up, they are going to be dealing with a reputation issue for a long time to come.

Mr. BOOZMAN. Excuse me, I will let you in a second, but I would agree with that, and yet again, in being pretty close to this thing as you all know and both sides working very hard, because what we all want is when that, you know, when that August date comes that we have a very successful transition into the new system. And right now it is, you know, we have had several hearings, you know, we are pushing forward, and those are really—those are updates, those aren't adversarial at all. I mean, that is just how can we help you? You know, what can we do? As are I think you all are. You know, how can we help? How can the VSOs push this thing forward?

But I think right now a lot of those questions, to be honest, they are really formulating right now, they are figuring it out, and so it is difficult to communicate, you know, what you are really not sure of yet, but that is the next step.

We have asked them to do a tremendous amount, and the good news is I think that they really are rising to the occasion. I can't speak for them, but I do think that is part of it, and I know Ms. Herseth Sandlin, you know, is committed to doing whatever it takes to get it done.

Mr. RIECKHOFF. Yeah, I think it is a tremendous opportunity for us all to work together, sir, but if you look at the VA's Web site it looks like it was created in the Gulf War, and if you look for GI Bill resources and how to navigate this new benefit you are probably going to come to one of our Web sites, rather than to the VA.

Mr. BOOZMAN. I think that is a point well taken.

Mr. RIECKHOFF. And I think the VSOs have stepped up and are trying to fill a critical gap right there.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman, and thank all of you for sticking it out late here. I thought when the Chairman left earlier he was going to pick the pizza up for us or something, so I appreciate you being here.

I have to tell you your advocacy for veterans is something I am truly appreciative of. As a dues paying member of some of these organizations that have testified today I am getting my money's worth, I can tell you that, so thank you very much.

A couple of questions. Of course the advanced appropriations issue is a big one for several reasons. One is we think it obviously allows for the programming and the care of our veterans, which is our first and foremost concern, but I think all of us realize too in these challenging economic times it is a way to be efficient with our resources, and I think we need to continue to push the Administration.

If this is truly about a change and not business as usual, I think this is smart, I think it is efficient, I think it could work. And I think one of the things is, is that with any deliberative body having a deadline is important, because otherwise nothing gets done until everybody asks, how come we don't get anything done until right before we recess or whatever? That is the nature of it because it is the give and take on all that. But if there is no drop dead deadline there, no one gets really serious about it.

And I can tell you, I have been absolutely ashamed as we finished the appropriations process for the VA and sat on it as leverage against 12 other appropriation bills. We could deliver this if we work together and put the pressure on and you help us put the pressure on each one of us, deliver the darn thing by October 1st.

Since I have been here the last 2 years it was ready to go, it wasn't delivered when it should have been. So I don't think we should back away 1 inch from asking this to happen. I think it is the right thing to do. I think it is obviously the right thing for veterans, and it is good stewardship to the public's money.

So I thank all of you for taking that one up.

Rick, I just had a question on this, because I am very curious about this. This is the type of stuff again being data driven, this migration study. Am I right to understand we never got an answer on that? We don't know what those numbers are?

Mr. WEIDMAN. That is correct, sir.

Mr. WALZ. And you were talking about in January of 2003. Was that something that VA took it upon themselves to do, or were they directed by Congress to do that?

Mr. WEIDMAN. No, it was a decision by the Secretary of Veterans Affairs to temporarily limit the registration of new Category 8s, that is what I was talking about.

Mr. WALZ. Okay.

Mr. WEIDMAN. And at a briefing 4 weeks later of the VSOs on the CARES process we saw the projections for 2023, and it was no Category 8s, and I said whoa, go back to that slide.

Mr. WALZ. Okay.

Mr. WEIDMAN. Why are you using those figures? We were told to. By whom? And it turns out that it didn't become temporary anymore, it was built into the long-term planning and into the CARES plan for the physical plant of freezing out Category 8s. And so basically we were sold a pig in a poke.

Mr. WALZ. Okay, well very good, I am very appreciative of that.

Last question I just throw out as you heard me ask the last panel on this. The two questions I had, this conundrum of trying

to deliver care, especially in rural areas, without diminishing the core services and delivery at the VA, and also this idea of seamless transition, the commitment that seems to be there to start alleviating some of these problems.

I will just let you just randomly comment if you would, just your perspective.

Mr. ROBERTSON. First of all, you know, the VA is affiliated with over I think it is 108 medical schools right now. I have never understood why VA did not reach out to rural community hospitals and try to work out partnerships with the—I mean, where would be a better place to send them than in New Town, North Dakota, rather than building in a CBOC? Work out some kind of an agreement with the hospital that you would contract the services there where they wouldn't have to make the trip all the way to Fargo.

Today Rick made a comment at an earlier hearing about the difference between remote areas versus rural areas, and that is a serious problem that I had never really thought of in that capacity where there are some places where you can't get to a VA hospital that are part of the continental United States. And I think that that is something that needs to be seriously addressed.

But the question you had about the Mayo Clinic. Why doesn't VA have a partnership with Mayo Clinic to be able to take people that are in that catchment area under some kind of a contract? That would seem a wise use of resources.

Mr. WEIDMAN. It would, and it has certainly been a lot of concern in a lot of the leadership exercise, particularly by this Committee in regard to dealing with rural health care and the distinction that Steve is talking about is actually—our Alaska state president has written a paper that is almost ready for release to the Hill on remote versus rural health care and it will help in our thinking and planning.

However, you all passed a number of laws having to do with rural health care and there is basically nobody at home at VA. They still have not staffed up that office, and it is—everybody is talking about the new team at VA. This is a pretty lonely team, because you have General Shinseki and you have John R. Gingrich, who is his Chief of Staff, and that are it, and I think there is a couple of speech writers, but other than that, he hasn't been able to get anybody else on board.

So in regard to rural health it would be helpful to us and the VSOs to—for you all to press hard about why the heck haven't you staffed up and done what we told you to back in 110th Congress?

Mr. RIECKHOFF. And other than pile on to what these gentlemen have already said. I think when we deal with remote and rural areas we look to technology. I am going to sound like a broken record, but this is an opportunity for innovation, and I think the VA has made good process, for example, in the suicide prevention hot line and finding new ways to do outreach, but as some of you know we have launched a massive public service announcement campaign with the ad counsel. We are going where the veterans are, and I think that is a critical way to reaching the newest generation of veterans especially. We have to be online, we have to be innovating, and I think that is an area where they can really uti-

lize new technology to bridge some of these gaps and create programs that work.

And when it comes to DoD and VA, you know, Congressman Walz, I share your optimism, and I think we have an opportunity here with General Shinseki and Secretary Gates to really bridge that gap. The GI Bill will be a good test. I mean, they have to work out transferability, they have to be communicating effectively. We get a lot of calls from recruiters who want to know how does the new GI Bill compare to the old GI Bill, how do I communicate to this incoming recruits? So I think that will be a critical test there as well.

Mr. WALZ. Well thank you all.

Thank you, Mr. Chairman.

Mr. SULLIVAN. And Congressman to add on to what they said. The Vet Center's new mobile Vet Centers, those are fantastic. We encourage those, and in fact expanding Vet Centers when it comes to mental health otherwise we agree with that they have said.

On seamless transition, the goal here is to bring VA to the veterans. And when a servicemember is about to get out of the military and become a veteran, they are at their military base, they are there already. By putting Benefits Delivery at Discharge at all VA facilities, making them permanent offices, and also at some of the National Guard permanent facilities, we can make a great step forward so that there is a good presentation, an initial contact with these servicemembers on their way out the door. And it is one stop shopping: GI Bill, disability compensation, home loan guarantee, their insurance, all of that can be done walking out the door with a permanent VA facility. That is when we truly have seamless transition is when that happens.

Mr. WALZ. Thanks so much.

Mr. Chairman, may I just add one other comment about transition, and transition, there is nothing seamless about it, and I hate it, because it is new speak. I would settle for a decent transition, period.

The combined physical that is happening at Walter Reed is not working well. It seems to be better at Bethesda, but Walter Reed it is not working well, and they are not doing it properly according to their other standard operating procedures. And the soldiers that I am in contact with regularly are really unhappy.

We brought it to the attention of the previous Secretary last fall several times, to current Under Secretary several times, to the Deputy Under Secretary a number of times, and it is still not really fixed, and it is to the point where many of the young people are turning to JAG, and JAG is getting involved in it because what happens is if they say that Form 3947 is wrong, then they say too bad. If you don't sign this it goes to hearing, and if it is hearing it is de novo and you may get nothing, and that is it.

So many of the less sophisticated ones cave in, and so they get a disability rating from the military that is much less than it should have been in the first place, and that is all because they are not doing what they are supposed to be doing, is the army person sitting down with the military medical file and going over it with the soldier and then a separate process, the VA person sitting down with that same medical file and going over it with the soldier

and filling out the Form 3947 again to make sure it is correct, and it ain't happening.

And we don't know what to say except I know that the Armed Services Committee, perhaps the Joint Oversight on this. Because they are about to expand this thing to 17 major military installation separation points and it is not even working for the people who are housed in Malone House right now.

The CHAIRMAN. We thank you all.

Mr. ROBERTSON. Mr. Chairman, before you hit the gavel, our commander testified last September on our "Joint Views and Estimates for Fiscal Year 2010 Budget." Do you mind if I submit this to the record?

The CHAIRMAN. No, that will be added to the record. Thank you.

Mr. ROBERTSON. Thank you, sir.

[The American Legion's "Joint Views and Estimates for Fiscal Year 2010 Budget" is attached to Mr. Robertson's prepared statement, and appears on p. 105.]

The CHAIRMAN. As a concluding note, I notice that several things are still on the plate from previous Administrations.

You might want to give us a summary of those issues or a list and we will give it to the new Administration. Not that you would get instant return, but let us restart it all, reset the button as Mrs. Clinton said.

Thank you all, this hearing is adjourned.

[Whereupon, at 5:27 p.m., the Committee was adjourned.]

A P P E N D I X

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

Welcome to the hearing on the Department of Veterans Affairs Budget Request for Fiscal Year 2010. Today's hearing is on the preliminary budget submission of the Department of Veterans Affairs for Fiscal Year 2010.

On February 26, 2009, the Administration submitted a preliminary budget to Congress. This 134-page document provides only top-line budget numbers and brief discussions regarding Administration priorities.

For FY 2010, the Administration proposes a VA discretionary budget number of $52.5 billion, an increase of $4.9 billion, or 10.3 percent, above FY 2009 levels.

In total discretionary resources (including collections), the Administration requests $55.9 billion, which exceeds *The Independent Budget* request by $1.3 billion.

This budget marks the first time any President has submitted a budget that exceeds the recommendations of *The Independent Budget*. I have often referred to *The Independent Budget* as the funding "bible" for the VA, and I am pleased that its recommendations are being accorded the weight they deserve.

This year's budget also marks a sharp departure from the previous Administration in that the budget includes increased funding over a 5-year period, in this instance an increase of $25 billion above baseline, as compared to last year's budget that included a net cut of $20 billion. Although we understand these numbers are not binding on future years, and the levels are lower than the amounts that will be needed, we applaud this move toward presenting an honest and accurate look at our financial picture.

I applaud the Administration's commitment to high priority areas of interest, which are shared by this Committee, including caring for our returning servicemembers, improving the VA's ability to provide mental heath care and services, addressing homelessness among veterans, and not forgetting the veterans of previous generations. We are committed to assisting the VA in their goal of turning the VA into a model organization of the 21st Century that puts the needs of veterans first.

We understand that VA cannot provide specific account-level funding details at this time, and we await more detailed information in April. We note that this Committee will fight diligently to ensure that veterans receive the funding they need and that this funding is provided in a timely fashion.

We applaud this Administration for this proposed robust funding increase for veterans, and look forward to hearing from our witnesses.

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

Mr. Chairman, Congressman Buyer, distinguished Members of the Committee:

Thank you for this opportunity to present an overview of the 2010 budget for the Department of Veterans Affairs (VA). President Obama has charged me with transforming VA into a 21st century organization—a transformation demanded by new times, new technologies, new demographic realities, and new commitments to today's Veterans.

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

Nearly two thirds of the increase ($9.7 billion) would go to mandatory programs (up 20 percent); the remaining third ($5.6 billion) would be discretionary funding

(up 11 percent). The total budget would almost evenly split between mandatory funding ($56.9 billion) and discretionary funding ($55.9 billion).

The President's 2010 budget is the first step toward increasing VA funding by $25 billion over the baseline over the next 5 years. This strong financial commitment will ensure Veterans receive timely access to the highest quality benefits and services we can provide and which they earned through their sacrifice and service to our Nation.

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

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

Dramatically Increasing Funding for Health Care

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

The 2010 budget request enables VA to achieve the President's pledge of strengthening the quality of health care for Veterans. We will increase our emphasis on treating those with vision and spinal cord injury and meet the rising demand for prosthetics and sensory aids. We will respond to the needs of an aging population and a growing number of women Veterans coming to VA for health care. The delivery of enhanced primary care for women Veterans is one of VA's top priorities. The number of women Veterans is growing rapidly. In addition, women are becoming increasingly dependent on VA for their health care. More than 450,000 women Veterans have enrolled for care and this number is expected to grow by 30 percent in the next 5 years. We will soon have 144 full-time Women Veterans Program Managers serving at VA medical facilities. They will serve as advisors to and advocates for women Veterans to help ensure their care is provided with the appropriate level of privacy and sensitivity.

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

Expanding Health Care Eligibility

For the first time since 2003, the President's budget expands eligibility for VA health care to non-disabled Veterans earning modest incomes. This commitment recognizes that economic conditions have changed and there are many lower income Priority 8 Veterans who are now facing serious financial difficulties due to the rising cost of health care. This year VA will open enrollment to Priority 8 Veterans whose incomes exceed last year's geographic and VA means test thresholds by no more than 10 percent. We estimate that 266,000 more Veterans will enroll for care in 2010 due to this policy change. Furthermore, the budget includes a gradual expansion of health care eligibility that is expected to result in nearly 550,000 new enrollees by 2013. The Department's 2010 budget contains sufficient resources to ensure we will maintain our quality of care, which sets the national standard of excellence. Further, there will be no adverse impact on wait times for those already enrolled in our system.

Enhancing Outreach and Services Related to Mental Health Care and Cognitive Injuries, including Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI), with a Focus on Access for Veterans in Rural Areas

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

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

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

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

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

Investing in Better Technology to Deliver Services and Benefits to Veterans with the Quality and Efficiency They Deserve

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

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

This budget strongly supports the most critical IT development program for medical care—advancement of VA's "Health*e*Vet" program, which is the future foundation of our electronic health record system. This system includes a health data repository, a patient scheduling system, and a reengineered pharmacy application. "Health*e*Vet" will equip our health care providers with the modern technology and tools they need to improve the safety and quality of care for Veterans.

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

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

Providing Greater Benefits to Veterans Who Are Medically Retired from Service

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

Combating Homelessness by Safeguarding Vulnerable Veterans

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

Facilitating Timely Implementation of the Comprehensive Education Benefits Veterans Earn through their Dedicated Military Service

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

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

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

Closing

Veterans are VA's sole reason for existence and my number one priority—bar none. I am inspired by this Committee's unwavering commitment to Veterans, and

I look forward to working with you to transform VA into an organization that reflects the change and commitment our country expects and our Veterans deserve.

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

Chairman Filner, Ranking Member Buyer, and Members of the Committee, as one of the four co-authors of *The Independent Budget* (*IB*), Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for FY 2010.

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

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

PVA is pleased to see that the initial information provided by the Administration suggests a very good budget for the VA in FY 2010. The discretionary funding levels provide for a truly significant increase. However, we will withhold final judgment on the budget submission until we have much more details about the FY 2010 budget. Moreover, we would like to highlight our concern that the out year projections for VA funding do not seem to reflect sufficient budgets to serve the needs of veterans. In fact, the projected increases in all cases are less than 3 percent. We would be very interested in an explanation and justification for the small out year spending increases.

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

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health care funding level. For FY 2010, *The Independent Budget* recommends approximately $36.6 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

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

Our increase in patient workload is based on a projected increase of 93,000 new unique patients—Priority Group 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $639 million. The increase in patient workload also includes a projected increase of 90,000 new Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans at a cost of approximately $279 million. Finally, our increase in workload includes the projected increase of new Priority Group 8 veterans who will use the VA health care system as a result of the recent decision to expand Priority Group 8 enrollment by

10 percent. The VA estimated that this policy change would allow enrollment of approximately 265,000 new enrollees. Based on a historic Priority Group 8 utilization rate of 25 percent, we estimate that approximately 66,250 of these new enrollees will become users of the system. This translates to a cost of approximately $255 million.

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

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

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

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

For Medical and Prosthetic Research, *The Independent Budget* recommends $575 million. This represents a $65 million increase over the FY 2009 appropriated level. We are particularly pleased that Congress has recognized the critical need for funding in the Medical and Prosthetic Research account in the last couple of years. Research is a vital part of veterans' health care, and an essential mission for our National health care system. VA research has been grossly underfunded in contrast to the growth rate of other Federal research initiatives. At a time of war, the government should be investing more, not less, in veterans' biomedical research programs.

The Independent Budget recommendation also includes a significant increase in funding for Information Technology (IT). For FY 2010, we recommend that the VA IT account be funded at approximately $2.713 billion. This amount includes approximately $130 million for an Information Systems Initiative to be carried out by the Veterans Benefits Administration. This initiative is explained in greater detail in the policy portion of *The Independent Budget*.

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

As explained in *The Independent Budget*, there is a significant backlog of major and minor construction projects awaiting action by the VA and funding from Congress. We have been disappointed that there has been inadequate follow through on

issues identified by the Capital Asset Realignment for Enhanced Services (CARES) process. In fact, we believe it may be time to revisit the CARES process all together. For FY 2010, *The Independent Budget* recommends approximately $1.123 billion for Major Construction and $827 million for Minor Construction. The Minor Construction recommendation includes $142 million for research facility construction needs.

Mr. Chairman, we would like to express our sincere thanks for your introduction of H.R. 1016, the "Veterans Health Care Budget Reform and Transparency Act." For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations including PVA, and our *IB* co-authors, has advocated for reform in the VA health care budget process. The Partnership worked with the House and Senate Committees on Veterans' Affairs last year to develop this alternative proposal that would change the VA's medical care appropriation to an "advance appropriation," guaranteeing funding for the health care system up to 1 year in advance of the operating year. This alternative proposal would ensure that the VA received its funding in a timely and predictable manner. Furthermore, it would provide an option the IBVSOs believe is politically more viable than mandatory funding, and is unquestionably better than the current process.

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

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

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

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

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

Prepared Statement of Kerry Baker,
Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Committee:

I am pleased to have this opportunity to appear before you on behalf of the Disabled American Veterans (DAV), one of four National veterans' organizations that create the annual *Independent Budget* (*IB*) for veterans programs, to summarize our recommendations for fiscal year (FY) 2009.

As you know Mr. Chairman, the *IB* is a budget and policy document that sets forth the collective views of DAV, AMVETS, Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars of the United States (VFW). Each organization accepts principal responsibility for production of a major component of our *IB*—a budget and policy document on which we all agree. Reflecting that division of re-

sponsibility, my testimony focuses primarily on the variety of Department of Veterans Affairs' (VA) benefits programs available to veterans.

In preparing this 23rd *IB*, the four partners draw upon our extensive experience with veterans' programs, our firsthand knowledge of the needs of America's veterans, and the information gained from continuous monitoring of workloads and demands upon, as well as the performance of, the veterans benefits and services system. Consequently, this Committee has acted favorably on many of our recommendations to improve services to veterans and their families. We ask that you give our recommendations serious consideration again this year.

The Veterans Benefits Administration and its Claims Process

To improve administration of VA's benefits programs, the *IB* veterans' service organizations (IBVSOs) recommend that Congress adopt both short- and long-term strategies for improvements within the Veterans Benefits Administration (VBA). These strategies focus on the VBA's information technology (IT) infrastructure as well as the claims and appeals process, to include the resulting backlog. Consequently, we are also seeking improvements in VBA's training programs and enhancements in accountability and quality assurance with respect to disability ratings. If Congress accepts our recommendations, VBA will be better positioned to serve all disabled veterans and their families.

VBA Information Technology

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

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

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

All IT initiatives are now being funded in the VA's IT appropriation and tightly controlled by the CIO. However, needed and ongoing VBA initiatives include expansion of web-based technology and deliverables, such as web portal and Training and Performance Support Systems (TPSS); "Virtual VA" paperless processing; enhanced veteran self-service and access to benefit application, status, and delivery; data integration across business lines; use of the corporate database; information exchange; quality assurance programs and controls; and, employee skills certification and training.

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

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

The VBA should accelerate implementation of Virtual Information Centers (VICs). By providing veterans regionalized telephone contact access from multiple offices

within specified geographic locations, VA could achieve greater efficiency and improved customer service. Accelerated deployment of VICs will more timely accomplish this beneficial effect.

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

Congress has taken notice of the chronic disconnect between VBA IT and lagging improvements in claims processing. Section 227 of Public Law 110–389 places new requirements on VA to closely examine all uses of current IT and comparable outside IT systems with respect to VBA claims processing for both compensation and pension. Following that examination, VA is required to develop a new plan to use these and other relevant technologies to reduce subjectivity, avoid remands and reduce variances in VA Regional Office ratings for similar specific disabilities in veteran claimants.

The act requires the VA Secretary to report the results of that examination to Congress in great detail, and includes a requirement that the Secretary ensure that the plan will result, within 3 years of implementation, in reduction in processing time for compensation and pension claims processed by VBA. The requirements of this section will cause heavy scrutiny on IT systems that VBA has been attempting to implement, improve and expand for years. We believe the examination will reveal that progress has been significantly stymied due to lack of directed funding to underwrite IT development and completion, and lack of accountability to ensure these programs work as intended.

Recommendations:

- Congress should provide the Veterans Benefits Administration adequate funding for its IT initiatives to improve multiple information and information-processing systems and to advance ongoing, approved and planned initiatives such as those enumerated in this section. We believe these IT programs should be increased annually by a minimum of 5 percent or more.
- VA should ensure that recent funding specifically designated by Congress to support the IT needs of VBA, and of new VBA staff authorized in fiscal year 2009, are provided to VBA as intended, and on an expedited basis.
- The Chief Information Officer and Under Secretary for Benefits should give high priority to the review and report required by Public Law 110–389, and redouble their efforts to ensure these ongoing VBA initiatives are fully funded and accomplish their stated intentions.
- The Secretary should examine the impact of the current level of IT centralization under the Chief Information Officer on these key VBA programs, and, if warranted, shift appropriate responsibility for their management, planning and budgeting from the CIO to the Under Secretary for Benefits.

The Claims Process

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

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

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

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

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

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

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

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

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

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

Congress should consider amending section 5103A(d)(1) to provide that when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request such evidence from a department health care facility. Some may view this suggestion as an attempt to tie VA's hands with respect to its consideration of private medical opinions. However, it does not. The language we suggest adding to section 5103A(d)(1) would not require VA to accept private medical evidence if, for example, VA finds that the evidence is not credible and therefore not adequate for VA rating purposes.

The IBVSOs also believe that other procedures add unnecessary delays to the claims process. For example, we believe VA routinely continues to develop claims rather than issue decisions even though evidence development appears complete. These actions result in numerous appeals and unnecessary remands from the Board

and the Court. Remands in fully developed cases do nothing but perpetuate the hamster-wheel reputation of veterans law. In fact, the Board remands an extremely large number of appeals solely for unnecessary medical opinions. In FY 2007, the Board remanded 12,269 appeals to obtain medical opinions. Far too many were remanded for no other reason but to obtain a VA medical opinion merely because the appellant had submitted a private medical opinion. Such actions are, we respectfully submit, a serious waste of VA's resources.

The suggested rulemaking actions and recommended changes to sections 5103 and 5103A(d)(1) may have a significant effect on ameliorating some problems. But to further improve these procedures, Congress should amend title 38, United States Code, section 5125. Congress enacted section 5125, for the express purpose of eliminating the former title 38, Code of Federal Regulations, section 3.157(b)(2) requirement that a private physician's medical examination report be verified by an official VA examination report before VA could award benefits. However, Congress enacted section 5125 with discretionary language. This discretionary language permits, but does not require, VA to accept medical opinions from private physicians. Therefore, Congress should amend section 5125 by adding new language that requires VA to accept a private examination report if the VA determines that the report is (1) provided by a competent health care professional; (2) probative to the issue being decided; (3) credible; and (4) otherwise adequate for adjudicating the claim.

Recommendations:

- VA should amend its notification forms to inform claimants of the procedures that are available for obtaining review of a VA decision by the Board of Veterans' Appeals along with providing an explanation of the types of reviews that are available to claimants.VA should issue proposed regulations to implement the recent amendment of title 38, United States Code, section 5103 as quickly as possible. The VA's proposed regulations should include provisions that will require VA to notify a claimant, in appropriate circumstances, of the elements that render medical opinions adequate for rating purposes.
- Congress should amend section 5103A(d)(1) to provide that when a claimant submits a private medical opinion that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request another medical opinion from a department health care facility.
- Congress should amend title 38, United States Code, section 5125, insofar as it states that a claimant's private examination report "may" be accepted. The new language should direct that the VA "must" accept such report if it is (1) provided by a competent health care professional, (2) probative to the issue being decided, (3) credible, and (4) otherwise adequate for adjudicating such claim.

Training:

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

Training has not been a high enough priority in VA. We have consistently asserted that proper training leads to better quality decisions, and that quality is the key to timeliness of VA decisionmaking. VA will only achieve such quality when it devotes adequate resources to perform comprehensive and ongoing training and imposes and enforces quality standards through effective quality assurance methods and accountability mechanisms.

The VBA's problems caused by a lack of accountability do not begin in the claims development and rating process—they begin in the training program. There is little measurable accountability in the VBA's training program.

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

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

to use online references and any other reference material, including individually prepared notes in order to pass the test.

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

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

The Veterans' Benefits Improvement Act of 2008 mandated some testing for claims processors and VBA managers, which is an improvement; however, it does not mandate the type of testing during the training process as explain herein. Measurable improvement in the quality of and accountability for training will not occur until such mandates exist. It is quite evident that a culture of quality neither exists, nor is much desired, in the VBA.

Recommendation:

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

Stronger Accountability

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

The quality assurance tool used by the VA for compensation and pension claims is the Systematic Technical Accuracy Review (STAR) program. Under the STAR program, VA reviews a sampling of decisions from regional offices and bases its national accuracy measures on the percentage with errors that affect entitlement, benefit amount, and effective date.

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

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

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

In the past 15 years the VBA has moved from a quality-control system for ratings that required three signatures on each rating before it could be promulgated to the requirement of but a single signature. Nearly all VA rating specialists, including those with just a few months' training, have been granted some measure of "single signature" authority. Considering the amount of time it takes to train an RVSR, the complexity of veterans disability law, the frequency of change mandated by judicial

decisions, and new legislation or regulatory amendments, a case could and should be made that the routine review of a second well-trained RVSR would avoid many of the problems that today clog the appeals system.

The Veterans' Benefits Improvement Act of 2008 (section 226) required VA to conduct a study on the effectiveness of the current employee work-credit system and work-management system. In carrying out the study, VA is required to consider, among other things: (1) measures to improve the accountability, quality, and accuracy for processing claims for compensation and pension benefits; (2) accountability for claims adjudication outcomes; and (3) the quality of claims adjudicated. The legislation requires VA to submit the report to Congress, which must include the components required to implement the updated system for evaluating VBA employees, no later than October 31, 2009.

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

Recommendation:

- The VA Secretary's upcoming report must focus on how the Department will establish a quality assurance and accountability program that will detect, track, and hold responsible those VA employees who commit errors while simultaneously providing employee motivation for the achievement of excellence. VA should generate the report in consultation with veterans service organizations most experienced in the claims process.

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

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

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

Prepared Statement of Dennis M. Cullinan,
Director, National Legislative Service,
Veterans of Foreign Wars of the United States

Mr. Chairman and Members of the Committee:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today. The VFW works alongside the other members of *The Independent Budget* (*IB*)—AMVETS, Disabled American Veterans and Paralyzed Veterans of America—to produce a set of policy and budget recommendations that reflect what we believe would meet the needs of America's veterans. The VFW is responsible for the construction portion of the *IB*, so I will limit my remarks to that portion of the budget.

On May 5, 2008, VA released the final results of its Capital Asset Realignment for Enhanced Services (CARES) business plan study for Boston, Massachusetts. The decision to keep the four Boston-area medical campuses open was the culmination of many years of work and 1910s of millions of dollars as it marked the final step of the CARES planning process.

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

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

VA's most recent Asset Management Plan provides an update of the state of CARES projects—including those only in the planning of acquisition process. Appendix E (pages 93–95) shows a need of future appropriations to complete these projects of $2.195 billion.

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

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

Meanwhile, VA continues to identify and reprioritize potential major construction projects. These priorities, which are assessed using the rigorous methodology that guided the CARES decisions are released in the Department's annual Five Year Capital Asset Plan, which is included in the Department's budget submission. The most recent one was included in Volume IV and is available on VA's Web site: http://www.va.gov/budget/summary/2009/index.htm

Pages 7–12 of that document shows the priority scoring of projects. Last year's budget request sought funding for only three of the top scored projects. No funding was requested for any other new project, including those in Seattle, Dallas, Louis-

ville or Roseburg, Oregon. In addition to the already-identified needs from that table, page 7–86 shows a long list of potential major construction projects the department plans to evaluate from now through FY 13. These 122 potential projects demonstrate the continued need for VA to upgrade and repair its aging infrastructure, and that continuous funding is necessary for not just the backlog of projects, but to keep VA viable for today's and future veterans.

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

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

Major Construction Account Recommendations

Category	Recommendation ($ in Thousands)
VHA Facility Construction	$900,000
NCA Construction	$80,000
Advance Planning	$45,000
Master Planning	$20,000
Historic Preservation	$20,000
Miscellaneous Accounts	$58,000
TOTAL	**$1,123,000**

- VHA Facility Construction—this amount would allow VA to continue digging into the $2 billion backlog of partially funded construction projects. Depending on the stages and ability to complete portions of the projects, any additional money could be used to fund new projects identified by VA as part of its prioritization methodology in the Five-Year Capital Plan.
- NCA Construction—page 7–143 of VA's Five-Year Capital Plan details numerous potential major construction projects for the National Cemetery Association throughout the country. This level of funding would allow VA to begin construction on at least three of its scored priority projects.
- Advance Planning—helps develop the scope of the major construction projects as well as identifying proper requirements for their construction. It allows VA to conduct necessary studies and research similar to planning processes in the private sector.
- Master Planning—a description of our request follows later in the text.
- Historic Preservation—a description of our request follows later in the text.
- Miscellaneous Accounts—these include the individual line items for accounts such as asbestos abatement, the judgment fund and hazardous waste disposal. Our recommendation is based upon the historic level for each of these accounts.

Minor Construction Account Recommendations

Category	Funding ($ in Thousands)
Veterans Health Administration	$550,000
Medical Research Infrastructure	$142,000
National Cemetery Administration	$100,000
Veterans Benefits Administration	$20,000
Staff Offices	$15,000
TOTAL	**$827,000**

- Veterans Health Administration—Page 7–95 of VA's Capital Plan reveals hundreds of already identified minor construction projects. These projects update and modernize VA's aging physical plant ensuring the health and safety of veterans and VA employees. Additionally, a great number of minor construction

projects address FCA-identified maintenance deficiencies, the backlog of which was nearly $5 billion at the start of FY 08 (page 7–64).
- Medical Research Infrastructure—a description of our request follows later in the text.
- National Cemetery Administration—Page 7–145 of the Capital Plan identifies numerous minor construction projects throughout the country including the construction of several columbaria, installation of crypts and landscaping and maintenance improvements. Some of these projects could be combined with VA's new NCA nonrecurring maintenance efforts.
- Veterans Benefits Administration—Page 7–126 of the Capital Plan lists several minor construction projects in addition to the leasing requirements VBA needs. This funding also includes $2 million it transfers yearly for the security requirements of its Manila office.
- Staff Offices—Page 7–166 lists numerous potential minor construction projects related to staff offices, including increased space and numerous renovations for VA's Inspector General's office.

Increase Spending on Nonrecurring Maintenance

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

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

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

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

The most recent estimate of VA's PRV is from the FY 08 Asset Management Plan. Using the standards of the Federal Government's Federal Real Property Council (FRPC), VA's PRV is just over $85 billion (page 26).

Accordingly, to fully maintain its facilities, VA needs a NRM budget of at least $1.7 billion. This number would represent a doubling of VA's budget request from FY 2009, but is in line with the total NRM budget when factoring in the increases Congress gave in the appropriations bill and the targeted funding included in the supplemental appropriations bills.

Increased funding is required not to just to fill current maintenance needs and levels, but also to dip into the extensive backlog of maintenance requirements VA has. VA monitors the condition of its structures and systems through the Facility Condition Assessment (FCA) reports. VA surveys each medical center periodically, giving each building a thorough assessment of all essential systems. Systems are assigned a letter grade based upon the age and condition of various systems, and VA gives each component a cost for repair or replacement.

The bulk of these repairs and replacements are conducted through the NRM program, although the large increases in minor construction over the last few years have helped VA to address some of these deficiencies.

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

VA uses the FCA reports as part of its Federal Real Property Council (FRPC) metrics. The department calculates a Facility Condition Index, which is the ratio of the cost of FCA repairs to the cost of replacement. According to the FY 08 Asset Management Plan, this metric has gone backward from 82 percent in 2006 to just

68 percent in 2008. VA's strategic goal is 87 percent, and for it to meet that, it would require a sizeable investment in NRM and minor construction.

Given the low level of funding the NRM account has historically received, the IBVSOs are not surprised at the metrics or the dollar cost of the FCA deficiencies. The 2007 "National Roll Up of Environment of Care Report," which was conducted in light of the shameful maintenance deficiencies at Walter Reed further prove the need for increased spending on this account. Maintenance has been neglected for far too long, and for VA to provide safe, high-quality health care in its aging facilities, it is essential that more money be allocated for this account.

We also have concerns with how NRM funding is actually apportioned. Since it falls under the Medical Care account, NRM funding has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This model works when divvying up health care dollars, targeting money to those areas with the greatest demand for health care. When dealing with maintenance needs, though, this same formula may actually intensify the problem, moving money away from older hospitals, such as in the northeast, to newer facilities where patient demand is greater, even if the maintenance needs are not as high. We were happy to see that the conference reports to the VA appropriations bills required NRM funding to be apportioned outside the VERA formula, and we would hope that this continues into the future.

Another issue related to apportionment of funding came to light in a May 2007 Government Accountability Office (GAO) report. They found that the bulk of NRM funding is not actually apportioned until September, the final month of the fiscal year. In September 2006, GAO found that VA allocated 60 percent of that year's NRM funding. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and since NRM funding is year-to-year, it means that it could lead to wasteful or unnecessary spending as hospital managers rushed in a flurry to spend their apportionment before forfeiting it back. We cannot expect VA to perform a year's worth of maintenance in a month. It is clearly poor policy and not in the best interest of veterans. The IBVSOs believe that Congress should consider allowing some NRM money to be carried over from one fiscal year to another. While we would hope that this would not resort to hospital managers hoarding money, it could result in more efficient spending and better planning, rather than the current situation where hospital managers sometimes have to spend through a large portion of maintenance funding before losing it at the end of the fiscal year.

Recommendations:

VA must dramatically increase funding for nonrecurring maintenance in line with the 2 percent–4 percent total that is the industry standard so as to maintain clean, safe and efficient facilities. VA also requires additional maintenance funding to allow the department to begin addressing the substantial maintenance backlog of FCA-identified projects.

Portions of the NRM account should be continued to be funded outside of the VERA formula so that funding is allocated to the facilities that actually have the greatest maintenance needs.

Congress should consider the strengths of allowing VA to carryover some maintenance funding from one fiscal year to another so as to reduce the temptation some VA hospital managers have of inefficiently spending their NRM money at the end of a fiscal year for fear of losing it.

Inadequate Funding and Declining Capital Asset Value

VA must protect against deterioration of its infrastructure and a declining capital asset value

The last decade of underfunded construction budgets has meant that VA has not adequately recapitalized its facilities. Recapitalization is necessary to protect the value of VA's capital assets through the renewal of the physical infrastructure. This ensures safe and fully functional facilities long into the future. VA's facilities have an average age of over 55 years, and it is essential that funding be increased to renovate, repair and replace these aging structures and physical systems.

As in past years, the IBVSOs cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). It found that from 1996–2001, VA's recapitalization rate was just 0.64 percent. At this rate, VA's structures would have an assumed life of 155 years.

The PTF cited a PriceWaterhouseCoopers study of VA's facilities management programs that found that to keep up with industry standards in the private sector and to maintain patient and employee safety and optimal health care delivery, VA

should spend a minimum of 5 to 8 percent of plant replacement value (PRV) on its total capital budget.

The FY 08 VA Asset Management Plan provides the most recent estimate of VA's PRV. Using the guidance of the Federal Government's Federal Real Property Council (FRPC), VA's PRV is just over $85 billion (page 26).

Accordingly, using that 5 to 8 percent-standard, VA's capital budget should be between $4.25 and $6.8 billion per year in order to maintain its infrastructure.

VA's capital budget request for FY 2009—which includes major and minor construction, maintenance, leases and equipment—was just $3.6 billion. We greatly appreciate that Congress increased funding above that level with an increase over the Administration request of $750 million in major and minor construction alone. That increased amount brought the total capital budget in line with industry standards, and we strongly urge that these targets continue to be met and we would hope that future VA requests use these guidelines as a starting point without requiring Congress to push them past the target.

Recommendation:

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

Maintain VA's Critical Infrastructure

The IBVSOs are concerned with VA's recent attempts to back away from the capital infrastructure blueprint laid out by CARES and we are worried that its plan to begin widespread leasing and contracting for inpatient services might not meet the needs of veterans.

VA acknowledges three main challenges with its capital infrastructure projects. First, they are costly. According to a March 2008 briefing given to the VSO community, over the next 5 years, VA would need $2 billion per year for its capital budget. Second, there is a large backlog of partially funded construction projects. That same briefing claimed that the difference in major construction requests given to OMB was $8.6 billion from FY 03 through FY 09, and that they have received slightly less than half that total. Additionally, there is a $2 billion funding backlog for projects that are partially but not completely funded. Third, VA is concerned about the timeliness of construction projects, noting that it can take the better part of a decade from the time VA initially proposes a project until the doors actually open for veterans.

Given these challenges, VA has floated the idea of a new model for health care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF, VA would begin leasing large outpatient clinics in lieu of major construction. These large clinics would provide a broad range of outpatient services including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

On the face of it, this sounds like a good initiative. Leasing has the advantage of being able to be completed quickly, as well as being adaptable, especially when compared to the major construction process. Leasing has been particularly valuable for VA as evidenced by the success of the Community Based Outpatient Clinics (CBOCs) and Vet Centers.

Our concern rests, however, with VA's plan for inpatient services. VA aims to contract for these essential services with affiliates or community hospitals. This program would privatize many services that the IBVSOs believe VA should continue to provide. We lay out our objections to privatization and widespread contracting for care elsewhere in *The Independent Budget*.

Beyond those objections, though, is the example of Grand Island, Nebraska. In 1997, the Grand Island VA Medical Center closed its inpatient facilities, contracting out with a local hospital for those services. Recently, the contract between the local facility and VA was canceled, meaning veterans in that area can no longer receive inpatient services locally. They must travel great distances to other VA facilities such as the Omaha VA Medical Center. In some cases, when Omaha is unable to provide specialized care, VA is flying patients at its expense to faraway VA medical centers, including those in St. Louis and Minneapolis.

Further, with the canceling of that contract, St. Francis no longer provides the same level of emergency services that a full VA Medical Center would provide. With VA's restrictions on paying for emergency services in non-VA facilities, especially for those who may have some form of private insurance, this amounts to a cut in essential services to veterans. Given the expenses of air travel and medevac services, the

current arrangement in Grand Island has likely not resulted in any cost savings for VA. Ferrying sick and disabled veterans great distances for inpatient care also raises patient safety and quality concerns.

The HCCF program raises many concerns for the IBVSOs that VA must address before we can support the program. Among these questions, we wonder how VA would handle governance, especially with respect to the large numbers of non-VA employees who would be treating veterans? How would the non-VA facility deal with VA directives and rule changes that govern health care delivery and that ensure safety and uniformity of the quality of care? Will VA apply its space planning criteria and design guides to non-VA facilities? How will VA's critical research activities, most of which improve the lives of all Americans and not only veterans, be affected if they are being conducted in shared facilities, and not a traditional part of VA's first-class research programs? What would this change mean for VA's electronic health record, which many have rightly lauded as the standard that other health care systems should aim to achieve? Without the electronic health record, how would VA maintain continuity of care for a veteran who moves to another area?

But most importantly, CARES required years to complete and consumed thousands of hours of effort and millions of dollars of study. We believe it to be a comprehensive and fully justified roadmap for VA's infrastructure as well as a model that VA can apply periodically to assess and adjust those priorities. Given the strengths of the CARES process and the lessons VA learned and has applied from it, why is the HCCF model, which to our knowledge has not been based on any sort of model or study of the long-term needs of veterans, the superior one? We have yet to see evidence that it is and until we see more convincing evidence that it will truly serve the best needs of veterans, the IBVSOs will have a difficult time supporting it.

Recommendation:

VA must resist implementing the HCCF model without fully addressing the many questions the IBVSOs have and VA must explain how the program would meet the needs of veterans, particularly as compared to the roadmap CARES has laid out.

Research Infrastructure Funding

The Department of Veterans Affairs must have increased funding for its research infrastructure to provide a state-of-the-art research and laboratory environment for its excellent programs, but also to ensure that VA hires and retains the top scientists and researchers.

VA Research Is a National Asset

Research conducted in the Department of Veterans Affairs has led to such innovations and advances as the cardiac pacemaker, nuclear scanning technologies, radioisotope diagnostic techniques, liver and other organ transplantation, the nicotine patch, and vast improvements in a variety of prosthetic and sensory aids. A state-of-the-art physical environment for conducting VA research promotes excellence in health professions education and VA patient care as well as the advancement of biomedical science. Adequate and up-to-date research facilities also help VA recruit and retain the best and brightest clinician scientists to care for enrolled veterans.

VA Research Infrastructure Funding Shortfalls

In recent years, funding for the VA Medical and Prosthetics Research Program has failed to provide the resources needed to maintain, upgrade, and replace VA's aging research facilities. Many VA facilities have exhausted their available research space. Along with space reconfiguration, ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades in VA's academic health centers. In the 2003 Draft National Capital Asset Realignment for Enhanced Services (CARES) plan, VA included $142 million designated for renovation of existing research space and build-out costs for leased researched facilities. However, these capital improvement costs were omitted from the Secretary's final report. Over the past decade, only $50 million has been spent on VA research construction or renovation nationwide, and only 24 of the 97 major VA research sites across the Nation have benefited.

In House Report 109–95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee directed VA to conduct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies." In FY 2008, the VA Office of Research and Development initiated a multiyear examination of all VA research infra-

structure for physical condition and capacity for current research, as well as program growth and sustainability of the space needed to conduct research.

Lack of a Mechanism to Ensure VA's Research Facilities Remain Competitive

In House Report 109–95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee expressed concern that "equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." A significant cause of research infrastructure's neglect is that there is no direct funding line for research facilities.

The VA Medical and Prosthetic Research appropriation does not include funding for construction, renovation, or maintenance of research facilities. VA researchers must rely on their local facility managements to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with other medical facilities' direct patient care needs—such as medical services infrastructure, capital equipment upgrades and replacements, and other maintenance needs—for funds provided under either the VA Medical Facilities appropriation account or the VA Major or Minor Medical Construction appropriations accounts.

Recommendations:

The Independent Budget veterans service organizations anticipate VA's analysis will find a need for funding significantly greater than VA had identified in the 2004 Capital Asset Realignment for Enhanced Services report. As VA moves forward with its research facilities assessment, the IBVSOs urge Congress to require the VA to submit the resulting report to the House and Senate Committees on Veterans' Affairs no later than October 1, 2009. This report will ensure that the Administration and Congress are well informed of VA's funding needs for research infrastructure so they may be fully considered at each stage of the FY 2011 budget process.

To address the current shortfalls, the IBVSOs recommend an appropriation in FY 2010 of $142 million, dedicated to renovating existing VA research facilities in line with the 2004 CARES findings.

To address the VA research infrastructure's defective funding mechanism, the IBVSOs encourage the Administration and Congress to support a new appropriations account in FY 2010 and thereafter to independently define and separate VA research infrastructure funding needs from those related to direct VA medical care. This division of appropriations accounts will empower VA to address research facility needs without interfering with the renovation and construction of VA direct health-care infrastructure.

Program for Architectural Master Plans:

Each VA medical facility must develop a detailed master plan.

The delivery models for quality health care are in a constant state of change. This is due to many factors including advances in research, changing patient demographics, and new technology.

The VA must design their facilities with a high level of flexibility in order to accommodate these new methods of patient care. The department must be able to plan for change to accommodate new patient care strategies in a logical manner with as little effect as possible on other existing patient care programs. VA must also provide for growth in already existing programs.

A facility master plan is a comprehensive tool to look at potential new patient care programs and how they might affect the existing health care facility. It also provides insight with respect to possible growth, current space deficiencies, and other facility needs for existing programs and how VA might accommodate these in the future.

In some cases in the past, VA has planned construction in a reactive manner. After funding, VA would place projects in the facility in the most expedient manner—often not considering other projects and facility needs. This would result in shortsighted construction that restricts, rather than expands options for the future.

The IBVSOs believe that each VA medical Center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility. Short and long-term CARES objectives should be the basis of the master plan.

Four critical programs were not included in the CARES initiative. They are long-term care, severe mental illness, domiciliary care, and Polytrauma. VA must develop a comprehensive plan addressing these needs and its facility master plans must account for these services.

VA has undertaken master planning for several VA facilities; most recently Tampa, Florida. This is a good start, but VA must ensure that all facilities develop a master plan strategy to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care.

Recommendation:

Congress must appropriate $20 million to provide funding for each medical facility to develop a master plan.

Each facility master plan should include the areas left out of CARES; long-term care, severe mental illness, domiciliary care, and Polytrauma programs as it relates to the particular facility.

VACO must develop a standard format for these master plans to ensure consistency throughout the VA health care system.

Empty or Underutilized Space

VA must not use empty space inappropriately and must continue disposing of unnecessary property where appropriate Studies have suggested that the VA medical system has extensive amounts of empty space that the Department can reuse for medical services. Others have suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function, but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. For example, VA cannot use unoccupied rooms on the eighth floor to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intra-departmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect of everything around it. These secondary impacts greatly increase construction expense, and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs of different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary costs, the renovation can end up costing more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA Medical Centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for modern needs. Most of these Bradley-style buildings were designed before the widespread use of air conditioning and the floor-to-floor heights are very low. Accordingly, it is impossible to retrofit them for modern mechanical systems. They also have long, narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise, VA would have previously renovated or demolished this space for new construction. This space is typically located in outlying buildings or on upper floor levels, and is unsuitable for modern use.

VA Space Planning Criteria/Design Guides:

VA must continue to maintain and update the Space Planning Criteria and Design Guides to reflect state-of-the-art methods of health care delivery.

VA has developed space-planning criteria it uses to allocate space for all VA health care projects. These criteria are organized into sixty chapters; one for each

health care service provided by VA as well as their associated support services. VA updates these criteria to reflect current methods of health care delivery.

In addition to updating these criteria, VA has utilized a computer program called VA SEPS (Space and Equipment Planning System) it uses as a tool to develop space and equipment allocation for all VA health care projects. This tool is operational and VA currently uses it on all VA health care projects.

The third component used in the design of VA health care projects is the design guides. Each of the sixty space planning criteria chapters has an associated design guide. These design guides go beyond the allocation of physical space and outline how this space is organized within each individual department, as well as how the department relates to the entire medical facility.

VA has updated several of the design guides to reflect current patient delivery models. These include those guides that cover Spinal Cord Injury/Disorders Center, Imaging, Polytrauma Centers, as well as several other services.

Recommendation:

The VA must continue to maintain and update the Space Planning Criteria and the VA SEPS space-planning tool. It also must continue the process of updating the Design Guides to reflect current delivery models for patient care. VA must regularly review and update all of these space-planning tools as needed, to reflect the highest level of patient care delivery.

Design-build Construction Delivery System

The VA must evaluate use of the Design-build construction delivery system.

For the past 10 years, VA has embraced the design-build construction delivery system as a method of project delivery for many health care projects. Design-build attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to the owner and reduce the project delivery schedule. Design-build, as used by VA, places the contractor as the design builder.

Under the contractor-led design build process, VA gives the contractor a great deal of control over how he or she designs and completes the project. In this method, the contractor hires the architect and design professionals. With the architect as a subordinate, a contractor may sacrifice the quality of material and systems in order to add to his own profits at the expense of the owner.

Use of design-build has several inherent problems. A short-cut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents may not provide adequate scope for the project, leaving out important details regarding the workmanship and/or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, which often compromises VA's design standards.

Design-build forces the owner to rely on the contractor to properly design a facility that meets the owner's needs. In the event that the finished project is not satisfactory to the owner, the owner may have no means to insist on correction of work done improperly unless the contractor agrees with the owner's assessment. This may force the owner to go to some form of formal dispute resolution such as litigation or arbitration.

Recommendation:

VA must evaluate the use of Design-build as a method of construction delivery to determine if design-build is an appropriate method of project delivery for VA health care projects.

The VA must institute a program of "lessons learned". This would involve revisiting past projects and determining what worked, what could be improved, and what did not work. VA should compile and use this information as a guide to future projects. VA must regularly update this document to include projects as they are completed.

Preservation of VA's Historic Structures:

The VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

The VA has an extensive inventory of historic structures that highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great Nation. Of the approximately 2,000 historic structures, many

are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected and preserved because they are an integral part our Nation's history.

Most of these historic facilities are not suitable for modern patient care. As a result, a preservation strategy was not included in the CARES process. For the past 6 years, the IBVSOs have recommended that VA conduct an inventory of these properties; classifying their physical condition and their potential for adaptive reuse. VA has been moving in that direction and historic properties are identified on their Web site. VA has placed many of these buildings in an "Oldest and Most Historic" list and these buildings require immediate attention.

At least one project has received funding. The VA has invested over $100,000 in the last year to address structural issues at a unique round structure in Hampton, VA. Built in 1860, it was originally a latrine and the funding is allowing VA to convert it into office space.

The cost for saving some of these buildings is not very high considering that they represent a part of history that enriches the texture of our landscape that once gone cannot be recaptured. For example, VA can restore the Greek Revival Mansion in Perry Point, MD, which was built in the 17fifties, to use as a training space for about $1.2 million. VA could restore the 1881 Milwaukee Ward Memorial Theater for use as a multi-purpose facility at a cost of $6 million. This is much less than the cost of a new facility.

As part of its adaptive reuse program, VA must ensure that the facilities that it leases or sells are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds.

We encourage the use of P.L. 108–422, the Veterans Health Programs Improvement Act, which authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property.

Recommendation:

VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

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

Prepared Statement of Raymond C. Kelley,
National Legislative Director, American Veterans (AMVETS)

Chairman Filner, Ranking Member Buyer, and Members of the Committee:

AMVETS is honored to join our fellow veterans service organizations and partners at this important hearing on the Department of Veterans Affairs budget request for fiscal year 2010. My name is Raymond C. Kelley, National Legislative Director of AMVETS, and I am pleased to provide you with our best estimates on the resources necessary to carry out a responsible budget for VA.

AMVETS testifies before you as a co-author of *The Independent Budget*. This is the 23rd year AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars have pooled our resources to produce a unique document, one that has stood the test of time.

In developing *The Independent Budget*, we believe in certain guiding principles. Veterans should not have to wait for benefits to which they are entitled. Veterans must be ensured access to high-quality medical care. Specialized care must remain the focus of VA. Veterans must be guaranteed timely access to the full continuum of health care services, including long-term care. And, veterans must be assured accessible burial in a state or national cemetery in every state.

The VA health care system is the best in the country and responsible for great advances in medical science. VHA is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected ailments. The delivery care system provides a wide array of specialized services to veterans like those with spinal cord injuries, blindness, traumatic brain injury, and post traumatic stress disorder.

Mr. Chairman, I want to thank you for introducing H.R. 1016, the Veterans Health Care Budget Reform and Transparency Act of 2009. Providing sufficient, predictable and timely funding for VA health care will go a long way in ensuring our veterans receive the care they need from fully staffed, state of the art VA medical centers. I also want to thank each Member of the Committee who has co-sponsored

this act, and for those how still have questions I look forward to further discussions so we can solve the problems of the current funding system.

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

The National Cemetery Administration

The Department of Veterans Affairs National Cemetery Administration (NCA) currently maintains more than 2.9 million gravesites at 125 national cemeteries in 39 states and Puerto Rico. Of these cemeteries, 65 will be open to all interments; 20 will accept only cremated remains and family members of those already interred; and 40 will only perform interments of family members in the same gravesite as a previously deceased family member. NCA also maintains 33 soldiers' lots and monument sites. All told, NCA manages 17,000 acres, half of which are developed.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean war, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the Global War on Terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from approximately 100,000 in 2007 to 111,000 in 2009. Historically, 12 percent of veterans opt for burial in a state or national cemetery.

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the armed forces. Therefore, the purpose of these cemeteries as national shrines is one of the NCA's top priorities. Many of the individual cemeteries within the system are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of the United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and cherished.

The Independent Budget veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families. We call on the Administration and Congress to provide the resources needed to meet the changing and critical nature of NCA's mission and fulfill the Nation's commitment to all veterans who have served their country honorably and faithfully.

In FY 2008, $195 was million appropriated for the operations and maintenance of NCA, $28.2 million over the Administration's request, with only $220,000 in carryover. NCA awarded 39 of the 42 minor construction projects that were in the operating plan. The State Cemetery Grants Service awarded $37.3 million of the $39.5 million that was appropriated. This carryover was caused by the cancellation of a contract that NCA had estimated to be $2 million but the contractor's estimation was considerable higher. Additionally, $25 million was invested in the National Shrine Commitment.

NCA has done an exceptional job of providing burial options for 88 percent of all veterans who fall within the 170,000 veterans within a 75 mile radius threshold model. However, under this model, no new geographical area will become eligible for a national Cemetery until 2015. St. Louis, Mo. will, at that time, meet the threshold due to the closing of Jefferson Barracks National Cemetery in 2017. Analysis shows that the five areas with the highest veteran population will not become eligible for a national Cemetery because they will not reach the 170,000 threshold.

NCA has spent years developing and maintaining a cemetery system based on a growing veteran population. In 2010 our veteran population will begin to decline. Because of this downward trend, a new threshold model must be developed to ensure more of our veterans will have reasonable access to their burial benefits. Reducing the mile radius to 65 miles would reduce the veteran population that is served from 90 percent to 82.4 percent, and reducing the radius to 55 miles would reduce the served population to 74.1 percent. Reducing the radius alone to 55 miles would only bring two geographical areas in to 170,000 population threshold in 2010, and only a few areas into this revised model by 2030.

Several geographical areas will remain unserved if the population threshold is not reduced. Lowering the population threshold to 100,000 veterans would immediately make several areas eligible for a national Cemetery regardless of any change to the mile radius threshold. A new threshold model must be implemented so more of our veterans will have access to this earned benefit.

National Cemetery Administration (NCA) Accounts

The Independent Budget recommends an operations budget of $241.5 million for the NCA for fiscal year 2010 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

The NCA is responsible for five primary missions: (1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application; (3) to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries; (4) to award a presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the Nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

Therefore, in accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress establish a 5-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the FY 2008 operations budget. *Volume 2* of the Independent Study provides a systemwide, comprehensive review of the conditions at 119 national cemeteries. It identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. These projects include cleaning, realigning, and setting headstones and markers; cleaning, caulking, and grouting the stone surfaces of columbaria; and maintaining the surrounding walkways. Grass, shrubbery, and trees in burial areas and other land must receive regular care as well. Additionally, cemetery infrastructure, i.e. buildings, grounds, walks, and drives must be repaired as needed. According to the Study, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options and maintenance programs.

The IBVSOs is encouraged that $25 million was set aside for the National Shrine Commitment for FY 07 and 08. The NCA has done an outstanding job thus far in improving the appearance of our National cemeteries, but we have a long way to go to get us where we need to be. By enacting a 5-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

In addition to the management of national cemeteries, the NCA is responsible for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107–103 and 107–330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries. Public Law 110–157 gives VA authority to provide a medallion to be attached to the headstone or marker of veterans who are buried in a private cemetery. This benefit is available to veterans in lieu of a government furnished headstone or marker.

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the Nation's commitment to all veterans who have served their country so honorably and faithfully. Congress should provide NCA with $241.5 million for fiscal year 2010 to offset the costs related to increased workload, additional staff needs, general inflation and wage increases and Congress should include as part of the NCA appropriation $50 million for the first stage of a $250 million 5-year program to restore and improve the condition and character of existing NCA cemeteries.

The State Cemetery Grants Program

The State Cemeteries Grant Program faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. The intent of the SCGP is to develop a true complement to, not a replacement for, our Federal system of national cemeteries. With the enactment of the Veterans Ben-

efits Improvements Act 1998, the NCA has been able to strengthen its partnership with states and increase burial service to veterans, especially those living in less densely populated areas not currently served by a national cemetery. Currently there are 55 state and tribal government cemetery construction grant pre-applications, 34 of which have the required state matching funds necessary totaling $120.7 million.

The Independent Budget recommends that Congress appropriate $52 million for SCGP for FY 2010. This funding level would allow SCGP to establish six new state cemeteries that will provide burial options for 179,000 veterans who live in a region that currently has no reasonably accessible state or national cemetery.

Burial Benefits

In 1973 NCA established a burial allowance that provided partial reimbursements for eligible funeral and burial costs. The current payment is $2,000 for burial expenses for service-connected (SC) death, $300 for non-service-connected (NSC) deaths, and $300 for plot allowance. At its inception, the payout covered 72 percent of the funeral cost for a service-connected death, 22 percent for a non-service-connected death, and 54 percent of the burial plot cost. In 2007 these benefits eroded to 23 percent, 4 percent, and 14 percent respectively. It is time to bring these benefits back to their original value.

Burial allowance was first introduced in 1917 to prevent veterans from being buried in potters' fields. In 1923 the allowance was modified. The benefit was determined by a means test, and then in 1936 the allowance was changed again, removing the means test. In its early history, the burial allowance was paid to all veterans, regardless of the service-connectivity of their death. In 1973 the allowance was modified to reflect the relationship of their death as service connected or not.

The plot allowance was introduced in 1973 as an attempt to provide a plot benefit for veterans who did not have reasonable access to a national cemetery. Although neither the plot allowance nor the burial allowances were intended to cover the full cost of a civilian burial in a private cemetery, the increase in the benefit's value indicates the intent to provide a meaningful benefit by adjusting for inflation.

The national average cost for a funeral and burial in a private cemetery has reached $8,555, and the cost for a burial plot is $2,133. At the inception of the benefit the average costs were $1,116 and $278 respectively. While the cost of a funeral has increased by nearly seven times the burial benefit has only increased by 2.5 times. To bring both burial allowances and the plot allowance back to its 1973 value, the SC benefit payment will be $6,160, the NSC benefit value payment will be $1,918, and the plot allowance will increase to $1,150. Readjusting the value of these benefits, under the current system, will increase the obligations from $70.1 million to $335.1 million per year.

Based on accessibility and the need to provide quality burial benefits, *The Independent Budget* recommends that VA separate burial benefits into two categories: veterans who live inside the VA accessibility threshold model and those who live outside the threshold. For those veterans who live outside the threshold, the SC burial benefit should be increased to $6,160, NSC veteran's burial benefit should be increased to $1,918, and plot allowance should increase to $1,150 to match the original value of the benefit. For veterans who live within reasonable accessibility to a state or national cemetery that is able to accommodate burial needs, but the veteran would rather be buried in a private cemetery the burial benefit should be adjusted. These veterans' burial benefits will be based on the average cost for VA to conduct a funeral. The benefit for a SC burial will be $2,793, the amount provided for a NSC burial will be $854, and the plot allowance will be $1,150. This will provide a burial benefit at equal percentages, but based on the average cost for a VA funeral and not on the private funeral cost that will be provided for those veterans who do not have access to a state or national cemetery.

The recommendations of past legislation provided an increased benefit for all eligible veterans but it currently fails to reach the intent of the original benefit. The new model will provide a meaningful benefit to those veterans whose access to a state or national cemetery is restricted as well as provides an improved benefit for eligible veterans who opt for private burial. Congress should increase the plot allowance from $300 to $1,150 for all eligible veterans and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime. Congress should divide the burial benefits into two categories: veterans within the accessibility model and veterans outside the accessibility model. Congress should increase the service-connected burial benefit from $2,000 to $6,160 for veterans outside the radius threshold and $2,793 for veterans inside the radius threshold. Congress should increase the non-service-connected burial benefit from $300 to $1,918 for veterans outside the radius

threshold and $854 for veterans inside the radius threshold. Congress should enact legislation to adjust these burial benefits for inflation annually.

The NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 2.8 million soldiers who died in every war and conflict are honored by burial in a VA national cemetery. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans; they are hallowed ground to those who died in our defense, and a memorial to those who survived.

Mr. Chairman, this concludes my testimony. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Prepared Statement of Paul Sullivan,
Executive Director, Veterans for Common Sense

Veterans for Common Sense (VCS) thanks Chairman Filner and Members of the Committee for inviting us to testify about the Department of Veterans Affairs' (VA) budget request for Fiscal Year 2010.

VCS applauds VA's fiscal year 2010 budget submission. President Barack Obama and VA Secretary Eric Shinseki plan to increase VA's budget by $15 billion for 2010. This enormous increase is fantastic and far exceeds our highest expectations. This dramatic improvement in funding should provide a desperately needed shot in the arm for VA to increase capacity, streamline policies, and resolve years of chronic underfunding. VCS awaits further details about VA's 2010 budget request expected to be released in April.

VCS thanks the Committee for your hearings and for your landmark legislation during the 110th Congress. We especially thank you for the "Joshua Omvig Veterans Suicide Prevention Act," the "Dignity for Wounded Warriors Act," and Chairman John Hall's landmark legislation launching an overhaul of the Veterans Benefits Administration (VBA). Other key legislation passed in the past 2 years includes significant budget increases, major cost of living increases, and a lift on VA's ban on advertising.

Measuring Success in Five Key Areas

As described in our recent report, "Looking Forward: The Status and Future of VA," http://www.veteransforcommonsense.org/files/vfcs/VCS_Looking_Forward_Report_02-09-2009.pdf, VCS urges Congress to focus on a narrow set of five key measures to monitor VA. We ask you to work with VA to consistently, accurately, and transparently define these terms and then monitor their quality and timely assistance:

1. Health care—excluding mental health
2. Health care—mental health
3. Suicide prevention
4. Reducing homelessness
5. Benefits (compensation, pension, education, vocational rehabilitation, home loan guaranty, and insurance), especially the disability compensation backlog

Key Budgeting Questions

VCS asks Congress to require that VA answer these key budgeting questions:

1. Does VA have enough funding, staffing, and legislative guidance to process all disability claims within 30 days?
2. Does VA have enough funding, staffing, and legislative guidance to provide all patients (physical health care and mental health care) with care within 30 days?
3. Does VA have enough information gathered at each point-of-service to answer questions one and two?

VA's 2008 Significant Estimation Failure

VCS begins our testimony by spotlighting an enormous red flag at VA in 2008. During the last Administration, VA repeatedly failed to accurately estimate the number of Iraq and Afghanistan war veteran patients. We hope we can look forward to a time when VA properly estimates demand so VA is not caught a day late and a dollar short. To the best of our knowledge, VA has never estimated the number of Iraq and Afghanistan war veteran disability compensation claims and the number

of issues per claim. We look forward to learning about VA's estimates in the coming months.

VA's pattern of planning failures has caused enormous harm to our veterans by creating massive delays obtaining health care and disability benefits. In 2005, VA testified before Congress that the agency had sufficient money to provide timely and high-quality health care and benefits. This turned out to be a vicious game of smoke and mirrors—a tragic game which our veterans always lose. A few months later, former VA Secretary Jim Nicholson returned to Congress, hat in hand, to request billions of dollars in emergency appropriations.

VA's planning errors were caused by the prior Administration's failure to consider the long-term health care and disability benefit needs of returning Iraq and Afghanistan war veterans. VA's planning errors continued through 2008, a trend we hope ends with the new Administration. In February 2008 statement by former VA Secretary James Peake. He told this Committee, "We expect to treat about 333,000 veterans in 2009 who served in Operation Enduring Freedom and Operation Iraqi Freedom." Not only was he wrong, he was wildly off the mark. In reality, as of September 30, 2008, VA had already treated more than 400,000 Iraq and Afghanistan war veterans. As of 6 months ago, VA had already underestimated the number of recent combat veteran patients by 20 percent.

The situation continues to worsen. Based on the current rate of more than 10,000 new Iraq and Afghanistan war veteran patients flooding into VA each month, VA may expect a total of 520,000 recent war patients by September 30, 2009. That would mean VA underestimated the number of new patients by nearly 187,000. VA's estimate may be off by as far as 56 percent. While VCS supports opening VA health care to Priority Group 8 veterans and those previously denied enrollment since 2003, we are concerned that VA may not accurately forecast demand, leading to additional challenges for an already overburdened system.

VA has not yet provided an estimate for Iraq and Afghanistan war veteran patients for FY 2010. We hope VA planners are monitoring the situation carefully so as to avoid repeating the same mistake over and over again. VCS asks Congress to require that VA produce accurate estimates for new patients and claims for the Iraq and Afghanistan wars so that VA leaders adequately prepare budget requests and so our veterans receive prompt and high-quality care and benefits. In addition, VA should provide more information about VA activities so the public can learn the total human and financial costs of the two wars—and be prepared to support significant increases in VA's budgets for the next several decades.

Important Facts About VA

Any discussion about VA and veterans must be based on the best available current information. VCS uses FOIA to obtain documents about VA policies and activities in order to better inform Congress, journalists, and the public about VA.

The information VCS obtained under FOIA provides incontrovertible evidence that VA's capacity crisis requires more active monitoring and significantly increased funding. We believe the Iraq and Afghanistan wars, as well as the current severe and worsening economic recession, have created extraordinary challenges to VA's future responsibilities.

- VA expects to treat 5.8 million patients this year. VCS supports President Obama's plan to open up VA to all eligible veterans, including Category 8. With proper planning, this transition can be accomplished within a few years.
- VA's Office of the Inspector General reported 25 percent, or as many as 1.5 million veterans per year, wait more than 1 month to see a VA doctor. This is unacceptable, as no veteran should ever wait more than 1 month for care. We also insist that emergent mental health patients be treated as equal to physical injuries—there should be no delay, especially for suicidal patients or new patients with symptoms of PTSD.
- VA regional offices are still working on 672,000 claims of all types. As the Afghanistan War expands, as Iraq War veterans return home, as VA and DoD conduct more PTSD and TBI screenings, as stigma is reduced, and as the 5 years of free VA health care for new war veterans begins to expire, VA may see an increase in new claims that will further exacerbate the existing claims backlog.
- According to VA, 21 percent of the rating-related claims, or 86,000 of all veterans with a claim pending, have already waited more than 6 months for a decision. This is an improvement of 4 percent compared with last year.

Here are salient facts regarding Iraq and Afghanistan war veterans:

- DoD reported 82,000 battlefield casualties: nearly 5,000 deaths plus more than 77,000 non-fatal casualties.

- VA hospitals already treated more than 400,000 veteran patients, including 178,000 diagnosed with at least one mental health condition.
- VA regional offices received 329,000 veterans' disability claims
- 54,000 veterans, or 16 percent, wait, on average 6 months, for a VA decision.
- VA diagnosed more than 105,000 veterans with PTSD
- VA approved 43,000 veterans' claims for PTSD, or 41 percent of those diagnosed.

We are also awaiting a Congressionally mandated review of discrepancies in claim adjudication outcomes, particularly among National Guard and Reserve who are half as likely to file a claim, yet twice as likely to be denied. At the request of Congress, VA is also reviewing the reason why only 41 percent of Iraq and Afghanistan war veterans diagnosed with post traumatic stress disorder (PTSD) by VA receive disability compensation for PTSD from VA.

Planning is critical during these difficult economic times. In a worst case scenario based on VA data reporting 10,000 new Iraq and Afghanistan war patients per month, VA may treat up to one million Iraq and Afghanistan war veterans as soon as the end of 2013. For more information about VA's significant challenges related to the Iraq and Afghanistan wars, please read our report, "Looking Forward: The Status and Future of VA," that can be viewed at: http://www.veteransforcommonsense.org/files/vfcs/VCS_Looking_Forward_Report_02-09-2009.pdf

VCS Budget Priorities for Fiscal Year 2010 and Beyond

VCS would like to share our top 15 priorities for VA's Fiscal Year 2010 budget and beyond. Each of these priorities addresses key items described in our report, "Looking Forward: The Status and Future of VA," published in February 2009. VCS supports implementing as many of these proposals as possible because of VA's current capacity crisis and because many of these initiatives overlap.

1. Streamline and Expedite Veterans' PTSD Claims

According to a 2008 report by RAND, as many as 338,000 Iraq and Afghanistan war veterans are expected to return home and develop post traumatic stress disorder (PTSD). VCS urges Congress to pass the "COMBAT PTSD Act," H.R. 952. Chairman John Hall's superb new bill properly defines deployment to combat in order to streamline disability compensation claims for PTSD. Our VCS analysis of health care use and claims activity among Iraq and Afghanistan war veterans revealed a serious discrepancy that demands immediate action by Congress. According to VA statistics released to VCS under the Freedom of Information Act (FOIA), more than 105,000 Iraq and Afghanistan war veterans were diagnosed by VA with PTSD. However, only 42,000 of those veterans are receiving disability compensation from VA for PTSD. The scientific evidence is conclusive: In 2008, the Institute of Medicine concluded there is a link between deployment to a war zone and the development of PTSD.

Now is the time to fix the problem of unreasonable PTSD claim delays so that our veterans can receive the PTSD disability benefits they earned. With a new law or regulation, VA should be able to quickly approve 1910s of thousands of PTSD claims filed by Iraq and Afghanistan war veterans. VA would be putting disability benefits in the hands of deserving veterans during an economic crisis when their need is most acute. Although this proposal may cost billions of dollars in the next year, these are entitlement payments VA will eventually pay. Furthermore, VA may realize a cost savings when VA employees working on PTSD claims are freed up to process other claims of equally deserving veterans.

2. Streamline and Expedite Veterans' TBI Claims

According to the same 2008 RAND report, as many as 357,000 Iraq and Afghanistan war veterans are expected to return home diagnosed with traumatic brain injury (TBI). In a manner similar to PTSD, VCS urges Congress and the VA to implement new rules designed to create a presumption for a concussive blast in order to streamline and expedite veterans' claims for TBI. VCS thanks VA for issuing new TBI regulations that improved the rating schedule for veterans suffering from this disabling signature physical wound of the wars. However, VA and Congress can go further by streamlining the claims process by presuming that veterans diagnosed with TBI were exposed to blasts and other TBI-causing injuries while deployed to the Iraq and Afghanistan wars (absent any other finding). We have a quickly closing window of opportunity to address this issue before it gets worse. If Congress and VA fail to streamline PTSD and TBI claims, VA faces the very real prospect of becoming overwhelmed by 600,000 to 700,000 of these difficult to process claims, thus further exacerbating VA's disability claim backlog. In a related matter, VCS became

alarmed at VA plans to close the Central Texas Veterans Health Care System Brain Imaging and Recovery Laboratory (BIRL), located on the University of Texas campus in Austin, Texas. VCS strongly supports continued funding of scientific research to better understand TBI and to find treatments for TBI, including the BIRL.

3. Open Hundreds of New VBA Offices

Now is the time to bring VA to our veterans and beneficiaries so they can meet face-to-face with VA claims processing staff and begin reversing the isolationist culture of VA. VCS urges Congress to significantly expand the Veterans Benefits Administration (VBA) and bring VA benefits to locations where our servicemembers leave the military and cities where our veterans live. VBA can do this by placing permanent claims processing staff at all active duty military facilities and in cities throughout the United States in a manner similar to the Social Security Administration. Congress should also allow VA to place VBA staff at VHA facilities and Vet Centers. VCS continues to support a massive expansion of VBA's successful Benefits Delivery at Discharge (BDD) program. We especially support VBA's efforts to transform BDD into a paperless process. During the 1990s, Under Secretary Ken Kizer restructured and reformed the Veterans Health Administration, a strong precedent that a new Under Secretary for Benefits can and must follow to reform VBA. Attached for the record is a one-page briefing paper VCS provided to the Presidential Transition Team.

4. Expand Scientific Research, Especially for Gulf War Veterans

The Research Advisory Committee on Gulf War Veterans' Illnesses (RAC), report published in 2008 confirms that between 175,000 and 210,000 Gulf War veterans remain ill. We are still waiting for treatment and benefits from VA. VCS urges Congress to expand research to better understand Gulf War Illness. VCS urges Congress to fully fund all $30 million for the Department of Defense for competitive research in the Congressionally Directed Medical Research Program to search for treatments, as recommended by the RAC. We also ask Congress to fund a new set of VA—Institute of Medicine contracts to review scientific research related to Gulf War toxic exposures that considers both human and animal studies. We especially ask that depleted uranium (DU) be re-examined based on animal studies linking DU exposure in laboratory animals to birth defects and cancer. Veterans for Common Sense encourages Members of Congress to read the full RAC report, especially the recommendations.

5. Better Long-Term Planning

Never again should VA be caught off guard to the point where VA is short billions of dollars in desperately needed funds to provide health care to our veterans. VCS urges Congress to continue consolidating VA's information technology so VA can collect and analyze more data more transparently at the local and national level. VA should be asked to provide Congress with a specific plan to collect, report, analyze, and share data so that VA, Congress, veterans groups, and academics can better monitor the situation for planning, staffing, and budgeting purposes over the long-term. Better planning also means better training. VCS urges VA to expand training for new employees who will be using the data at the local and national level to assist veterans and plan for the future, especially with the advent of advanced funding for VA.

6. Ending Homelessness

According to VA, one-in-four homeless people are veterans, and this is a national disgrace. Iraq and Afghanistan war veterans are already showing up in homeless shelters, a sign of VA's challenges as well as the overall dismal state of our economy. VCS believes VA and Congress should learn a lesson from the Vietnam War, where our Nation lied to send our troops to war and then failed to provide for their return. In 2003, the prior Administration misled us into another war, and again failed to plan for our veterans' homecoming. There should be zero tolerance for homeless veterans. We have an opportunity now to prevent a national tragedy from happening again by instituting aggressive homeless prevention initiatives for all veterans, especially Iraq and Afghanistan war veterans. A full compliment of supportive services includes employment assistance, drug and alcohol counseling, and mental health treatment, as well as VA health care and benefits assistance. Please read the entire statement prepared by Swords to Plowshares that we ask to be placed into the record.

7. Advanced Funding and Mandatory Full Funding

VCS supports advanced funding for VA as well as mandatory full funding for VA's health care budget. VA needs advanced funding so VA is properly prepared to han-

dle changes in patient demand at the local and national levels. VA needs mandatory full funding so veterans don't wait for medical care—for physical or psychological conditions. VCS supports transparent VA budgeting from the bottom up so veterans, legislators, and the public are aware of VA's financial needs at the local and national levels.

8. Ending Stigma and Discrimination

One of our top priorities is ending the stigma that often blocks servicemembers and veterans from seeking mental health treatment early, when it is most effective and least expensive. VCS urges Congress to fund anti-stigma programs that allow VA to collaborate with the Department of Defense (DoD) and the Department of Labor (DOL). VCS salutes the new DOL Web site, http://www.americasheroesatwork.gov, and recommends that VA and DoD launch similar public education efforts. VCS urges Congress to investigate why DoD has not fully implemented the 1997 Force Health Protection laws (Public Law 105–85, section 701), a law intended to prevent a repeat of the Gulf War illness debacle. VCS believes DoD must begin providing pre- and post-deployment medical exams to all servicemembers as a way to de-stigmatize mental health conditions. VA needs the pre- and post-deployment exam records as part of the veteran's medical history for treatment and disability benefits.

9. Open a Polytrauma Center at Every VA

VCS believes every VA medical center should be capable of treating polytrauma patients in order to meet the growing demand that more than 6 years of on-going warfare requires. All VA medical centers should have this ability so veterans can be treated near their homes where family members and friends can provide comfort and support. This is especially important since RAND estimated up to 19.5 percent of our returning Iraq and Afghanistan war veterans may suffer from TBI. According to the Department of Defense, they have already identified more than 180,000 TBI cases from the two wars (Associated Press,

10. Ending Veteran Suicide Epidemic

VCS thanks VA for implementing their toll-free suicide prevention hotline, a tremendously successful effort that received 100,000 calls and performed more than 2,600 "rescues"—saving the lives of thousands of distraught veterans. VCS supports a full and prompt implementation of VA's Mental Health Strategic Plan. We also support VA's new Suicide Prevention Coordinators and Local Recovery Coordinators. VCS urges Congress to fund a state-of-the-art suicide data collection, reporting, and analysis office at VA that can collaborate with the Department of Defense, Department of Health and Human Services, and other government agencies. The national office should identify local, state, and Federal data about veterans who attempted or committed suicide so VA can implement the best policies to reduce suicide among all veterans, especially recent war veterans. This should include monitoring of specific cohorts of veterans by period of war, gender, race, number of deployments, length of deployments, use of VA medical centers, use of VA Vet Centers, and use of VA disability benefits. VCS remains alarmed at the anecdotal evidence from press reports of veterans, often in the National Guard or Reserve, who complete suicide shortly after notification of a second or subsequent deployment to the combat zone.

11. Expanding Vet Centers

Congress should enact legislation to expand VA's highly successful Vet Centers. VCS urges Congress to allow Vet Centers to provide mental health services to active duty servicemembers, either at existing VA facilities or at new offices on military bases. This expanded service might first be targeted at military installations that have shortages of mental health care providers and bases expecting large redeployments from the war zones. Congress should allow families to participate in the readjustment counseling process at all Vet Centers. Congress should also allow Vet Centers to house VBA staff to assist veterans with disability claims. This should be part of an overall long-term VA strategic plan to bring all of VA to our veterans so veterans are not required to visit several locations for assistance.

12. Supporting Vietnam War Veterans

VCS continues to support research and treatments for Vietnam War veterans poisoned by dioxin contained in Agent Orange. VCS also supports VA advertising and outreach to veterans with diabetes, prostate cancer, and other war-related medical conditions so they are aware of new VA health care and disability benefits available for those conditions. VCS urges Congress to declare "Blue Water" veterans eligible for VA health care and benefits related to Agent Orange.

13. Due Process

VCS believes all veterans should have the right to full due process and the right to retain an attorney to assist them with obtaining VA health care or disability benefits starting from the first day a veteran or beneficiary seeks any VA benefit. Sound legal advice is especially critical when a veteran has a serious injury, such as TBI or PTSD, or where the veteran may have diminished capacity to wage a complex and protracted legal battle against VA. Legal assistance means the ability to hire an experienced and trained advocate who will fight for you, an advocate who will explain VA's complicated and adversarial process, an advocate who will to obtain military and other documents for your claim, and an advocate who can quickly obtain your VA benefits. While Veteran Service Organization (VSO) assistance is often beneficial to veterans and beneficiaries filing claims against VA, VCS also strongly supports the right of veterans and beneficiaries to obtain competent and compensated legal counsel for those who defended our Constitution. Due process also means that VCS supports efforts by VA to cooperate with local law enforcement and legal systems to offer treatment programs to veterans arrested for minor offenses. We believe that pro-active action to identify veterans in our legal system and offer VA treatment may mitigate the long-term social consequences of untreated PTSD and TBI.

14. Outreach

VCS urges VA to begin more advertising to increase awareness about VA. The most important outreach effort should be to reduce stigma against veterans with mental health conditions and to publicize VA's suicide prevention hotline. VCS is pleased with Chairman Harry Mitchell's successful effort to allow VA to conduct advertising about health care and benefits. This change represents a progressive policy improvement. VCS believes VA should consider broadcasting public service announcements describing VA services especially for members of the National Guard and Reserve. An analysis by VCS found that they are using VA services less than their Active Duty peers. VCS believes Congress should fund VA training and outreach to universities so law students are encouraged to learn about laws designed to assist veterans, plus ongoing education to remain current on changes in the laws. If the military can spend billions recruiting new soldiers, then VA should be able to spend some money making sure veterans and their families know what they earned and making sure they can quickly obtain it.

15. Transparency

VCS is pleased with VA's handling of recent challenges by providing greater information earlier. For example, in the past few weeks, VA informed the public about a problem with a contractor conducting transcriptions. Transparency in government should be applauded. This is why VCS urges Congress to review VA's handling of Freedom of Information Act (FOIA) requests so that more information about VA is more readily available to the public. Much of the information VCS presents to Congress came from our extensive FOIA research efforts. VCS provided Congress, veterans, and the public with critical information at a time when VA intentionally concealed bad news.

For the Committee

VCS provides four documents related to our testimony for the Committee's files:

- Swords to Plowshares, Statement to Presidential Transition Team (PTT), Dec. 2008.
- VCS, "Proposal to Restructure Veterans Benefits Administration Facilities," presented to the PTT on Dec. 6, 2008.
- Nora Eisenberg, "Why the Dark Secrets of the Gulf War are Still Haunting Us," AlterNet, Feb. 27, 2009.
- VCS, "Looking Forward: The Status and Future of VA," Feb. 2009.

[The documents are being retained in the Committee files.]

Prepared Statement of Paul Rieckhoff,
Executive Director, Iraq and Afghanistan Veterans of America

On behalf of IAVA and our more than 125,000 members and supporters, thank you for inviting Iraq and Afghanistan Veterans of America to testify today regarding the VA's budget for Fiscal Year 2010. I would also like to thank you for your commitment to our Nation's veterans. From the passage of the new GI Bill to the dramatic increases in veterans' health care funding, the remarkable legislative victories for veterans we've seen in the last 3 years would not have been possible without your leadership.

At IAVA, we are committed to making sure that no servicemember, and no veteran, is ever left behind. The mission of IAVA is to improve the lives of the more than 1.7 million Iraq and Afghanistan veterans and their families. As veterans come home from Iraq and Afghanistan to the worst economy in decades, we need to show real support for our troops and veterans.

Overall, we are pleased with the limited information currently available about the FY 2010 Budget. The top line number for veterans' discretionary funding is about $1.2 billion higher than the amount recommended by leading veterans' organizations, including IAVA, in *The Independent Budget*. The budget plans increases in VA funding by $25 billion over 5 years. This funding will be crucial if we are to provide proper care and support to the surge of veterans who will be coming home from combat in the coming years.

We are also pleased to see the renewed focus on mental health care in the DoD budget, including the comprehensive TBI registry, and also the rollback of concurrent receipt limitations that unfairly cut the benefits available to disabled military retirees. We were also pleased to see the Administration's planned expansion of VA health care access to about 500,000 moderate-income veterans. This is a good first step, although we'd like to see it happen faster. About 1.8 million veterans lack health insurance, and about 565,000 veterans have been denied VA care because their income level was too high. IAVA believes every single veteran should be eligible for VA health care.

From what we've seen so far, the budget looks strong. But the devil is in the details. Until we have had the opportunity to go through this budget line-by-line in April, we can not entirely endorse the plan. Above all, we must ensure that this budget does not rest on increased copays, premiums and fees for veterans.

Our biggest disappointment about the current budget is that the President has not opted to include advance appropriations for the VA in his proposal. Advance appropriations doesn't cost any additional money, it just gives VA hospitals and clinics advance notice of the funding they will receive the following year. Right now, VA hospitals have no way of knowing what their budget will be next year, and when the budget is passed late (and it usually is), they often have to ration the care they give veterans.

The bottom line is, VA budget delays hurt veterans. I want to tell you about one of the thousands of veterans of all generations who would benefit from advance appropriations. Rey Leal served as a Marine in Fallujah during some of the heaviest fighting, earning a Bronze Star with valor as a Private First Class, an almost unheard of accomplishment for a soldier of his rank. But when he returned to southern Texas, his closest VA hospital was over 5 hours away. Rey's a tough Marine, and a boxer, but he shouldn't have to fight to get care at a veterans' hospital. And at his nearest outpatient clinic, there was just one psychologist, taking appointments only 2 days a week.

The psychologist only works 2 days because that Texas clinic, like many VA clinics and hospitals, has to stretch it's funding to make sure the money lasts the whole year. They don't know how much funding they'll have next year because the VA budget is routinely passed late. For the millions of veterans like Rey, we must fix this broken VA funding system. Advance appropriations is a common-sense solution that President Obama supported as a candidate, and it's something we would have liked to see in the budget.

If the Obama Administration is not going to lead the fight for advance appropriations, we will need Congress to step in. A number of Members of this Committee, including, of course, Chairman Filner, have already proven themselves to be key allies in the fight for advance appropriations, and we thank you for your support. IAVA is a proud endorser of H.R. 1016/S. 423, and we will work with the Committees in any way we can to move this legislation forward. With your help, we can ensure that veterans are not kept waiting, as they have in 19 of the last 22 years, while Congress plays politics with the budget.

Last month, President Obama traveled to Camp Lejeune to announce the eventual drawdown of combat troops in Iraq. No matter what you think of his plan, one

thing is clear: the new strategy in Iraq will create a surge of new veterans coming home in 2009 and 2010. America needs to be ready, and the 2010 veterans' budget will be a crucial first step.

Thank you for your time.

Sincerely,

Paul Rieckhoff

Prepared Statement of Richard F. Weidman, Executive Director for Policy and Government Affairs, Vietnam Veterans of America

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

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

Mr. Chairman, VVA thanks you for sponsoring advanced Appropriations legislation in the Senate (H.R. 1016). As you know, VVA and other major veterans' service organizations have been long-time supporters of legislation to achieve assured funding. When the VA budget is late 19 or of the last 22 times, it is clear that there is a need for a new mechanism to correct the problems in the current system of funding. While VVA remains committed to the assured funding concept, we currently strongly support the Advanced Appropriations legislation contained in H.R. 1016 as being so much better than what we currently have in place. As we have this discussion in regard to the FY 10 budget for the VA, the readily apparent need for this legislation has never been more pressing. We look forward to working with you to ensure its enactment, as it will move us toward our common goal of predictable, fully adequate, and timely funding for VA health care that is sufficient to truly meet the needs of all veterans in vital need of such care.

Overview

Concerning the proposal at hand, the President's FY 10 budget for the VA, VVA is pleased with the overall amount of the request, which is for a $5.5 Billion overall increase over the FY 2010 budget. It is unclear how much of that is slated for the Veterans Health Administration (VHA), and how much for other purposes given the sketchy outline of the VA budget thus far available. However, it is clear that the bulk of those funds needs to VHA to meet the rising needs of medical inflation continue the process of adding needed organizational capacity as the population served expands, and for modernizing equipment and facilities.

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

While VVA is adamant that VA needs to allow these veterans to register and to receive health care, it needs to be done in a manner that avoids overwhelming the system all at once leading to long delays in receiving care. The system is in many

cases too "thin" to be able to accommodate more people for more than a brief amount of time. VVA believes that these staff enhancements and increases in organizational capacity will require at least another $2 Billion for VHA to increase the size of permanent staff.

Vet Centers

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

Research

VVA calls for an increased outlay for Research and Development. Traumatic Brain Injuries, or TBI, needs to be better understood for treatment to be more effective. Other mental health issues, too, that are afflicting too many of our returning troops, need to be better understood. Research, for which VA scientists and epidemiologists can be justifiably proud, benefit not only troops who are forever changed by their experiences in combat but the general populace as well. VVVA believes that we must become more serious about research at the VA, given that the National Institutes of Health (NIH) continues to totally ignore veterans and the long term health effects of military service. Other than one head injury study, we know of no other NIH research project that even tangentially asks about military service and uses that as a variable (and possible confounder). VVA recommends that Research & Development be provided at least $ 750 million for FY 2010 and commensurately large increases in the out years, so that over 5 years this activity is funded at least at the $1 Billion level.

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

NVVRS

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

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

VVA is concerned that previous leadership at VA felt they were above the law and ignored this mandate, and were unapologetic about being scofflaws. We hope this

provision will again be included in the Appropriations act and that General Shinseki will see to it that VA obeys the law and gets this done on his watch.

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

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

Military History Needed on CPRS

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

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

In 2009, VA and DoD is supposed to complete the pilot of a new disability evaluation system for wounded returnees at major medical facilities in the Washington, D.C. area, and expand it to most other large military medical centers. We hope that what results from this effort "to eliminate the duplicative and often confusing elements of the current disability process of the two departments" will lead to less confusion and a single, viable disability rating determined by the VA. However the process is currently not working as it is supposed to work. VVA repeatedly brought this to the attention on the former Secretary of Veterans Affairs and the current Undersecretary for Benefits and his staff since last November. There is a real need for joint oversight of this process by the Veterans Affairs Committee and the Armed Services Committee to ensure that wounded and ill soldiers are treated fairly in their waning days of military service.

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

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

Mental Health—Need to Restore Organizational Capacity for Substance Abuse Treatment

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

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

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

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

VVA urges the Congress to direct the Secretary to provide quarterly reports beginning with a baseline report by each Veterans Integrated Service Network (VISN) on the initiatives set forth in the VHA Strategic Plan for Mental Health Services, specifically to improve VA's treatment of substance use disorders. These reports will provide an ongoing indication of VHA's progress in the implementation of its adopted Strategic Plan as described in section 1.2.8 of "A Comprehensive VHA Strategic Plan of Mental Health Services", May 2, 2005. In addition to baseline information, at minimum these reports should include: the current ranking of networks on their percentage of substance abuse treatment capacity along with plans developed by the lowest quartile of networks to bring their percentage up to the national average; and, the locations of VA facilities that provide 5 days or more of inpatient/residential detoxification services, either on site, at a nearby VA facility, or at a facility under contract to provide such care; and, the locations of VA health care facilities without specialized substance use disorder providers on staff, with a statement of intentions by each such facility director of plans to employ such providers or take other actions to provide such specialized care.

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

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

Up until recently, VA has not made enough progress in preparing for the needs of troops returning from Iraq and Afghanistan—particularly in the area of mental health care. In addition to the funds VVA is recommending elsewhere, we specifically recommend an increase of an additional $500 million dollars over and above the $3.9 Billion that VA now says they will allocate to assist VA in meeting the mental health care needs of all veterans. These funds should be used to develop or augment with permanent staff at VA Vet Centers (Readjustment Counseling Service or RCS), as well as PTSD teams and substance use disorder programs at VA Medical Centers and clinician who are skilled in treating both PTSD and substance abuse at the CBOC, which will be sought after as more troops (including demobilized National Guard and Reserve members) return from ongoing deployments. VVA also urges that the Secretary be required to work much more closely with the Sec-

retary of Health and Human Services, and the states, to provide counseling to the whole family of those returning from combat deployments by means of utilizing the community mental health centers that dot the Nation. Promising work is now going on in Connecticut in and possibly elsewhere in this regard that could possibly be a model. In addition, VA should be augmenting its nursing home beds and community resources for long term care, particularly at the state veterans' homes.

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

Blind and Low Vision Veterans Need Much Greater Resources and Attention

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

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

In a system in which so much of the infrastructure would be deemed obsolete by the private sector (in a 1999 report GAO found that more than 60 percent of its buildings were more than 25 years old), this has and may again lead to serious trouble. We are recommending that Congress provide an additional $1.5 billion to the medical facilities account to allow them to begin to address the system's current needs. We also believe that Congress should fully fund the major and minor construction accounts to allow for the remaining CARES proposals to be properly addressed by funding these accounts. This would be in addition to the almost $ 1 Billion contained in the stimulus package.

Homeless Veterans

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

Homeless Provider Grant and Per Diem Program

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

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

The VA provides grants to VA health care facilities and existing GPD recipients to assist them in serving homeless veterans with special needs including women, women who have care of dependent children, chronically mentally ill, frail elderly

and terminally ill veterans. Initiated in FY 2004, VA has provided special needs funding to 29 organizations totaling $15.7 million. The VA Advisory Committee on Homeless Veterans 2007 report states the need and complexity of issues involving women veterans who become homeless are increasingly unexpected. Recognizing women veterans are one of the fastest growing homeless populations, the Committee recommended future notices of funding availability target women veteran programs including special needs grant offerings. P.L. 109–461 authorizes appropriations of $7 million for FY 2007 through FY 2011 for special needs grants.

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

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

Veterans Benefits Administration

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

Compensation & Pension

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

Vocational Rehabilitation

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

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

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

Computerization of the Claims Process

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

Accountability at the VA

There is no excuse for the dissembling and lack of accountability in so much of what happens at the VA. It is certainly better than it used to be, but there is a long way to go in regard to cleaning up that corporate culture to make it the kind

of system that it can be with existing resources, and even largely the same personnel as they currently have on board. It can be cleaned up and done right the first time, if there is the political will to hold people accountable for doing their job properly.

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

Thank you again, Mr. Chairman, for allowing VVA to be heard at this forum. We look forward to working with you and this distinguished Committee to obtain an excellent budget for the VA in this fiscal year, and to ensure the next generation of veterans' well-being by enacting H.R. 1016 at the earliest possible time. I will be happy to answer any questions you or your distinguished colleagues may have.

Prepared Statement of Steve Robertson,
Director, National Legislative Commission, American Legion

Mr. Chairman and Members of the Committee:

The American Legion welcomes this opportunity to comment on President Obama's "top line" budget request for Fiscal Year 2010. The American Legion is pleased by the $113 billion total appropriations for the Department of Veterans Affairs (VA) in FY 2010 and the projected $57 billion in mandatory appropriations and $56 billion in discretionary appropriations.

As a nation at war, America has a moral, ethical and legal commitment to the men and women of the Armed Forces of the United States and their survivors. These current defenders of democracy will eventually join the ranks of their 23.5 million comrades, we refer to as veterans. The active-duty, Reserve components and veterans continue to make up the Nation's best recruiters for the armed forces. Young men and women across the country see servicemembers and veterans as role models. Chances are before enlisting in the armed forces, these young people will seek the advice of those they see in uniform or family members who served in the armed forces for their recommendations on military service.

Therefore, it is absolutely critical that the entire veterans' community (active-duty, Reserve component, and veterans) continue to remain supportive of honorable military service. No servicemember should ever be in doubt about:

- the quality of health care he or she will receive if injured;
- the availability of earned benefits for honorable military service upon discharge; or
- the quality of survivors' benefits should he or she pay the ultimate sacrifice.

The American Legion and many other veterans' and military service organizations are united in advocating enactment of timely, predictable and sufficient budgets for VA medical care. In FY 2009, Congress passed and the President signed this budget at the start of the fiscal year. Clearly, Secretary Shinseki is much more fortunate than many of his colleagues in the Cabinet because he has a timely, predictable and sufficient budget with which to administer. The American Legion urges Congress to once again pass the VA budget for FY 2010 prior to the start of the fiscal year—it does make a difference!

Mr. Chairman, The American Legion sincerely appreciated your introduction of H.R. 1016, Veterans Health Care Budget Reform and Transparency Act of 2009. This legislation should help achieve the timeliness and predictability goals, while giving us the remainder of the budget cycle to assure the sufficiency goal. Working together, the veterans' community is actively seeking additional cosponsors to this legislation.

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

- A Tax Credit for Hiring Unemployed Veterans: Provides a tax credit to businesses for hiring unemployed veterans. Specifically, veterans would qualify if they were discharged or released from active duty from the Armed Forces during the previous 5 years and received unemployment benefits for more than 4 weeks before being hired.
- Disabled Veterans Payment of $250: Provides a payment of $250 to all disabled veterans receiving benefits from the Department of Veterans Affairs. VA Medical Facilities: Provides $1 billion for non-recurring maintenance, including en-

ergy efficiency projects, to address deficiencies and avoid serious maintenance problems at the 153 VA hospitals across the country.
- Increase the Number of VA Claims Processors: Provides $150 million for an increase in VA claims processing staff, in order to address the large backlog in processing veterans' claims. This backlog has been a key complaint of veterans across the country.
- Improve Automation of VA Benefit Processing: Provides $50 million to improve the automation of the processing of veterans' benefits, to get benefits out sooner and more accurately.
- Construction of Extended Care Facilities for Veterans: Provides $150 million for state grants for the construction of additional extended care facilities for veterans.

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

- **Increases funding for the Department of Veterans Affairs by $25 billion above baseline over the next 5 years.—*Supported by The American Legion**
- **Dramatically increases funding for veterans health care.—*Supported by The American Legion**
- **Expands eligibility for veterans health care to over 500,000 veterans by 2013.—*Supported by The American Legion**
- **Enhances outreach and services related to mental health care and cognitive injuries, including post-traumatic stress disorder and traumatic brain injury, with a focus on access for veterans in rural areas—*Supported by The American Legion**
- **Invests in better technology to deliver services and benefits to veterans with the quality and efficiency they deserve.—*Supported by The American Legion**
- **Provides greater benefits to veterans who are medically retired from service.—*Supported by The American Legion**
- **Combats homelessness by safeguarding vulnerable veterans.—*Supported by The American Legion**
- **Facilitates timely implementation of the comprehensive education benefits that veterans earn through their dedicated military service.—*Supported by The American Legion**

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

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

Medical Care Collections Fund

The Balanced Budget Act 1997, Public Law (P.L.) 105–33, established the VA Medical Care Collections Fund (MCCF), requiring amounts collected or recovered from third-party payers after June 30, 1997, be deposited into this fund. The MCCF is a depository for collections from third-party insurance, outpatient prescription copayments and other medical charges and user fees. Funds collected may only be used to provide VA medical care and services, as well as VA expenses for identification, billing, auditing and collection of amounts owed the Federal Government.

The American Legion supported legislation to allow VA to bill, collect, and reinvest third-party reimbursements and copayments; however, The American Legion adamantly opposes the scoring of MCCF as an offset to the annual discretionary appropriations since the majority of these funds come from the treatment of non-service-connected medical conditions. Previously, these collection goals have far exceeded VA's ability to collect accounts receivable.

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

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

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

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

Third-Party Reimbursements for Treatment of Service-Connected Medical Conditions

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

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

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

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

Medicare Reimbursements

As do most American workers, veterans pay into the Medicare system, without choice, throughout their working lives, including while on active duty or as active service Reservists in the Armed Forces. A portion of each earned dollar is allocated to the Medicare Trust Fund and, although veterans must pay into the Medicare system, VA is prohibited from collecting any Medicare reimbursements for the treatment of allowable, non-service-connected medical conditions. Since over half of VA's enrolled patient population is Medicare-eligible, this prohibition constitutes a multi-billion dollar annual subsidy to the Medicare Trust Fund.

The American Legion would support a legislative initiative to allow VHA to bill, collect and reinvest third-party reimbursements from the Centers for Medicare and Medicaid Services for the treatment of allowable, non-service-connected medical conditions of enrolled Medicare-eligible veterans. This legislative change would generate approximately $3—5 billion in new third-party collections annually. The Congressional Budget Office predicts that enrolled veterans in Priority Groups 7 and 8 alone would generate $12 billion from 2010 to 2014 and $26 billion from 2010 to 2019.

State Extended Care Facility Construction Grants Program

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans' Homes (SVHs) and contracts with public and private nursing homes. The reason for this is obvious: for FY 2004, VA paid a per diem of $59.48 for each veteran it placed in SVHs, compared to the $354 VA claims it cost in FY 2002 to maintain a veteran for 1 day in its own nursing home care units (NHCUs).

Under the provisions of title 38, USC, VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 133 SVHs in 47 states with over 27,000 beds providing nursing home, hospital, and domiciliary care. Grants for Construction of State Extended Care Facilities provide funding for 65 percent of the total cost of building new veterans' homes. Recognizing the growing LTC needs of older veterans, it is essential the State Veterans' Homes

Program be maintained as an important alternative health care provider to the VA system.

The American Legion opposes attempts to place a moratorium on new SVH construction grants. State authorizing legislation has been enacted and state funds have been committed. Delaying projects will result in cost overruns and may result in states deciding to cancel these much needed facilities.

The American Legion supports increasing the amount of authorized per diem payments to 50 percent for nursing home and domiciliary care provided to veterans in State Veterans' Homes; providing prescription drugs and over-the-counter medications to State Homes Aid and Attendance patients along with the payment of authorized per diem to State Veterans' Homes; and allowing full reimbursement of nursing home care to 70 percent or higher service-connected disabled veterans, if those veterans reside in a State Veterans' Home.

The American Legion recommends $275 million for the State Extended Care Facility Construction Grants Program in FY 2010.

Medical and Prosthetics Research

The American Legion believes VA's focus in research must remain on understanding and improving treatment for medical conditions that are unique to veterans. servicemembers are surviving catastrophically disabling blast injuries due to the superior armor they are wearing in the combat theater and the timely access to quality combat medical care. The unique injuries sustained by the new generation of veterans clearly demand particular attention. It has been reported that VA does not have state-of-the-art prostheses like DoD and that the fitting of prostheses for women has presented problems due to their smaller stature.

The American Legion also supports adequate funding of other VA research activities, including basic biomedical research and bench-to-bedside projects for FY 2010. Congress and the Administration should continue to encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans, such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and other research that is conducted jointly with DoD, the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends $532 million for Medical and Prosthetics Research in FY 2010.

Blinded Veterans

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

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

Given the critical skills a BROS teaches to help blind veterans and their families adjust to such a devastating injury, The American Legion urges VA to recruit more specialists and continue with expansion of Blind Rehabilitation Outpatient Specialists and Visual Impairment Services Teams.

Major VHA Construction

The CARES process identified approximately 100 major construction projects throughout the VA Medical Center System, the District of Columbia, and Puerto Rico. Construction projects are categorized as major if the estimated cost is over $10 million. Now that VA has disclosed the plan to deliver health care through 2022, Congress has the responsibility to provide adequate funds. The CARES plan calls for the construction of new hospitals in Orlando and Las Vegas and replacement facilities in Louisville and Denver for a total cost estimated over $1 billion for these four facilities.

VA has not had this type of progressive construction agenda in decades. Major construction costs can be significant and proper utilization of funds must be well

planned. However, if timely completion is truly a national priority, The American Legion continues to have concerns due to inadequate funding.

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

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

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

Minor VHA Construction

VA's minor construction program has also suffered significant neglect over the past several years. Maintaining the infrastructure of VA's buildings is no small task, due to the age of these buildings, continuous renovations, relocations and expansions. When combined with the added cost of the CARES program recommendations, it is easy to see that a major increase over the previous funding level is crucial and overdue.

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

Information Technology Funding

Since the data theft occurrence in May 2006, the VA has implemented a complete overhaul of its Information Technology (IT) division nationwide. The American Legion is hopeful VA takes the appropriate steps to strengthen its IT security to regain the confidence and trust of veterans who depend on VA for the benefits they have earned.

Within VA Medical Center Nursing Home Care Units, it was discovered there was conflict with IT and each respective VAMC regarding provision of Internet access to veteran residents. VA has acknowledged the Internet would represent a positive tool in veteran rehabilitation. The American Legion believes Internet access should be provided to these veterans without delay for time is of the essence in the journey to recovery. In addition, veterans should not have to suffer due to VA's gross negligence in the matter.

The American Legion hopes Congress will not attempt to fund the solution to this problem with scarce fiscal resources allocated to the VA for health care delivery. With this in mind, The American Legion is encouraged by the fact that IT is its own line item in the budget recommendation.

The American Legion believes there should be a complete review of IT security government wide. VA isn't the only agency within the government requiring an overhaul of its IT security protocol. The American Legion urges Congress to exercise its oversight authority and review each Federal agency to ensure that the personal information of all Americans is secure.

The American Legion supports the centralization of VA's IT. The amount of work required to secure information managed by VA is immense. The American Legion urges Congress to maintain close oversight of VA's IT restructuring efforts and fund VA's IT to ensure the most rapid implementation of all proposed security measures.

The American Legion recommends $2.7 billion for Information Technology.

State Approving Agencies

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

Any delay in receipt of education benefits or approval of courses taken at institutions of higher learning can adversely affect a veteran's life. There are time restric-

tions on most veterans' education benefits; significantly, the National Guard and Reserve must remain in the Selected Reserve to use their earned benefits.

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

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

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

Make TAP and DTAP Mandatory

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

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

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

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

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

Studies show servicemembers who participate in TAP employment workshops find their first civilian job 3 weeks earlier than veterans who do not participate in TAP. The Department of Labor's Veterans Employment Training Services (DOL–VETS) ensures every TAP participant leaves the program with a draft resume, a practice interview session, and a visit to their state job board.

VETS only received a modest 4 percent-increase since 2002. Transition assistance, education, and employment are each a pillar of financial stability. They will prevent homelessness; assist the veteran to compete in the private sector, and allow our Nation's veterans to contribute their military skills and education to the civilian sector. By placing veterans in suitable employment quickly, the country benefits from in-

creased income tax revenue and reduced unemployment compensation payments, thus greatly offsetting the cost of TAP training.

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

Military Occupational Specialty Transition (MOST) Program

The American Legion supports legislation to reauthorize and fund $60 million for the next 10 years for the servicemembers' Occupational Conversion and Training Act (SMOCTA). SMOCTA is a training program developed in the early 1990's for those leaving military service with few or no job skills transferable to the civilian marketplace. SMOCTA was renamed the Military Occupational Specialty Transition (MOST) program in legislation proposed last year, but the language and intent of the program still apply.

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

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

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

Homelessness

The American Legion notes there are approximately 154,000 homeless veterans on the street each night. This number, compounded with 300,000 servicemembers entering the civilian sector each year since 2001 with at least a third of them potentially suffering from mental illness, indicates that programs to prevent and assist homeless veterans are needed.

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

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

NVTI

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

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

Veterans Workforce Investment Program

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

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

Employment Rights and Veterans' Preference

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects civilian job rights and benefits of veterans and members of the armed forces, including National Guard and Reserve servicemembers. USERRA prohibits employer discrimination due to military obligations and provides reemployment

rights to returning servicemembers. VETS administers this law; it conducts investigations for USERRA and Veterans' Preference cases, conducts outreach and education, and investigates complaints by servicemembers.

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

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

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

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

Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Businesses

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

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

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

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

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

Homeless Providers Grant and Per Diem Program Reauthorization

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem Program under the Homeless Veterans Comprehensive Service Programs Act of 1992, P.L. 102–590. The Grant and Per Diem Program is offered annually (as funding permits) by the VA to fund community agencies providing service to homeless veterans.

VA can provide grants and per diem payments to help public and nonprofit organizations establish and operate supportive housing and/or service centers for homeless veterans. Funds are available for assistance in the form of grants to provide transitional housing (up to 24 months) with supportive services, supportive services in a service center facility for homeless veterans not in conjunction with supportive housing; or to purchase vans.

The American Legion recommends $200 million for the Grant and Per Diem Program for FY 2010.

CONCLUSION

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

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

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

- **Increases funding for the Department of Veterans Affairs by $25 billion above baseline over the next 5 years.**
- **Dramatically increases funding for veterans health care.**
- **Expands eligibility for veterans health care to over 500,000 veterans by 2013.**
- **Enhances outreach and services related to mental health care and cognitive injuries, including post-traumatic stress disorder and traumatic brain injury, with a focus on access for veterans in rural areas.**
- **Invests in better technology to deliver services and benefits to veterans with the quality and efficiency they deserve.**
- **Provides greater benefits to veterans who are medically retired from service.**
- **Combats homelessness by safeguarding vulnerable veterans.**
- **Facilitates timely implementation of the comprehensive education benefits that veterans earn through their dedicated military service.**

The American Legion welcomes the opportunity to work with this Committee and the Administration on the enactment of a timely, predictable and sufficient budget for the Department of Veterans Affairs.

Mr. Chairman, that concludes my testimony and The American Legion would welcome any questions you or your colleagues may have.

The American Legion, National Commander's Testimony,
Statement of David K. Rehbein, National Commander,
The American Legion, Before a Joint Session of
The Veterans' Affairs Committees, U.S. Congress
On The Legislative Priorities of The American Legion
SEPTEMBER 11, 2008

INTRODUCTION

The American Legion's National Commander, David K. Rehbein to the House and Senate Committees on Veterans' Affairs

Messrs. Chairmen and Members of the Committees:

As The American Legion's newly elected National Commander, I thank you for this opportunity to present the views of its 2.7 million members on issues under the jurisdiction of your Committees. At the conclusion of The American Legion's 90th National Convention in Phoenix, Arizona, delegates adopted 242 organizational resolutions, with 212 having legislative intent. These mandates create the legislative portfolio of The American Legion for the remainder of the 110th Congress as well as the upcoming 111th Congress.

As the summer of 2008 turns to fall, America is poised at a critical point in history. In just over 2 months, voters will usher in a new Administration and a new Congress. There is no incumbent, not even an incumbent vice president, running for the Nation's highest office.

America's leadership will change after the general election of 2008. But what cannot change is The American Legion's obligation to ensure that the brave men and women who have worn the uniform of this Nation are not forgotten. The war on terrorism—Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF)—has already generated nearly one million discharged veterans, all of whom are guaranteed access to health care through the Department of Veterans Affairs (VA) for the first 5 years after their return home. Hundreds of thousands of OIF and OEF veterans are now using their VA health care benefits, increasing the workload of a health care system that was overburdened before the war began. It is a sacred and time honored obligation of The American Legion to make sure these veterans have the services they need and timely access to the care they have earned and deserve.

By working together, The American Legion and the Members of both the House and Senate Veterans Affairs Committees have made considerable progress in recent years to meet that obligation. We have fought for better funding for the VA health care system, and received it. We have argued for greater attention to mental health services, including Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury care, which have become known as the "signature wounds" of the wars we are fighting today. We have offered up American Legion services across the Nation, to care for those who come home severely wounded, through our Heroes to Hometowns program, and through our corps of expert service officers. We have worked with Congress, the White House, states and local communities—at every level—to ensure that our government, particularly VA, has what it needs to provide quality health care, disability compensation, rehabilitation and transitional programs to all eligible veterans. We have made progress. But we are not there yet.

The backlog of VA benefits claims remains a source of continuous frustration nationwide. And while new attention has been given to mental health care for returning veterans, VA providers themselves say they cannot keep up with it all. In some communities, it's a crisis. Funds have been budgeted for new VA medical facilities that have been in blueprints far too long. VA must undertake a new future, with a new generation of war veterans with unique needs entering the system, while at the same time honoring the service of—and caring for—those of past wars and conflicts.

The American Legion applauds the 110th Congress for recommending FY 2008 funding allocations for many VA accounts that meet or exceed funding targets proposed by The American Legion in testimony presented earlier this year. We are also thankful for the hard work of both chambers in passing a comprehensive and effective GI Bill that more accurately reflects the sacrifices of America's servicemembers—Active Duty, Guard and Reserve.

The process of providing adequate and compassionate services to our veterans is, as we all know, continuous. We must stay on top of the changes in health care, in technology, and foremost, among the veterans we serve. With that in mind and on behalf of The American Legion, I offer the following budget recommendations for the Department of Veterans Affairs for FY 2010:

BUDGET PROPOSALS FOR SELECTED DISCRETIONARY PROGRAMS FOR DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2009

Program	FY 2008	H.R. 6599	Appropriations Committee S. 3301	The American Legion's FY 2010 Recommendations
Medical Services +	*$29.1 billion*	*$30.9 billion*	*$35.6 billion* (see + note.)	
Medical Administration +	*$3.5 billion*	*$4.4 billion*	*(see + note.)*	***$42.8 billion***
Medical Facilities	*$4.1 billion*	*$5 billion*	*$5 billion*	(includes medical and prosthetics research)
Medical Care Total	***$36.7 billion***	***$40.3 billion***	***$40.6 billion***	
Medical Care Recovery Fund	($2.4 billion)	($2.5 billion)	($2.5 billion)	*
Medical and Prosthetic Research	$480 million	$500 million	$527 million	$532 million
Major Construction	$1.1 billion	$923 million	$1.2 billion	$1.8 billion
Minor Construction	$630 million	$991 million	$729 million	$1.5 billion
State Veterans Homes Grants	$165 million	$165 million	$250 million	$275 million
State Veterans Cemetery Grants	$40 million	$45 million	$42 million	$49 million
National Cemetery Administration	$195 million	$240 million	$230 million	$249 million
Information Technology	$2 billion	$2.5 billion	$2.5 billion	$2.7 billion
General Operating Expenses	$1.6 billion	$1.8 billion	$1.8 billion	$2.8 billion

*The American Legion continues to support using Medical Care Recovery Funds as supplements, not offsets to discretionary VA funding.

+Medical Services and Medical Administration accounts—VA's FY 2009 budget request proposed merging the Medical Services account and the Medical Administration account. The Senate concurred with this recommendation for consolidation. The House renamed the Medical Administration account the "Medical Support and Compliance", but maintained it as a separate account.

VETERAN'S HEALTH CARE

A System Worth Saving

In 2002, The American Legion initiated the "I Am Not A Number" campaign to ascertain the quality and timeliness of health care delivery within VA. This program surveyed veterans on their personal experiences with the VA health care system and provided The American Legion with a clear snapshot of the needs of VA systemwide. These actual accounts of veterans' experiences highlighted a trend within VA; veterans reported the quality of care was exceptional, but criticized the difficulty of access to treatment.

During that time, then National Commander Ronald Conley conducted site visits to 60 VA Medical Centers nationwide and compiled a report highlighting the issues affecting VA, which was a result of years of inadequate funding. This report, titled, "A System Worth Saving," covered issues from Medical Care Collection Fund (MCCF) targets; wait times; budgetary shortfalls; and staffing levels.

By 2004, The American Legion had conducted a full cycle of site visits to VA Medical Centers (VAMC) throughout VA's 21 Veterans Integrated Service Networks (VISN). In 2005, The American Legion conducted site visits to selected VAMC's, with attention on the progression of the Capital Asset Realignment for Enhanced Services (CARES). Due to the initial lack of headway from the CARES initiative, The American Legion was prompted to conduct site visits with additional focus on various medical areas within the VA Medical Center system to ascertain the level of progression. The focus included Polytrauma Centers and Vet Centers, and Nursing Home Care Units/Community Living Centers (NHCU/CLC) in 2006 and 2007. Although emphasis was placed on the aforementioned areas, The American Legion continued to focus on the overall progress of VA Medical Centers.

Since 2002, these comprehensive reports, created from the compilation of site visit reports, have been presented to Congress and shared with VA in an attempt to bring attention to the budgetary needs of the VA health care system. This year marks the printing of the sixth "A System Worth Saving" report. The American Legion's 2008 "A System Worth Saving" report, a compilation of information gathered from site visits conducted by field service representatives and the System Worth Saving Task Force members, focuses on Nursing Home Care Units/Community Living Centers (NHCUs/CLCs) located within the VA Medical Center System. Of the total 134 Nursing Home Care Units/Community Living Centers, approximately 49 were selected. The reports highlighted key issues in determining quality care, staffing levels, funding, physical plant, as well as obstacles and challenges to providing quality care.

Although it has been 6 years since the initial visits, The American Legion continues to have concerns of the effects of current budgets on VA's ability to deliver quality care in a timely manner. America's veterans are turning to VA for their health care needs and, as we welcome home injured veterans, it is forever our responsibility as advocates to work together to ensure VA is indeed capable of treating all eligible veterans.

Budget Reform for Veterans' HealthCare

The annual discretionary appropriations in Fiscal Year (FY) 2007 and FY 2008 represented a dramatic improvement over years of consistent budgetary shortfalls, but these funding levels were achieved only through dynamic leadership in both chambers. However, even these two outstanding appropriations did not follow the normal appropriations process—one was achieved through a year-long continuing resolution with significant markups for VA medical care and the second required the President to declare a need for emergency appropriations for VA medical care.

As the current generation of young Americans sequentially answer the Nation's call to arms, and deploying and returning from around the world, their more complex issues warrant the demand for additional support and accommodations, to include assured funding, clinical providers, nurses, and space. Many have survived combat wounds that were fatal to servicemembers in past conflicts; this is due to modern technology in the combat zones and hot spots around the world.

Like so many brave men and women who honorably served before them, these new veterans are fighting for the freedom and security of us all. Therefore, today's veterans deserve the respect of a grateful Nation upon their return home. Generations of wartime veterans of the past were unconditionally welcomed at VA medical facilities until the 1980s.

The American Legion believes the absence of appropriate urgent changes in Federal health care funding will continue to add to the strife that has plagued the VA, as well as the veterans it serves. New veterans may soon discover their battles are not over; that is, if the aforementioned doesn't come to past. Instead, the Nation's newest heroes will inevitably fight for the life of the VA health care system, as veterans in the 20th century fought for care they were eligible to receive.

With the influx of those returning from Iraq and Afghanistan, the demand for various clinical providers, nurses, space, and structural peripherals are mounting. As each fiscal year comes, assured funding is essential to proactively meet various challenges faced at VA medical facilities. The American Legion believes the time for serious reform of the Federal appropriations for veterans' health care that would provide timely, predictable, and sufficient appropriations for VA medical care. We hereby urge Congress to act now to ensure that we, as a nation, will always provide the funding necessary to ensure the complete care for those who seek timely access to quality health care through the VA health care delivery system.

The American Legion believes the solution to the Veterans Health Administration's (VHA's) recurring fiscal difficulties will only be achieved through meaningful reform of the Federal appropriations process as recommended by the President's Task Force to Improve Health Care Delivery for our Nation's Veterans (in 2003). This Task Force clearly identified the consistent mismatch between VA health care funding and the growing demand for health care services.

The American Legion and eight other major veterans' and military service organizations have joined forces to urge Congress to provide annual Federal appropriations that are timely, predictable, and sufficient. These three components are critical for effective long- and short-range decisionmaking by VA management. The Partnership for Veterans Health Care Budget Reform has supported legislation that would make VA health care funding mandatory rather than discretionary. Under this concept, VA health care funding would be formula-based, much like other mandatory benefits like Medicare, Social Security, and VA compensation and pension.

This concept has met a great deal of resistance by many lawmakers on Capitol Hill; so The American Legion and its colleagues now recommends an alternative to mandatory funding—advanced appropriations. The American Legion believes this change would assure timeliness and predictability. Under advanced appropriations, VA medical care discretionary appropriations would be approved prior to the start of the next fiscal year. Should The American Legion have concern about the sufficiency of the advanced appropriations, it would have an opportunity to address any shortfalls while testifying for the remainder of the VA appropriations for that fiscal year.

The American Legion recommends reform of the Federal appropriation process with regard to VA health care that would guarantee timely, predictable, and sufficient annual appropriations.

MEDICAL CARE COLLECTIONS

The Balanced Budget Act 1997, Public Law (PL) 105–33, established the VA Medical Care Collections Fund (MCCF), requiring amounts collected or recovered from third-party payers after June 30, 1997, be deposited into this fund. The MCCF is a depository for collections from third-party insurance, outpatient prescription copayments and other medical charges and user fees. Funds collected may only be used to provide VA medical care and services, as well as VA expenses for identification, billing, auditing and collection of amounts owed the Federal Government.

The American Legion supported legislation to allow VA to bill, collect, and reinvest third-party reimbursements and copayments; however, The American Legion adamantly opposes the scoring of MCCF as an offset to the annual discretionary appropriations since the majority of these funds come from the treatment of non-service-connected medical conditions. Previously, these collection goals have far exceeded VA's ability to collect accounts receivable.

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

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

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

The American Legion opposes offsetting annual VA discretionary funding by the MCCF goal, especially since VA is prohibited from collecting any third-party reimbursements from the Nation's largest federally-mandated health insurer, Medicare.

MEDICARE

As do most American workers, veterans pay into the Medicare system, without choice, throughout their working lives, including while on active duty or as Reservists in the Armed Forces. A portion of each earned dollar is allocated to the Medicare Trust Fund and, although veterans must pay into the Medicare system, VA is prohibited from collecting any Medicare reimbursements for the treatment of allowable, non-service-connected medical conditions.

Since over half of VA's enrolled patient population is Medicare-eligible, this prohibition constitutes a multi-billion dollar annual subsidy to the Medicare Trust Fund.

The American Legion is opposed to the current policy on Medicare reimbursement and supports Medicare reimbursement for VHA for the treatment of allowable, non-service-connected medical conditions of enrolled Medicare-eligible veterans.

VET CENTERS

The American Legion is proud to have been involved with the Vet Center program since its inception in 1979. During the developmental phase, some Vet Centers operated from local American Legion posts during their search for permanent locations.

They were designed to provide services exclusively for veterans who served in theaters of conflict, or those who experienced military sexual trauma.

Vet Centers are community-based and veterans are assessed the day they seek services. In addition, they also provide mental health counseling to those within the veteran's support system, such as spouses and children. Recently, VA announced the addition of 39 Vet Centers, increasing the total to 278. These facilities are mandated for completion by the fall of 2009.

During The American Legion's 2007 site visits to Vet Centers, it was acknowledged their overall challenge included limited staffing, which was a result of occurring and anticipated influx of returning Operations Enduring Freedom/Iraqi Freedom (OEF/OIF) veterans. Services have also expanded to provide bereavement counseling to family members of those who have died while fighting in support of OEF and OIF.

The American Legion continues to acknowledge the success of Vet Centers and the quality services they provide to the Nation's veterans and their families. The Vet Centers' distinctive locations, personnel, and overall growing missions continue to stand beyond other programs offered by VA.

Vet Centers also provide services in a non-clinical environment, which may appeal to those who would be reluctant to seek mental health care in a medical facility. A high percentage of the staff, more than 80 percent, are combat veterans and can relate to the readjustment issues experienced by the those seeking services.

The most important aspect of Vet Centers is the provision of timely accessibility. Since Vet Centers are community-based and veterans are assessed within minutes of their arrival, eligible veterans are not subjected to long wait times for disability claims decisions to determine eligibility for enrollment, or long wait times for available appointments.

Although Vet Centers have an extensive outreach plan, more outreach is required to reach other groups of veterans who are unaware they are eligible to use Vet Centers or those who may not be familiar with the program in general. According to VA, many veterans learn of Vet Centers by word-of-mouth; reaching veterans residing in rural areas continues to be a challenge.

VA has recently recognized the importance of Vet Centers and the current and potential services they are capable of rendering veterans within their respective communities. The plan to open 39 additional Vet Centers validates their acknowledgement and commitment to ensure veterans receive access to all VA related services. The completion date for the project is the fall of 2009. This plan will also call for more funding to operate and lease space for the new Vet Centers.

As more servicemembers return from theater, the demand for more services will be required. Upon completion of Vet Centers in 2009, The American Legion urges VA to assess the surrounding areas to ensure the amount of Centers is adequate to accommodate these new veterans.

The American Legion believes all Vet Centers should be fully staffed with qualified providers to ensure combat veterans seeking care for readjustment are afforded the same standard of quality care, no matter which Vet Center they use.

TRAUMATIC BRAIN INJURY (TBI)

A recent GAO report acknowledged VA's challenge of facing a number of clinical challenges in its efforts to screen OEF/OIF veterans for mild TBI and evaluate those who screen positive on the TBI screening tool, to include the absence of no objective diagnostic tests, such as laboratory tests or neuroimaging tests like MRI and computed tomography (CT) scans that can definitively and reliably identify mild TBI. Other challenges include the similarity of many symptoms of mild TBI to symptoms associated with other conditions, which makes a definitive diagnosis of mild TBI more difficult to reach; OEF/OIF veterans with mild TBI might not realize that they have an injury and should seek health care.

According to the **New England Journal of Medicine**, the U.S. Army surveyed approximately 2525 soldiers three to 4 months after their return from a year-long deployment in Iraq. Of the 2525 soldiers, 124 reported injuries with loss of consciousness, 260 reported injuries with altered mental status, and 435 reported other injuries during deployment. In addition, those who reported loss of consciousness, 43.9 percent met criteria for post-traumatic stress disorder (PTSD), in comparison to 27.3 percent who reported an altered mental status.

Soldiers with mild traumatic brain injury were more likely to report poor health, missed workdays, medical visits, and a high number of somatic and post concussive symptoms than were soldiers with other injuries. On the other hand, after adjustment for PTSD and depression, mild traumatic brain injury was no longer signifi-

cantly associated with these physical health outcomes or symptoms, except for headache.

The report's conclusion stated mild traumatic brain injury occurring among soldiers deployed in Iraq is strongly associated with PTSD and physical health problems three to 4 months after the soldiers' return home while PTSD and depression are important mediators of the relationship between mild TBI and physical health problems.

In a July 2006, VA's Office of Inspector General (OIG) issued a report entitled "Health Status of and Services for Operation Enduring Freedom and Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation." The VA's OIG examined VHA's ability to meet the needs of OEF/OIF veterans who suffered from TBI. It reports that 52 patients from around the country—including Montana, Colorado, North Dakota, and Washington—were interviewed at least 1 year after completing inpatient rehabilitation from a Lead Center (Minneapolis, MN; Palo Alto, CA; Richmond, VA; and Tampa, FL) that included those who lived in rural states.

Many of the obstacles for TBI veterans and their family members were similar. Some 48 percent of the patients indicated that there were few resources in the community for brain injury-related problems. Approximately 38 percent indicated that transportation was a major obstacle. Another 17 percent indicated that they did not have money to pay for medical, rehabilitation, and injury-related services.

Some of the challenges noted by family members who care for these veterans in rural settings include the necessity for complicated special arrangements and the absence of VA rehabilitative care in their communities. Case managers working at Lead Centers and several secondary centers noted limited ability to follow patients after discharge to rural areas and lack of adequate transportation.

These limitations place undue hardship on the veterans' families as well. Those contributing to the report, as well as veterans who have contacted The American Legion, have shared many examples of the manner in which family have been devastated by caring for TBI injured veterans. They have sacrificed financially, have lost jobs that provided the sole income for the family, and have endured extended separations from children.

POLYTRAUMA CENTERS

To date, VHA has designated five VA Medical Centers as Polytrauma Rehabilitation Centers (PRC). These Centers provide specialized care for returning servicemembers and veterans who suffer from multiple and severe injuries. They also provide specialized rehabilitation to help injured servicemembers or veterans optimize the level of independence and functionality they are capable of achieving.

The Polytrauma Centers are located in Minneapolis, MN; Palo Alto, CA; Richmond, VA; San Antonio, TX; and Tampa, FL. Another unique aspect of the Polytrauma Center includes the administration of care for TBI, amputations, blindness and psychosocial/mental health issues in one location.

In addition to the five designated sites, VA has established 17 Polytrauma Network Sites (PNS)—one in each Veterans Integrated Services Network (VISNs); and approximately 75 Polytrauma Support Clinic Teams to augment the care for those with multiple injuries.

During the "System Worth Saving" site visits to the PRC Centers, many of them had vacancies for highly specialized rehabilitative fields and nursing. The major challenge to filling vacancies included the inability to offer competitive salaries. It is the declaration of The American Legion that VA must be adequately staffed to maintain or enhance services provided to veterans and servicemembers recovering from multiple injuries.

ACCESS TO CARE FOR RURAL VETERANS

Research conducted by VA indicated veterans residing in rural areas are in poorer health than their urban counterparts. It was further reported that nationwide, one in five veterans who enrolled to receive VA health care lives in rural areas. Providing quality health care in a rural setting has proven to be very challenging, given factors such as limited availability of skilled care providers and inadequate access to care. Even more challenging will be VA's ability to provide treatment and rehabilitation to rural veterans who suffer from the signature ailments of the on-going Global War on Terror—traumatic blast injuries and combat-related mental health conditions. VA's efforts need to be especially focused on these issues.

A vital element of VA's transformation in the 1990s was the creation of Community Based Outpatient Clinics (CBOCs) that proximate access to VA primary care within veterans' communities. Recently, VA scheduled the opening of 44 additional CBOCs in 21 states. The new clinics will be fully activated by 2009, increasing VA's network of independent and community-based clinics to 782. The American Legion

believes the clinics are warranted due to the growing population of veterans within rural areas of the Nation. More veterans are also migrating to less populated areas with an abundance of automobiles, which are the primary catalysts that transport Improvised Explosive Devises (IED's) in Iraq.

While VA has taken the right step with the addition of more CBOCs, The American Legion believes more are warranted. There continues to be great difficulty serving veterans in rural areas, such as Nebraska, Nevada, Utah, South Dakota, Wyoming, and Montana where veterans face extremely long drives, a shortage of health care providers, and bad weather. VISNs rely heavily upon CBOCs to close the gap.

Many veterans continue to express concerns to The American Legion about their limited financial resources prohibiting travel, citing the rising cost of gas, the limitations of the mileage reimbursement rate, and the need to pay for overnight accommodations as obstacles. Providing contracted care in highly rural communities—when VA health care services are not possible—would alleviate the unwarranted hardships these veterans encounter when seeking access to VA health care.

SEAMLESS TRANSITION

VA has an Office of Seamless Transition that is available to participate in Department of Defense (DoD), National Guard and Reserves Transition Assistance Programs (TAP) and Disabled Transition Assistance Programs (DTAP). However, The American Legion remains concerned that many servicemembers returning home from OEF/OIF duty are not being properly advised of the benefits and services available to them from VA and other Federal and state agencies. This is especially true of Reserve and National Guard units that are demobilized at hometown Reserve Centers and National Guard armories, rather than at active duty demobilization centers.

Legionnaires at the state level have briefed Guard and Reserve units on VA's benefits and services. Many transitioning servicemembers were unaware of the existence of the Office of Seamless Transition and did not know the office has staff available to provide briefings to their respective units that had recently returned from or planned to deploy in support of GWOT.

The American Legion asserts the importance of improved communication between VA and Reserve and National Guard units to ensure eligible Reservists are aware of all entitled VA benefits. In addition, there must be a concerted, proactive effort on behalf of DoD and VA to ensure every veteran is thoroughly screened and properly handed off from the former to the latter. In a recent GAO site visit to DoD medical facilities, it was discovered that health care providers were unaware a medical record review was required and that medical records were not consistently reviewed by providers conducting the pre-deployment health assessment.

Health assessment mistakes or inconsistencies occurring when veterans are active servicemembers will follow them to civilian life and eventually be overlooked. When those mistakes and inconsistencies become routine, the numbers increase, which will continually give birth to veterans with issues that could have been previously alleviated before entering the civilian community.

The American Legion believes a stern system of checks and balances underlined with current and future plans and policies will ensure ongoing communication and successful transition of the Nation's heroes from DoD to VA.

THE AGING OF AMERICA'S VETERANS

VA's Long-Term Care Mission

Public Law (PL) 106–117, the Millennium Health Care and Benefits Act, enacted in November 1999, required VA to continue to ensure 1998 levels of extended care services (defined as VA nursing home care, VA domiciliary, VA home-based primary care, and VA adult day health care) in its facilities. Yet, VA has not consistently maintained the 1998 bed levels mandated by law.

VA's inability to adequately address the long-term care problem facing the agency was most notable during the Capital Assets Realignment for Enhanced Services (CARES) process and continues. The planning for the long-term care mission, one of the major services VA provides to veterans, was not addressed in the initial CARES initiative, which is touted as the most comprehensive analysis of VA's health care infrastructure ever conducted.

The American Legion met with the Office of Geriatrics and Extended Care (GEC) in November 2007 to discuss this rapidly changing and demanding source of unique health care and the newly implemented Cultural Transformation of its 134 Nursing Home Care Units (NHCU). Initially implemented in 2004, the conversion to the Cultural Transformation plan seeks to overcome barriers to change; create a peer sup-

port network; and link providers with long-term care leaders to establish evidence for best practices and models of care.

In addition, VA has reiterated the Joint Commission on Accreditation of Health care Organizations' (JACHO) Standard Ethics, Rights and Responsibility, which states, "Residents have a right to an environment that preserves dignity and contributes to a positive self image." This includes appropriate accommodations for sufficient space with access to personal living space and a home-like atmosphere.

During The American Legion's 2008 site visits, which focused on VA Nursing Home Care Units, Task Force members and Field Service representatives discussed VA long-term care, as well as its support systems and all it supports. In this round table and physical tour engagement, The American Legion sought to ascertain that all was being carried out as discussed during the 2004 implementation of the cultural transformation. Challenges which continue to impede full operation include: the three budgets split along with the separation of Information Technologies (IT), Cultural Transformation, and being understaffed.

The American Legion continues to state its support for the publishing and implementation of a Long-Term Care (LTC) strategic plan that addresses the rising long-term care needs of America's veterans. We remain disappointed it has now been over 4 years since the CARES decision and no plan has been published. We assert VA should take proactive steps to provide the care mandated by Congress. Congress should in turn do its part and provide adequate mandatory funding to VA to implement its mandates.

The American Legion will continue to support current legislation that will ensure appropriate payments for the cost of LTC provided to veterans in State Veterans' Homes, stronger oversight of payments to State Veterans' Homes, full reimbursement for the treatment of veterans 70 percent service-connected or higher, and the more efficient delivery of pharmaceuticals.

It is vital that VA meet the LTC requirements of the Millennium Health Care and Benefits Act; we urge your Committees to support adequate funding for VA to meet the LTC needs of America's veterans.

State Extended Care Facility Construction Grants Program

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans' Homes (SVHs) and contracts with public and private nursing homes. The reason for this is obvious: for FY 2004, VA paid a per diem of $59.48 for each veteran it placed in SVHs, compared to the $354 VA claims it cost in FY 2002 to maintain a veteran for 1 day in its own nursing home care units (NHCUs).

Under the provisions of title 38, United States Code (USC), VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 133 SVHs in 47 states with over 27,000 beds providing nursing home, hospital, and domiciliary care. Grants for Construction of State Extended Care Facilities provide funding for 65 percent of the total cost of building new veterans' homes. Recognizing the growing LTC needs of older veterans, it is essential the State Veterans' Home Program be maintained as an important alternative health care provider to the VA system.

The American Legion opposes attempts to place a moratorium on new SVH construction grants. State authorizing legislation has been enacted and state funds have been committed. Delaying projects will result in cost overruns from increasing building materials costs and may result in states deciding to cancel these much needed facilities.

The American Legion supports:

- **Increasing the amount of authorized per diem payments to 50 percent for nursing home and domiciliary care provided to veterans in State Veterans' Homes;**
- **Providing prescription drugs and over-the-counter medications to State Homes Aid and Attendance patients along with the payment of authorized per diem to State Veterans' Homes; and**
- **Allowing for full reimbursement of nursing home care to 70 percent service-connected veterans or higher, if veterans reside in a State Veterans' Home.**

The American Legion recommends $275 million for the State Extended Care Facility Construction Grants Program in FY 2010.

Medical and Nursing School Affiliations

VHA and its medical school affiliates continue to enjoy a longstanding and exemplary relationship that has endured for virtually 60 years. This relationship continues to thrive and evolve to present day. Currently, there are 129 accredited med-

ical schools in the United States. Of these, 107 have formal affiliation agreements with VA Medical Centers (VAMCs). More than 30,000 medical residents and 22,000 medical students receive a portion of their medical training in VA facilities annually. VA estimates that 70 percent of its physician workforce has university appointments.

VHA conducts the largest coordinated education and training program for health care professions in the Nation. The medical school affiliations allow VA to train new health professionals to meet the health care needs of veterans and the Nation. Medical school affiliations have been a major factor in VA's ability to recruit and retain high quality physicians. It also affords veterans access to the some of the most advanced medical technology and cutting edge research. VHA research continues to make meaningful contributions to improve the quality of life for veterans and the general population.

VHA's recent and numerous recognitions as a leader in providing safe, high-quality health care to the Nation's veterans can be directly attributed to the relationship that has been fostered through the affiliates. The American Legion remains committed to this mutually beneficial affiliation between VHA and the medical schools of this Nation. We also believe that medical school affiliates should be appropriately represented as a stakeholder on any national task force, commission, or Committee established to deliberate on veterans' health care.

VA recently established a Nursing Academy to address the nationwide nursing shortage issue. The Nursing Academy has embarked on a 5-year pilot program that will establish partnerships with a total of 12 nursing schools. The initial set of partnerships implemented this year included nursing schools in Florida, California, Utah and Connecticut. This pilot program will train nurses to understand the health care needs of veterans and make more nurses available to allow VA to continue to provide veterans with the quality care they deserve.

Academic Year (AY) 2007–08 was the first of a multi-year expansion in order to address the recommendations of the federally Chartered External Advisory Committee on VHA Resident Education. The Advisory Committee was charged with an examination of the philosophy and deployment of VA's residency training positions.

The Committee acknowledged the critical role VA plays in provision of high-quality graduate medical education (GME) and recommended VA increase its proportional support of the national GME enterprise. With 2008 being the second year of expansion, the VA Office of Academic Affiliations has developed three Requests for Proposals (RFPs) which will create about 400 new, permanent resident positions nationwide in AY 2009–2010. In addition to the GME Enhancement initiative, 698 physician resident positions were awarded to 72 facilities in 61 specialty training programs.

The American Legion affirms its strong commitment and support for the mutually beneficial affiliations between VHA and the medical and nursing schools of this Nation.

MEDICAL AND PROSTHETICS RESEARCH

The American Legion believes VA's focus in research should remain on understanding and improving treatment for conditions that are unique to veterans. servicemembers are surviving catastrophically disabling blast injuries due to the superior armor they are wearing in the combat theater and the timely access to quality triage. The unique injuries sustained by the new generation of veterans clearly demand particular attention. It has been reported that VA does not have state-of-the-art prostheses like DoD, and that the fitting of the prostheses for women has presented problems due to their smaller stature.

The American Legion supports adequate funding of other VA research activities, including basic biomedical research and bench-to-bedside projects for FY 2010. Congress and the Administration should continue to encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans—such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others jointly with DoD, the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends $532 million for Medical and Prosthetics Research in FY 2010

ENVIRONMENTAL EXPOSURES

Agent Orange

One of the top priorities of The American Legion has been to ensure that long overdue major epidemiological studies of Vietnam veterans who were exposed to the herbicide Agent Orange are carried out. In the early 1980s, Congress held hearings on the need for such epidemiological studies. The Veterans' Health Programs Exten-

sion and Improvement Act 1979, Public Law 96–151, directed VA to conduct a study of long-term adverse health effects in veterans who served in Vietnam as a result of exposure to herbicides. When VA was unable to do the job, the responsibility was passed to the Centers for Disease Control (CDC). In 1986, CDC also abandoned the project, asserting that a study could not be conducted based on available records.

The American Legion did not give up. Three separate panels of the National Academy of Sciences have agreed with The American Legion and concluded that CDC was wrong and that epidemiological studies based on DoD records are possible.

The Institute of Medicine (IOM) report, Characterizing Exposure of Veterans to Agent Orange and Other Herbicides Used in Vietnam, is based on the research conducted by a Columbia University team. Headed by principal investigator Dr. Jeanne Mager Stellman, the team has developed a powerful method for characterizing exposure to herbicides in Vietnam. The American Legion is proud to have collaborated in this research effort. In its final report on the study, the IOM urgently recommends that epidemiological studies be undertaken now that an accepted exposure methodology is available. The American Legion strongly endorses this IOM report.

The IOM's most recent report on veterans' herbicide exposure in Vietnam, Veterans and Agent Orange: Update 2006, released July 27, 2007,added two new illnesses to the category of "limited or suggestive evidence of association," AL amyloidosis and hypertension. This is a profound finding since many Vietnam War veterans suffer from hypertension.

The "limited or suggestive" evidence finding meets the threshold of a positive association between the exposure of humans to a herbicide agent and the occurrence of a disease in humans, as set forth in title 38, United States Code § 1116, and has been used by VA to add other conditions, including type 2 diabetes, to the list of herbicide presumptive disabilities. Although the Secretary of Veterans Affairs, in violation of specific reporting requirements set forth in § 1116, has yet to publish his official determination regarding this latest IOM report in the Federal Register, The American Legion received a letter from the Secretary on June 26, 2008, informing our organization that AL amyloidosis is the only condition, based on the July 2007 IOM report, that would be added to the list of disabilities presumed to be service-connected due to herbicide exposure. The Secretary specifically stated that he has "determined that the evidence available at this time does not warrant the establishment of a new presumption of service connection based on service in Vietnam for any additional diseases reviewed in the NAS report."

Since, at of the time of this writing, the Secretary has not published a notice of his determination in the Federal Register, which will include an explanation of the scientific basis for that determination; The American Legion is unable to comment on the reasoning behind VA's decision not to recognize hypertension as presumptively service-connected to herbicide exposure among Vietnam veterans. Rest assured, we will carefully review the Secretary's determination once it is published in the Federal Register and will take appropriate action, including, but not limited to, seeking a legislative remedy to correct this injustice.

The American Legion is extremely concerned about the timely disclosure and release of all information by DoD on the use and testing of herbicides in locations other than Vietnam during the war. Over the years, The American Legion has represented veterans who claim to have been exposed to herbicides in places other than Vietnam. Without official acknowledgement by the Federal Government of the use of herbicides, proving such exposure is virtually impossible. Information has come to light in the last few years leaving no doubt that Agent Orange, and other herbicides contaminated with dioxin, were released in locations other than Vietnam. This information is slowly being disclosed by DoD and provided to VA.

In April 2001, officials from DoD briefed VA on the use of Agent Orange along the Korean demilitarized zone (DMZ) from April 1968 through July 1969. It was applied through hand spraying and by hand distribution of pelletized herbicides to defoliate the fields of fire between the frontline defensive positions and the south barrier fence. The size of the treated area was a strip 151 miles long and up to 350 yards from the fence to north of the civilian control line. According to available records, the effects of the spraying were sometimes observed as far as 200 meters downwind. DoD identified the units that were stationed along the DMZ during the period in which the spraying took place. This information was given to VA's Compensation and Pension Service, which provided it to all of the regional offices. VA Central Office has instructed its Regional Offices to concede exposure for veterans who served in the identified units during the period the spraying took place.

In January 2003, DoD provided VA with an inventory of documents containing brief descriptions of records of herbicides used at specific times and locations outside of Vietnam. The information, unlike the information on the Korean DMZ, does not contain units involved or individual identifying information. Also, according to VA,

this information is incomplete, reflecting only 70 to 85 percent of herbicide use, testing and disposal locations outside of Vietnam. VA requested that DoD provide it with information regarding the units involved with herbicide operations or other information that may be useful to place veterans at sites where herbicide operations or testing was conducted. Unfortunately, as of this date, additional information has not been provided by DoD.

Obtaining the most accurate information available concerning possible exposure is extremely important for the adjudication of herbicide-related disability claims of veterans claiming exposure outside of Vietnam. For herbicide-related disability claims, veterans who served in Vietnam during the period of January 9, 1962 to May 7, 1975 are presumed by law to have been exposed to Agent Orange. Veterans claiming exposure to herbicides outside of Vietnam are required to submit proof of exposure. This is why it is crucial that all information pertaining to herbicide use, testing, and disposal in locations other than Vietnam be released to VA in a timely manner. Congressional oversight is needed to ensure that additional information identifying involved personnel or units for the locations already known by VA is released by DoD, as well as all relevant information pertaining to other locations that have yet to be identified. Locating this information and providing it to VA must be a national priority.

The American Legion endorses this IOM report and strongly urges VA to make a timely decision on its recommendations and provide notification of the decision to add or not add to the presumptive list.

Gulf War Illness

In the Research Advisory Committee on Gulf War Veterans' Illness (RACGWI) initial report released in November 2004, it was found that, for a large majority of ill Gulf War veterans, their illnesses could not be explained by stress or psychiatric illness and concluded that current scientific evidence supports a probable link between neurotoxin exposure and subsequent development of Gulf War veterans' illnesses. Earlier government panels concluded that deployment-related stress, not the numerous environmental and other exposures troops were exposed to during the war, was likely responsible for the numerous unexplained symptoms reported by thousands of Gulf War veterans.

Gulf War research is moving away from the previous stress theories and is beginning to narrow down possible causes. However, research regarding viable treatment options is still lacking. The American Legion applauds Congress for having the foresight to provide funding to the Southwestern Medical Center's Gulf War Illness research program. The Center, headed by Dr. Robert Haley at the University of Texas Southwestern, was awarded $15 million, renewable for 5 years, to further the scientific knowledge on Gulf War Veterans Illnesses research. This research will not only impact veterans of the 1991 Gulf War, but may prove beneficial for those currently serving in the Southwest Asia Theater and the Middle East. The purpose of the research is to fill in the gaps of knowledge where there is little, yet suggestive information. Dr. Haley's research will further this knowledge about Gulf War veterans' illnesses and hopefully help improve the lives of ill Gulf War veterans and their families who suffer beside them. We owe ill Gulf War veterans our exhaustive efforts in finding treatments for their ailments.

VA must continue to fund research projects consistent with the recommendations of the Research Advisory Committee on Gulf War Veterans' Illness (RACGWI). It is important that VA continues to focus its research on finding medical treatments that will alleviate veterans' suffering as well as on figuring out the causes of that suffering. The American Legion also recommends that your Committees thoroughly review the RACGWI's second report, which will be released this fall.

Public Law 103–210, which authorized the Secretary of Veterans Affairs to provide priority health care to the veterans of the Persian Gulf War who have been exposed to toxic substances and environmental hazards, allowed Gulf War Veterans—and veterans of the Vietnam War—to enroll into Priority Group 6. The last sunset date for this authority was December 31, 2002. Since this date, information provided to veterans and VA hospitals has been conflicting. Some hospitals continue to honor Priority Group 6 enrollment for ill Gulf War veterans seeking care for their ailments. Other hospitals, well aware of the sunset date, deny Priority Group 6 enrollment for these veterans and notify them that they qualify for Priority Group 8. To these veterans' dismay, they are completely denied enrollment because of VA's restricted enrollment for Priority Group 8 since January 2003. Even more confounding is the fact that eligibility information disseminated via Internet and printed materials does not consistently reflect this change in enrollment eligibility for Priority Group 6. VA has assured The American Legion that this issue will be rectified.

Although these veterans can file claims for these ailments and possibly gain access to the health care system once a disability percentage rate is granted, those whose claims are denied cannot enroll. According to the May 2007 version of VA's Gulf War Veterans Information System (GWVIS), there were 14,874 claims processed for undiagnosed illnesses. Of those undiagnosed illness claims processed, 11,136 claims were denied. Due to their nature, these illnesses are difficult to understand and information about individual exposures may not be available, many ill veterans are not able to present strong claims. They are then forced to seek care from private physicians who may not have enough information about Gulf War Veterans' illnesses to provide appropriate care.

NOTE: VA also published another negative presumption determination in the Federal Register on July 21, 2008—Joe, you might want to add something about this report.

VA published its comments on the IOM's Gulf War and Health, Volume 2: Insecticides and Solvents report, released in February 2003 in the Federal Register. The Department decided not to establish a presumption of service connection for any diseases, illnesses or health effects considered in the report, based on exposure to insecticides or solvents during service in the Persian Gulf during the Persian Gulf War. Many of VA's justifications for not establishing presumption mirror the reasons why ill Gulf War veterans have problems justifying their claims. The IOM report notes that little information is known about the use of solvents in the theater.

VA notes that veterans may still be granted service connection, if evidence indicates an association between their diseases and their exposures. This places the burden of proof on Gulf War veterans to prove their exposures and that the level of exposure is sufficient enough to warrant service connection. IOM and VA have acknowledged that there is insufficient information on the use of the identified solvents and pesticides during the Gulf War.

VA states that PL105–277 does not explain the meaning of the phrase, "known or presumed to be associated with service in the Armed forces in the Southwest Asia theater of operations during the Persian Gulf War" and that there is no legislative history explaining the meaning of the phrase. VA has had adequate time to get Congress to clarify the statute's intent and should have clarified the intent prior to delivering a charge to the IOM for the report. VA's interpretation is that Congress did not intend VA to establish presumptions for known health effects of all substances common to military and civilian life, but that it should focus on the unique exposure environment in the Persian Gulf during the war. The IOM was commissioned to ascertain long-term health effects of service in the Persian Gulf during the war, based on exposures **associated** with service in theater during the war as identified by Congress, not exposures **unique** to the Southwest Asia Theater. The determination to not grant presumption for the ailments identified should be based solely on the research findings, not on the legitimacy of the exposures identified by Congress.

The IOM has a similar charge to address veterans who served in Vietnam during the war. Herbicides were not unique to the operations in the Southeast Asia theater of conflict and there had not been, until recently, a definitive notion of the amounts of herbicides to which servicemembers had been exposed. Peer-reviewed, occupational studies are evaluated to make recommendations on which illnesses are associated with exposure the herbicides—and their components known to be used in theater. For ailments that demonstrate sufficient evidence of a causal relationship, sufficient evidence of an association, and limited evidence of an association, the Secretary may consider presumption. Gulf War and Health Volume 2 identifies several illnesses in these categories. However the Secretary determined that presumption is not warranted

VA needs to clearly define what type of information is required to determine possible health effects, for instance clarification of any guidance or mandate for the research. VA also needs to ensure that its charge to the IOM is specific enough to help it make determinations about presumptive illnesses. VA noted that neither the report, nor the studies considered for the report identified increased risk of disease based on episodic exposures to insecticides or solvents and that the report states no conclusion whether any of the diseases are associated with "less than chronic exposure," possibly indicating a lack of data to make a determination. If this was necessary, it should have been clearly identified.

Finally, section 1118, title 38, USC, mandates how the Secretary should respond to the recommendations made in the IOM reports. The Secretary is required to make a determination of whether or not a presumption for service connection is warranted for each illness covered in the report no later than 60 days after the date the report is received. If the Secretary determines that presumption is not warranted for any of the illnesses or conditions considered in the report, a notice explaining scientific basis for the determination has to be published in the Federal

Register within 60 days after the determination has been made. Gulf War and Health, Volume 2 was released in 2003, 4 years ago. Since then, IOM has released several other reports and VA has yet to publish its determination on those reports as well.

The American Legion urges VA to provide clarity in the charge for the IOM reports concerning what type of information is needed to make determinations of presumption of service connection for illnesses that may be associated with service in the Gulf during the war.

The American Legion urges VA to get clarification from Congress on the intent of the phrase "known or presumed to be associated with service in the Armed forces in the Southwest Asia theater of operations during the Persian Gulf War," get clarification from the IOM Committee to fill in as many gaps of information as possible, and re-evaluate the findings of the IOM report with the clarification provided.

The American Legion also urges Congress to provide oversight to ensure VA provides timely responses to the recommendations made in the IOM reports.

Atomic Veterans

Since the 1980s, claims by Atomic Veterans exposed to ionizing radiation for a radiogenic disease, for conditions not among those listed in section 1112(c)(2), title 38, USC, have required an assessment to be made by the Defense Threat Reduction Agency (DTRA) as to nature and amount of the veteran's radiation dosing. Under this guideline, when dose estimates provided are reported as a range of doses to which a veteran may have been exposed, exposure at the highest level of the dose range is presumed. From a practical standpoint, VA routinely denied the claims by many atomic veterans on the basis of dose estimates indicating minimal or very low-level radiation exposure.

As a result of the court decision in National Association of Radiation Survivors v. VA and studies by GAO and others of the U.S.'s nuclear weapons test program, the accuracy and reliability of the assumptions underlying DTRA's dose estimate procedures have come into question. On May 8, 2003, the National Research Council's Committee to Review the DTRA Dose Reconstruction Program released its report. It confirmed the complaints of thousands of Atomic Veterans that DTRA's dose estimates have often been based on arbitrary assumptions resulting in underestimation of the actual radiation exposures. Based on a sampling of DTRA cases, it was found that existing documentation of the individual's dose reconstruction, in a large number of cases, was unsatisfactory and evidence of any quality control was absent. The Committee concluded their report with a number of recommendations that would improve the dose reconstruction process of DTRA and VA's adjudication of radiation claims.

The American Legion was encouraged by the mandate for a study of the dose reconstruction program; nonetheless, we are concerned that the dose reconstruction program may still not be able to provide the type of information that is needed for Atomic Veterans to receive fair and proper decisions from VA. Congress should not ignore the National Research Council's findings and other reports that dose estimates furnished VA by DTRA over the past 50 years have been flawed and have prejudiced the adjudication of the claims of 1910s of thousands of Atomic Veterans. It remains practically impossible for Atomic Veterans or their survivors to effectively challenge a DTRA dose estimate.

It is not possible to accurately reconstruct the radiation dosages to which these veterans were exposed. The process prolongs claims decisions on ionizing radiation cases, ultimately delaying treatment and compensation for veterans with fatal diseases.

The American Legion believes the dose reconstruction program should not continue. We urge the enactment of legislation to eliminate this provision in the claim of veterans with a recognized radiogenic disease who was exposed to ionizing radiation during military service.

Mustard Gas Exposure

In March 2005, VA initiated a national outreach effort to locate veterans exposed to mustard gas and Lewisite as participants in chemical warfare testing programs while in the military. The purpose of the testing programs was to evaluate the effectiveness of various types of protective clothing, ointments and equipment that could be used to protect American soldiers on the battlefield. Some participants were exposed during full-body exposure wearing various degrees of protective gear and some were tested by having a droplet of the agent applied to their forearms. For this recent initiative, VA is targeting veterans who have been newly identified by

DoD for their participation in the testing, most of which had participated in programs conducted during WWII. DoD estimated 4,500 servicemembers had been exposed.

Since the most recent VA outreach effort was announced, The American Legion has been contacted by veterans who contend that the number of participants identified was understated by 1910s of thousands, and that participation in these clandestine chemical programs extended decades beyond the World War II era. Investigators have not always maintained thorough records of the events; adverse health effects were not always annotated in the servicemember's medical records; and participants were warned not to speak of the program. Without adequate documentation of their participation, participants may not be able to prove their current ailments are related to the testing.

It is important DoD commits to investigating these claims as they arise to determine if they have merit. It is also important VA commit to locating those identified by DoD in a timely manner, as many of them are WWII era veterans. Congressional oversight may be necessary to ensure these veterans are granted the consideration they deserve.

BLINDED VETERANS

There are currently approximately 38,000 blind veterans enrolled in the VA health care system. Additionally, demographic data suggests that in the United States, there are over 160,000 veterans with low-vision problems and eligible for Blind Rehabilitative services. Due to staffing shortages, over 1,500 blind veterans will wait months to get into one of the 10 blind rehabilitative centers.

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

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

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

Major Construction

The CARES process identified approximately 100 major construction projects in throughout the VA Medical Center System, the District of Columbia, and Puerto Rico. Construction projects are categorized as major if the estimated cost is over $10 million. Now that VA has disclosed the plan to deliver health care through 2022, Congress has the sequential responsibility to provide adequate funds. The CARES plan continually calls for the construction of new hospitals in Orlando and Las Vegas, and replacement facilities in Louisville and Denver for a total cost estimated to be well over $1 billion for these four facilities.

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

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

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

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

Minor Construction

VA's minor construction program has also suffered significant neglect over the past several years. Maintaining the infrastructure of VA's buildings is no small

task. Due to the age of these building, continuous renovations, relocations and expansions are quite common. A slight hesitation in provision of funding leaves a profound impact, as it has in recent years. When combined with the added cost of the CARES program recommendations, it is easy to see that a major increase over the previous funding level is crucial and overdue.

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

INFORMATION TECHNOLOGY FUNDING

Since the data theft occurrence in May 2006, the VA has implemented a complete overhaul of its Information Technology (IT) division nationwide. Although not quite from its beginning stages, The American Legion is hopeful VA takes the appropriate steps to strengthen its IT security to renew the confidence and trust of veterans who depend on VA for the benefits they have earned.

Within VA Medical Center Nursing Home Care Units, it was discovered there was conflict with IT and each respective VAMC regarding provision of Internet access to veteran residents. VA has acknowledged the Internet would represent a positive tool in the veteran's rehabilitation. The American Legion believes Internet access should be provided to these veterans without delay, for time is of the essence in the journey to recovery. In addition, veterans should not have to suffer due to VA's gross negligence in the matter.

The American Legion hopes Congress will not attempt to fund the solution to this problem with scarce fiscal resources allocated to the VA for health care delivery. With this in mind, The American Legion is encouraged by the fact that IT is its own line item in the budget recommendation.

The American Legion believes there should be a complete review of IT security government wide. VA isn't the only agency within the government requiring an overhaul of its IT security protocol. The American Legion urges Congress to exercise its oversight authority and review each Federal agency to ensure that the personal information of all Americans is secure.

The American Legion supports the centralization of VA's IT. The quantity of work required to secure information managed by VA is immense. The American Legion urges Congress to maintain close oversight of VA's IT restructuring efforts and fund VA's IT to ensure the most rapid implementation of all proposed security measures.

The American Legion recommends $2.7 billion for Information Technology.

COMPENSATION AND PENSION

VETERANS BENEFITS ADMINISTRATION

VA has a statutory responsibility to ensure the welfare of the Nation's veterans, their families, and survivors. Providing quality decisions in a timely manner has been, and will continue to be one of VA's most difficult challenges.

CLAIMS BACKLOG & STAFFING

In FY 2007, more than 2.8 million veterans received disability compensation benefits. Providing quality decisions in a timely manner has been, and will continue to be, one of the VA's most difficult challenges. A majority of the claims processed by the Veterans Benefits Administration's (VBA) 57 regional offices involve multiple issues that are legally and medically complex and time consuming to adjudicate.

As of August 9, 2008, there were 618,314 claims pending in VBA, 394,201 of which are rating cases. There has been a steady increase in VA's pending claim backlog since the end of FY 2004 when there were 321,458 rating cases pending. At the end of FY 2007, there were more than 391,000 rating cases pending in the VBA system, up approximately 14,000 from FY 2006. Of these, more than 100,000 (25.7 percent) were pending for more than 180 days. Including non-rating claims pending, the total compensation and pension claims backlog was more than 627,000, with 26.5 percent of these claims pending more that 180 days.

There were also more than 164,000 appeals pending at VA regional offices, with more than 142,000 requiring some type of further adjudicative action. At the end of FY 2007, the average number of days to complete a claim from date of receipt (182.5 days) was up 5.4 days from FY 2006.

Inadequate staffing levels, inadequate continuing education, and pressure to make quick decisions, resulting in an overall decrease in quality of work, has been a consistent complaint among regional office employees interviewed by The American Legion staff during regional office quality checks. It is an extreme disservice to veterans, not to mention unrealistic, to expect VA to continue to process an ever increasing workload, while maintaining quality and timeliness, with the current staff

levels. The current wartime situation provides an excellent opportunity for VA to actively seek out returning veterans from OEF and OIF, especially those with service-connected disabilities, for employment opportunities within VBA. Despite the recent hiring initiatives, regional offices will clearly need more personnel given current and projected future workload demands.

However, VBA must be required to provide better justification for the resources it says are needed to carry out its mission and, in particular, how it intends to improve the level of adjudicator training, job competency, and quality assurance.

PRODUCTION VS. QUALITY

Since 1996, The American Legion, in conjunction with the National Veterans Legal Services Program (NVLSP), has conducted quality review site visits at more than 40 regional offices for the purpose of assessing overall operation. This Quality Review Team visits a regional office for a week and conducts informal interviews with both VA and veterans service organization (VSO) staff. The Quality Review Team then reviews a random sample of approximately 30–40 recently adjudicated American Legion-represented claims. The Team finds errors in approximately 20–30 percent of cases reviewed.

The most common errors include the following:

- Inadequate claim development leading to premature adjudication of claim;
- Failure to consider reasonably inferred claims based on evidence of record;
- Rating based on inadequate VA examination; and/or
- Under evaluation of disability (especially mental conditions).

These errors are a direct reflection of VA's emphasis of quantity over quality of work. This seems to validate The American Legion's concerns that emphasis on production continues to be a driving force in most VA regional offices, often taking priority over such things as training and quality assurance. Clearly, this frequently results in premature adjudications, improper denials of benefits and inconsistent decisions

VETERANS' DISABILITY BENEFITS COMMISSION

In October 2007, after almost 2½ years of study, the Veterans' Disability Benefits Commission (VDBC or Commission), released its extensive report, Honoring the Call to Duty: Veterans' Disability Benefits in the 21st century, to the President and Congress. Due to the history surrounding the establishment of the Commission, The American Legion and others in the VSO community feared that it would be used as a tool to restrict veterans' benefits. In fact, key Members of Congress and other Federal Government officials publicly expressed their desire to use the VDBC as a vehicle to institute radical changes in the VA disability system that would negatively impact and restrict entitlement to benefits for a large number of veterans.

Concerned about the questionable history surrounding the creation of the VDBC and the impact its recommendations would undoubtedly have on VA's disability compensation program, American Legion staff closely monitored the Commission's activities and provided written and oral testimony, as well as other input, on several occasions. From the very beginning, Commission Chairman Terry Scott assured the VSOs and others that the Commission did not have a hidden agenda and its purpose was not to cut or otherwise restrict veterans' benefits. During the course of the Commission's 2½-year study The American Legion's concerns diminished and our skepticism turned to optimism as the release of its final report approached. Our approach, however, is still "trust, but verify."

The American Legion appreciates the Commission's hard work and commitment and we are generally pleased with its recommendations. As the final report contains 113 recommendations, this statement will focus, for the most part, on recommendations that will directly impact the disability compensation system as well as those addressed as high priority in the Executive Summary.

EXECUTIVE SUMMARY PRIORITY RECOMMENDATIONS

Recommendation 4–23 (Chapter 4, Section I.5)

VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of post-traumatic stress disorder and other mental disorders and of traumatic brain injury. Then proceed through the other body systems until the Rating Schedule has been comprehensively revised. There vision process should be completed within 5 years. VA should create a system for keeping the Rating Schedule up to date, including a published schedule for revising each system.

American Legion Position: Most major body systems in the rating schedule have been updated over the last few years. The American Legion supports the updating of conditions such as traumatic brain injury that have not been recently updated. We wish to also note that the rating schedule is not the major cause of problems with the VA disability compensation process. VA problems such as inadequate staffing, inadequate funding, ineffective quality assurance, premature adjudications, and inadequate training still plague the VA regional offices. The American Legion wants to emphasize that, in most cases, it would be inappropriate to reduce the value of a disability as long as our troops are in harm's way.

Recommendation 5–28 (Chapter 5, Section III.3)

VA should develop and implement new criteria specific to post-traumatic stress disorder in the VA Schedule for Rating Disabilities. VA should base those criteria on the Diagnostic and Statistical Manual of Mental Disorders and should consider a multidimensional framework for characterizing disability due to post-traumatic stress disorder.

American Legion Position: The rating schedule currently uses one set of rating criteria for all mental disorders. There are unique aspects of PTSD that are not properly evaluated by the current rating criteria and it makes sense to develop rating criteria that address the specific symptoms involved with PTSD.

Recommendation 5–30 (Chapter 5, Section III.3)

VA should establish a holistic approach that couples posttraumatic stress disorder treatment, compensation and vocational assessment. Reevaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness.

American Legion Position: While The American Legion supports a holistic approach to the treatment and compensation of post-traumatic stress disorder (PTSD) that encourages wellness, we are concerned that a mandatory reevaluation every 2–3 years could result in undue stress among PTSD service-connected veterans. They may be fearful that the sole purpose of such reevaluation would be to reduce compensation benefits. This perception could undermine the treatment process. We would, therefore, encourage study and review of possible unintended consequences regarding this portion of the Commission's recommendation.

Recommendation 6–14 (Chapter 6, Section IV.2)

Congress should eliminate the ban on concurrent receipt for all military retirees and for all servicemembers who separated from the military due to service-connected disabilities. In the future, priority should be given to veterans who separated or retired from the military under Chapter 61 with:

- **fewer than 20 years service and a service-connected disability rating greater than 50 percent, or**
- **disability as the result of combat.**

American Legion Position: The American Legion strongly supports full concurrent receipt and we are pleased with that portion of the recommendation.

Recommendation 7–4 (Chapter 7, Section II.3)

Eligibility for Individual Unemployability should be consistently based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and medical effects of an individual's age or potential employability. VA should implement a periodic and comprehensive evaluation of Individual Unemployability-eligible veterans. Authorize a gradual reduction in compensation for Individual Unemployability recipients who are eligible to return to substantially gainful employment rather than abruptly terminating disability payments at an arbitrary level of earning.

American Legion Position: Although The American Legion supports the provision of this recommendation calling for the gradual reduction in compensation benefits for Individual Unemployability (IU) recipients who are able to return to substantially gainful employment, we strongly oppose the portion of the recommendation that could be interpreted as requiring the consideration of age in determining eligibility to IU. It is inherently unfair to punish an older veteran who would not be able to work at any age because of a service-connected condition while awarding the benefit to a similarly disabled younger veteran. The current rule states (in essence) that the impact of a service-connected condition on a veteran cannot be evaluated to a higher degree because the veteran is old; 38 C.F.R. § 3.341(a). The schedule is based on the average impairment in earning capacity. If the veteran cannot

work because of service-connected disability(s) then IU should be awarded. Moreover, we have found that younger veterans have to overcome VA bias when they apply for IU because VA raters think that younger people have a better chance of going back to work. Thus, allowing age to be used as a factor in determining eligibility for IU purposes may end up adversely impacting both older and younger veterans.

Recommendation 7–5 (Chapter 7, Section II.3)

Recognizing that Individual Unemployability is an attempt to accommodate individuals with multiple lesser ratings but who remain unable to work, the Commission recommends that as the VA Schedule for Rating Disabilities is revised, every effort should be made to accommodate such individuals fairly within the basic rating system without the need for an Individual Unemployability rating.

American Legion Position: The American Legion is extremely leery of any recommendation that would encourage the elimination of a specific benefit program on the anticipation of a revised rating schedule which would supposedly eliminate the need for that benefit. The current policy as enunciated by 38 CFR §3.340 states, "[T]otal disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation." This policy is fair and consistent with the non-adversarial nature of the VA claims process. Therefore, this policy should not be altered.

38 CFR §4.16b states:

> (b) It is the established policy of the Department of Veterans Affairs that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled.

The bottom line is that veterans who are unable to work due to service-connected disability should be compensated at the 100 percent-level, whether it be based on a scheduler evaluation (either single service-connected disability or a combined scheduler evaluation) or based on Individual Unemployability. This has been a longstanding VA policy and we see no need to change it. See 38 CFR §3.340.

Recommendation 7–6 (Chapter 7, Section III.2)

Congress should increase the compensation rates up to 25 percent as an interim and baseline future benefit for loss of quality of life, pending development and implementation of quality of life measure in the Rating Schedule. In particular, the measure should take into account the quality of life and other non-work related effects of severe disabilities on veterans and family members.

American Legion Position: The American Legion supports an increase in compensation benefits to adequately account for a service-connected disability's impact on a veteran's quality of life. Before any change is made, however, we would like to carefully analyze how this would impact special monthly compensation, which is based in part on loss of quality of life.

Recommendation 7–8 (Chapter 7, Section III.2)

Congress should consider increasing special monthly compensation (SMC), where appropriate, to address the more profound impact on quality of life by disabilities subject to special monthly compensation and review ancillary benefits to determine where additional benefits could improve a disabled veteran's quality of life.

American Legion Position: The American Legion fully supports increasing special monthly compensation to address profound impacts on quality of life for disabilities subject to SMC as well as reviewing ancillary benefits for the purpose of determining where additional benefits could improve a disabled veteran's quality of life.

Recommendation 7–12 (Chapter 7, Section V.3)

VA and DoD should realign the disability evaluation process so that the Services determine fitness for duty, and servicemembers who are found unfit are referred to VA for disability rating. All conditions that are identified as part of a single, comprehensive medical examination should be rated and compensated.

American Legion Position: The American Legion has long been concerned with low disability ratings issued by the military's disability evaluation system and we fully support limiting the military's role to determination of fitness while leaving

the rating process to VA. However, we do have concerns as to how this extra work for the VA would be funded.

Recommendation 7–13 (Chapter 7, Section VI)

Congress should enact legislation that would bring the ancillary and special purpose benefits to levels originally intended considering cost of living and provide for annual adjustments to keep pace with the cost of living.

American Legion Position: This recommendation is appropriate as ancillary and special purpose benefits, as reflected in the VDBC's report, have not been adjusted to keep pace with cost of living changes resulting in the failure of the benefits to fulfill their intended purposes.

Recommendation 8–2 (Chapter 8, Section III.1B)

Congress should eliminate the Survivor Benefit/Dependency and Indemnity Compensation offset for survivors of retirees and in-service deaths.

American Legion Position: The American Legion fully supports this recommendation.

Recommendation 9–1 (Chapter 9, Section II.6.A.b)

Improve claims cycle time by:

Establishing a simplified and expedited process for well documented claims, using best business practices and maximum feasible use of information technology; and Implementing an expedited process by which the claimant can state the claim information is complete and waive the time period (60 days) allowed for further development.

Congress should mandate and provide appropriate resources to reduce the VA claims backlog by 50 percent within 2 years.

American Legion Position: While we are fully supportive of initiatives to expedite the claims process and reduce the claims backlog, The American Legion, however, is not supportive of imposing arbitrary deadlines to reduce the claims backlog because experience has shown that such production driven efforts have a tendency to sacrifice quality for quantity, resulting in more errors and, ultimately, an increase in appeals. Additionally, while we support an expedited process to grant benefits, compliance with statutory duties to assist and notify must be fully complied with in claims in which benefits would be denied. An immediate reduction in the backlog could be accomplished by VA management encouraging VA raters to grant benefits when there is sufficient evidence in the record rather than developing the record to support a denial.

Recommendation 10–11 (Chapter 10, Section VII)

VA and DoD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment.

American Legion Position: The American Legion supports this recommendation.

Recommendation 11–1 (Chapter 11)

Congress should establish an oversight group to ensure timely and effective implementation of the Commission's recommendations. This group should be co chaired by VA and DoD and consist of senior representatives from appropriate departments and agencies. It is further recommended that the Veterans' Affairs Committees hold hearings and require annual reports to measure and assess progress.

American Legion Position: The American Legion has no objections to this recommendation. We do, however, urge that this recommendation be amended to specifically address VSO participation in this oversight process.

Other Recommendations

Recommendation 5–1 (Chapter 5, Section I.1)

Congress should change the character-of—discharge standard to require that when an individual is discharged from his or her last period of active service with a bad conduct or dishonorable discharge, it bars all benefits.

American Legion Position: The American Legion strongly opposes this recommendation. The Commission voted twice not to recommend a change to the current 30-year old policy that allows eligibility for VA benefits based on separate honorable periods of service. The VDBC finally decided on this position after a third vote of 8–4. We are disappointed in not only the recommendation, but also the nature in which the Commission arrived at its decision.

As noted in the VDBC's report, it is clear from a review of the legislative history that Congress intended to liberalize the overly strict requirement of discharge under honorable conditions when it enacted the current "under conditions other than dishonorable" standard in 1944. The current standard correctly and fairly acknowledges that those who were discharged for relatively minor offenses should not be barred from receiving veterans' benefits. Congress' intent was also clear when it amended the law in 1977 to allow an individual who was discharged under dishonorable conditions, or conditions otherwise precluding basic eligibility, to receive VA benefits based upon a separate period of service if VA determined that the individual was discharged from the other period of service under conditions other than dishonorable or would have been discharged under conditions other than dishonorable if not for reenlistment.

Endorsing a change in the character of discharge standard where one period of service under other than honorable conditions would negate other periods of service that were under conditions other than dishonorable is both unfair and in direct conflict with the intent of Congress when it enacted the current Character of Discharge standards.

Recommendation 5–2 (Chapter 5, Section I.2.B)

Maintain the present definition of line of duty: that servicemembers are on duty 24 hours a day, 7 days a week.

American Legion Position: The American Legion fully supports this position and we are hopeful that the Commission's recommendation regarding this issue will end further debate calling for a line of duty (LOD) definition that only covers injuries, diseases, or deaths incurred while performing military duties.

The intent of Congress regarding the LOD definition and the equal treatment of all veterans, no matter how, when or where a service related condition was incurred, is clearly expressed in the legislative history and current statutory provisions. Previous recommendations to limit the line of duty definition to only those disabilities that are a direct result of performance of military duties have not been acted on by Congress, despite large potential savings touted by the recommending agencies. The American Legion believes that there are very good reasons previous recommendations to limit or restrict the current LOD definition have not been implemented. First, there is the basic question of fairness. Limiting the line of duty definition to only those disabilities, deaths and illnesses incurred while actually performing one's military duties, despite the fact that an active duty servicemember is considered, under the Uniform Code of Military Justice (UCMJ), to be on duty 24/7 is inherently unfair and fundamentally wrong. Additionally, the message such a change would send to current servicemembers and prospective members would undoubtedly have a negative impact on both recruitment and retention. Finally, the additional administrative costs and other burdens resulting from a change in the line of duty definition would offset any projected savings.

Recommendation 5–3 (Chapter 4, Section I.2.B)

Benefits should be awarded at the same level according to the severity of the disability, regardless of whether the injury was incurred or disease was contracted during combat or training, wartime or peacetime.

American Legion Position: The American Legion fully supports this recommendation. An injury, disease or death is just as debilitating and traumatic to an individual and his or her family no matter how the condition was incurred or where the veteran was at the time it was incurred. Making a distinction between combat and non-combat disabilities is fundamentally wrong and demeaning to the honorable service of all veterans. Moreover, implementing such a provision would add another level of complexity to an already overburdened and complex adjudication system.

Recommendation 5–4 (Chapter 5, Section I.3.B)

Maintain the current reasonable doubt standard.

American Legion Position: The reasonable doubt standard is the hallmark of VA's non-adversarial disability compensation program and we fully support this recommendation.

Recommendation 5–5 (Chapter 5, Section I.4B)

Age should not be a factor for rating service connection or severity of disability, but may be a factor in setting compensation rates.

American Legion Position: The American Legion does not support the use of age for establishing entitlement to service connection or for determining severity of disability, nor do we support using age as a factor in setting compensation rates. Although we understand the reasoning behind the Commission's recommendation

calling for age to be used as a factor in setting service-connected disability compensation rates, The American Legion maintains that compensation rates should be based on the severity of disability and should not be applied differently based on the age of the veteran.

Recommendation 5–6 (Chapter 5, Section I.5B)

Maintain the current standard of an unlimited time limit for filing an original claim for service connection.

American Legion Position: The American Legion fully supports this recommendation. Although we recognize that it is prudent for veterans to file service connection disability claims as soon as possible after separating from service, and we strongly encourage such action whenever possible, that option, for various reasons, is not always feasible. Therefore, if sufficient evidence to establish entitlement to service connection is submitted, the benefit sought should be awarded, regardless of how long after service the claim was filed.

Recommendation 5–7 (Chapter 5, Section I.5B)

DoD should require a mandatory benefits briefing to all separating military personnel, including Reserve and National Guard components, prior to discharge from service.

American Legion Position: The American Legion fully supports this recommendation. It is extremely important that separating members receive sufficient information regarding all VA benefits to which they may be entitled after separation from service.

Recommendations 5–11, 5–12 & 5–14 (Chapter 5, Section II.1)

Recommendation 5–11

The goal of the presumptive disability decisionmaking process should be to ensure compensation for veterans whose diseases are caused by military service and this goal must serve as the foundation for the work of the Science Review Board. The Committee recommends that the Science Review Board implement its proposed two-step process. [IOMRec.4]

Recommendation 5–12

The Science Review Board should use the proposed four-level classification scheme, as follows, in the first step of its evaluation. A standard should be adopted for "causal effect" such that if there is at least as much evidence in favor of the exposure having a causal effect on the severity or frequency of a disease as there is evidence against, then a service-connected presumption will be considered. [IOMRec.5]

- **Sufficient:** The evidence is sufficient to conclude that a causal relationship exists.
- **Equipoise and Above:** The evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exits.
- **Below Equipoise:** The evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
- **Against:** The evidence suggests the lack of a causal relationship.

Recommendation 5–14

When the causal evidence is at Equipoise and Above, an estimate also should be made of the size of the causal effect among those exposed. [IOMRec.7]

American Legion Position: The American Legion does not support these recommendations because the "association" standard currently used in the presumption determination process is consistent with the non-adversarial and liberal nature of the VA disability claims process. Moreover, as is the case of the 1991 Gulf War, there is often a lack of specific or reliable exposure data. Due to improper record-keeping, resulting in a lack of reliable exposure data, during Operations Desert Shield/Storm, there is insufficient information to properly determine servicemember exposure to the numerous environmental and other hazards U.S. troops were exposed to in the Southwest Asia theater of operations during the war. A lack of such data would clearly diminish the value and reliability of a "causation" standard as recommended by the IOM. It should also be noted that despite its recommendation, the Commission stated that it was concerned that "causation rather than association may be too stringent" and encouraged further study of the matter.

Recommendation 7–15 (Chapter 7, section VIII.2)

Lump sum payments should not be considered to compensate veterans for their disabilities.

American Legion Position: The Commission thoroughly studied this issue and we are hopeful that this recommendation will put an end to future proposals in favor of lump sum payments.

FILIPINO VETERANS' BENEFITS

The American Legion fully supports the Filipino Veterans Equity Act and has testified in support of this legislation on a number of occasions for several years. The American Legion's objection rests with how Congress plans to pay for larger bill that contains the Filipino Equity Act provision. In order to meet its PAY GO obligations, Congress plans to repeal the ***Hartness v. Nicholson*** decision. In fact, some Filipino veterans may very well benefit from the ***Hartness v. Nicholson*** decision; especially should the Filipino Veterans Equity Act become law.

By repealing this decision, Congress would be denying one group of veterans (elderly, disabled homebound) an earned benefit to give another group of veterans (the Filipino veterans and others) benefits. The American Legion believes it is wrong and sets an unacceptable precedence.

There is nothing that would prevent Congress from next year, repealing the Filipino Equity Act to use that money to pay for some other group of veterans. Such a "rob Peter to pay Paul" scheme clearly dishonors and disrespects all veterans involved. Even worse, it pits veterans against veterans.

In ***Hartness v. Nicholson***, a veteran appealed a May 5, 2004, decision of the Board of Veterans' Appeals that denied housebound (HB) benefits because VA determined that the veteran did not meet either of the two alternative criteria for HB benefits:

- he did not have a single disability rated 100 percent disabling combined with substantial confinement to the home; and
- he did not have entitlement under the alternative basis a 100 percent-disability rating with an additional independently ratable 60 percent-disability.

The Court of Appeals for Veterans Claims agreed held that a wartime veteran may be awarded housebound benefits if, in addition to being 65 years old, he or she has been rated at least 60 percent disabling or is considered permanently housebound. Section 1513, Title 38, USC, currently benefits many wartime veterans from the "Greatest Generation" and other veterans from subsequent conflicts.

The American Legion strongly supports the Filipino Veterans Equity Act, but cannot support this proposed PAYGO funding stream. The American Legion believes the sacrifice of these heroes warrants relief. Balancing the books on the backs of the very patriots that protected and defended this Nation is unconscionable. Congress must not make a grave mistake in the name of fairness, equality, or even fiscal responsibility.

We urge Congress to do what is right. It has other funding options—not just the repeal of ***Hartness v. Nicholson***:

- waive the budget rules, which Congress has already done to fund other bills; or
- pass the Filipino Veterans Equity Act as part of an emergency supplemental appropriations.

VETERANS MEMORIALS

National Cemetery Administration

The mission of The National Cemetery Administration (NCA) is to honor veterans with final resting places in national shrines and with lasting tributes that commemorate their service to this Nation. The National Cemetery Administration's mission is to serve all veterans and their families with the utmost dignity, respect, and compassion. Every national cemetery should be a place that inspires visitors to understand and appreciate the service and sacrifice of our Nation's veterans.

The American Legion recognizes NCA's excellent record in providing timely and dignified burials to all veterans who opt to be buried in a national Cemetery. Equally noteworthy is NCA's fine record in providing memorial headstones, markers and Presidential Memorial Certificates (PMC) to all who request such benefits. We also recognize the hard work that is required to restore and maintain National Cemeteries as national shrines and applaud NCA for its commitment and success toward that endeavor.

The American Legion looks forward to evaluation results and recommendations that VA is currently conducting, and which is expected to be available by the end of the 2008 calendar year. The evaluation will cover program outcomes and policies including the "75-mile service area/170,000 veteran population" threshold that currently serves as the benchmark for establishing a new national cemetery. The American Legion is pleased that driving (commuting) times will also be considered in this evaluation. Inner-city traffic can significantly increase travel times to distant cemeteries. Driving time needs to be factored in when trying to determine if the veteran population is being served effectively.

National Cemetery Expansion

The requested overall budget for 2009 is $425 million, of which $181 million and 1,603 full time equivalents (FTE) were requested for Operations and Maintenance, and $83.4 million for cemetery expansion and improvement. According to NCA's own estimates in the President's budget request for FY 2009, which is also warranted by the opening of new national cemeteries, annual interments will increase to 111,000, a 10 percent rise from FY 2007. Interments in FY 2013 are expected to be about 109,000, a 9 percent-increase from FY 2007. The total number of graves maintained is also expected to increase during the planning timeframe from almost 2.8 million in FY 2007 to over 3.3 million in FY 2013.

NCA has only requested 6 additional FTEs to maintain its current 125 cemeteries and 30 FTEs to prepare for the activation of interment operations of six new national cemeteries as directed by the National Cemetery Expansion Act of 2003, Public Law 108–109. NCA has to complete fast track parcels as part of Phase I construction of the new cemeteries in the following areas: Bakersfield, CA; Birmingham, AL; Columbia-Greenville, SC; Jacksonville, FL; Southeastern PA; and Sarasota County, FL. Full Phase I operations are underway in each cemetery now.

Since it takes approximately 20 to 30 FTEs to run a national cemetery (depending on the size and workload); and whereas it takes 8 to 10 FTEs to run a newly opened cemetery (cemeteries are opened to interments long before completion of the full site) it seems reasonable to believe that at least 50 new employees would be needed to operate the 6 new cemeteries that NCA plans to bring online in FY 2008. It is likely that they will need the full 20 to 30 by FY 2009. The average employee salary with benefits is $67,000.

The American Legion recommends that moneys for additional employees also be included in the FY 2010 budget.

National Shrine Commitment

Maintaining cemeteries as national shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. Adequate funding is the key to maintaining this very important commitment. The American Legion supported NCA's goal of completing the National Shrine Commitment within 5 years. VA assessed burial sections, roadways, buildings, and historic structures and identified 928 potential improvement projects at an estimated cost of $280 million. With the addition of six new national cemeteries, of which five are included to be fast tracked between late 2008 and early 2009, and the opening of the sixth in mid-2009, resources will be strained. The American Legion recommends that $60 million be put toward the National Shrine Commitment in order to fulfill this commitment.

The American Legion recommends $249 million for the National Cemetery Administration in FY 2010.

State Cemetery Construction Grants Program

VA's State Cemetery Grants Program complements VA's 126 national cemeteries across the country. The program helps states establish, expand or improve state veterans' cemeteries. To date, the VA program has helped establish 66 veterans' cemeteries in 35 states, Saipan and Guam, which provided more than 22,000 burials in FY 2006. Since the program began in 1980, VA has awarded 156 grants totaling nearly $286 million.

NCA received $32 million for the current fiscal year to be used to establish six new cemeteries (Abilene, TX; Des Moines, IA; Glennville, GA; Fort Stanton, NM; Missoula, MT; and Williamstown, KY) and to expand four others (Cheltenham, MD; Crownsville, MD; Jacksonville, NC; and Kona Coast, HI). Determining an "average cost" to build a new state cemetery or to expand an existing one is very difficult. Many factors influence cost, such as location, size and the availability of public utilities.

The American Legion believes states will increasingly use the State Cemetery Grants Program to fill the needs of veteran populations that are still not well served by the "75-mile service area/170,000 veteran population" threshold that currently

serves as the benchmark for establishing a new national cemetery. New state cemeteries, and expansions and improvements of existing cemeteries are therefore likely to increase. With increasing costs, especially the high costs of land in urban areas, and increased demand, The American Legion suggests that the amount of money for the State Cemetery Grants Program be substantially increased.

The American Legion recommends $49 million for the State Cemetery Grants Program in FY 2010.

NATIONAL ECONOMIC COMMISSION

STATE APPROVING AGENCIES

The American Legion is deeply concerned with the timely manner that veterans, especially returning wartime veterans, receive their education benefits. Annually, approximately 300,000 servicemembers (90,000 of them belonging to the National Guard and Reserve) return to the civilian sector and use their earned education benefits from the VA. Any delay in receipt of education benefits or approval of courses taken at institutions of higher learning can adversely affect a veteran's life.

S. 22, the Post-9/11 Veterans Education Assistance Act of 2008 is a new benefit providing educational assistance to individuals who served on active duty on or after September 11, 2001. This New GI Bill will be fully implemented by August 2009. The American Legion strongly supported the enhancements to the Montgomery GI Bill and is grateful that the House and Senate passed this bill. The President in turn signed this vital piece of legislation on June 30, 2008. This New GI Bill is well deserved for the men and women who have protected, sacrificed, and served our country honorably.

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

GAO report entitled "VA Student Financial Aid; Management Actions Needed to Reduce Overlap in Approving Education and Training Programs and to Assess State Approving Agencies" (GAO–07–384) focuses on the need to "ensure that Federal dollars are spent efficiently and effectively."

GAO recommends that VA should require State Approving Agencies (SAAs) to track and report data on resources spent on approval activities, such as site visits, catalog review, and outreach in a cost-efficient manner. The American Legion agrees. Additionally, GAO recommended that VA establish outcome-oriented performance measures to assess the effectiveness of SAAs efforts. The American Legion fully agrees. In response, VA Deputy Secretary Mansfield plans to establish a working group with SAAs to create a reporting system for approval activities and develop outcome-oriented measures with a goal of implementation in the FY 2008 budget cycle.

Finally, GAO recommended that VA should collaborate with other agencies to identify any duplicate efforts and use the agency's administrative and regulatory authority to streamline the approval process. The American Legion agrees. VA Deputy Secretary Mansfield responded that VA would initiate contact with appropriate officials at the Departments of Education and Labor to help identify any duplicate efforts.

Section 301 of PL 107–330 created increases in the aggregate annual amount available for state approving agencies for administrative expenses from FY 2003–FY 2007 to the current funding level of $19 million. The American Legion fully supports reauthorization of SAAs funding.

The American Legion strongly recommends SAAs funding at $19 million to assure current staffing and activities in FY 2010.

VOCATIONAL REHABILITATION AND EMPLOYMENT SERVICE (VR&E)

The mission of the VR&E program is to help qualified, service-disabled veterans achieve independence in daily living and, to the maximum extent feasible, obtain and maintain suitable employment. The American Legion fully supports these goals. As a nation at war, there continues to be an increasing need for VR&E services to assist Operations Iraqi Freedom and Enduring Freedom veterans in reintegrating into independent living, achieving the highest possible quality of life, and securing meaningful employment. To meet America's obligation to these specific veterans, VA leadership must focus on marked improvements in case management, vocational counseling, and—most importantly—job placement.

The success of the rehabilitation of our severely disabled veterans is determined by the coordinated efforts of every Federal agency involved in the seamless transition from the battlefield to the civilian workplace. Timely access to quality health care services, favorable physical rehabilitation, vocational training, and job placement play a critical role in the "seamless transition" of each veteran, as well as his or her family.

Administration of VR&E and its programs is a responsibility of the VBA. Providing effective employment programs through VR&E must become a priority. Until recently, VR&E's primary focus has been providing veterans with skills training, rather than providing assistance in obtaining meaningful employment. Clearly, any employability plan that doesn't achieve the ultimate objective—a job—is falling short of actually helping those veterans seeking assistance in transitioning into the civilian workforce.

Vocational counseling also plays a vital role in identifying barriers to employment and matching veterans' transferable job skills with those career opportunities available for fully qualified candidates. Becoming fully qualified becomes the next logical objective toward successful transition. It is our observations from talking to veterans, counselors, Disabled Veteran Outreach Program Specialists (DVOPs) and Local Veteran Employment Representatives (LVERs) that it would be beneficial if VR&E counselors take on an additional duty of finding or assisting in employment of veterans. Because these counselors deal directly with veterans on a full time basis, as opposed to DVOPs and LVERs on a part time basis, they are more devoted and specialized in their approach to an individual veteran. These counselors may have input into the employability of a service-connected veteran, but The American Legion asserts that the VA must rely on an expert medical opinion from a qualified, competent physician to determine unemployability.

We appreciate the significance of a vocational assessment in establishing entitlement to total disability ratings for compensation based on unemployability of the individual (TDIU) and we welcome the participation of a vocational or rehabilitation specialist in this process. However, a medical opinion is still extremely important in determining unemployability and must be given proper consideration and weight.

INTERAGENCY COOPERATION BETWEEN DOL–VETS AND VA

It is our experience that the interagency collaboration and communication between the VR&E program, and the Department of Labor (DOL) Veterans Employment and Training Service (VETS) is lacking.

In recent years, many states did not refer veterans from the VR&E program to VETS for assistance in obtaining employment. Veterans with high-tech skills and advanced education were referred to expensive commercial placement agencies that do not specialize in employment assistance for veterans, and difficult to place veterans were sent to VETS. Therefore, to assist in the correction of these deficiencies a memorandum of understanding between VA and DOL was developed and signed in October 2005 stating that each agency would work for the smooth transition of veterans to the civilian workforce. This agreement is authorized in accordance with section 4102A (b) (3), title 38, U.S.C.

In discussions with numerous VETS representatives across the country, The American Legion is hearing a variety of opinions on the current implementation process and progress of the MOU. Some states report a total lack of communication and information sharing while other states already enjoy a strong relationship between the local VETS and VR&E Offices.

A majority of VETS representatives contacted spoke of a markedly improved level of communication between the two agencies, along with other positive developments such as improvement in local data sharing and combined training on the local and national levels. In addition, national representatives from the two agencies are currently reporting a close and cooperative relationship, and the expectation is that this relationship will continue to improve over time.

In some states, however, it has been reported that the signing of the MOU has not led to an improvement in cooperation between the two agencies. Some problems cited were a difference in the perceptions of the primary mission, differing education levels of VA case managers and the DVOPs and LVERs, and the unenforceable mandate for the two agencies to communicate and cooperate on a local level. The DVOPs and LVERs are controlled by each individual state and have their own requirements, making a state and Federal program difficult to synchronize.

Concerns such as education levels of VA's case managers and DOL DVOPs and LVERs (case managers from the VA generally have BA or MA degrees while the DVOPs and LVERs require only a high school education), job philosophies, and performance standards are cited as problems that affect the delivery of employment and rehab services to veterans.

While poor coordination between VR&E counselors and their VETS counterparts has contributed to the shortfalls of the VR&E program, a number of states have begun to improve communications. The outlook is not completely negative. A majority of VETS representatives have commended their VR&E counterparts for their willingness to ensure the successful implementation of the joint MOU that is designed to improve rehabilitation, training and employment outcomes for disabled veterans.

The American Legion recommends exploring possible training programs geared specifically for VR&E Counselors through the National Veterans Training Institute (NVTI). Contracting for standardized or specialized training for VR&E employees could very well strengthen and improve overall program performance. NVTI serves as a valuable resource for VETS employment specialists and has contributed to a marked improvement in VETS performance.

Veterans' preference should play a large role in job placement

The Federal Government has scores of employment opportunities that educated, well-trained, and motivated veterans can fill given a fair and equitable chance to compete. Working together, all Federal agencies should identify those vocational fields, especially those with high turnover rates, suitable for VR&E applicants. Career fields like information technology, claims adjudications, and debt collection offer employment opportunities and challenges for career-oriented applicants that also create career opportunities outside the Federal Government.

There are three ways veterans can be appointed to jobs in the competitive civil service: by competitive appointment through an OPM list of eligibles (or agency equivalent); by noncompetitive appointment under special authorities that provide for conversion to the competitive service; or, by Merit Promotion selection under the Veterans Employment Opportunities Act (VEOA).

Provide military occupational skills and experience translation for civilian employment counseling

The American Legion notes that due to the current demands of the military, greater emphasis on the Reserve component of the Armed Forces created employment hardships for many Reservists. The American Legion supports amending Section 4101(5), title 38, USC, to add Subsection (D) to the list of "Eligible Persons" for Job Counseling, Training, and Placement Service for Veterans, to include members in good standing of Active Reserve and Guard Units of the Armed Forces of the United States who have completed basic and advanced Duty for Training (ACDUTRA) and have been awarded a Military Occupation Specialty.

DoD provides some of the best vocational training in the Nation for its military personnel and establishes measures and evaluates performance standards for every occupation with the armed forces. There are many occupational career fields in the armed forces that can easily translate to a civilian counterpart. Many occupations in the civilian workforce require a license or certification. In the Armed Forces, these unique occupations are performed to approved military standards that may meet or exceed the civilian license or certification criteria.

Upon separation, many former military personnel, certified as proficient in their military occupational career, are not licensed or certified to perform the comparable job in the civilian workforce, thus hindering chances for immediate civilian employment and delaying career advancement. This situation creates an artificial barrier to employment upon separation from military service.

A study by the Presidential Commission on servicemembers' and Veterans' Transition Assistance identified a total of 105 military professions where civilian credentialing is required. The most easily identifiable job is that of a Commercial Truck Driver in which there is a drastic shortage of qualified drivers. Thousands of veterans must venture through each state's laws instead of a single national test or transfer of credentials from the military. We have testified alongside members of the trucking industry to the U.S. House of Veterans' Affairs Subcommittee on Economic Opportunity for the need for accelerated MGIB payments for these courses and other matters.

The American Legion supports efforts to eliminate employment barriers that impede the transfer of military job skills to the civilian labor market, and supports efforts to DoD take appropriate steps to ensure that servicemembers be trained, tested, evaluated and issued any licensure or certification that may be required in the civilian workforce. The American Legion supports efforts to increase the civilian labor market's acceptance of the occupational training provided by the military.

DEPARTMENT OF LABOR VETERANS EMPLOYMENT AND TRAINING SERVICE (DOL–VETS)

The American Legion's position regarding VETS programs is that this is and should remain a national program with Federal oversight and accountability. The American Legion is eager to see this program grow and especially would like to see greater expansion of entrepreneurial based, self-employment opportunity training. The mission of VETS is to promote the economic security of America's veterans. This stated mission is executed by assisting veterans in finding meaningful employment. The American Legion believes that by strengthening American veterans, we in turn strengthen America. Annually, DoD discharges approximately 300,000 servicemembers. Recently separated service personnel will seek immediate employment or increasingly have chosen some form of self-employment. In order for the VETS program to assist these veterans to achieve their goals, it needs to:

- Improve by expanding its outreach efforts with creative initiatives designed to improve employment and training services for veterans;
- Provide employers with a labor pool of quality applicants with marketable and transferable job skills;
- Provide information on identifying military occupations that require licenses, certificates or other credentials at the local, state, or national levels;
- Eliminate barriers to recently separated service personnel and assist in the transition from military service to the civilian labor market;
- Strive to be a proactive agent between the business and veterans' communities in order to provide greater employment opportunities for veterans; and
- Increase training opportunities, support and options for veterans who seek self-employment and entrepreneurial careers.

The American Legion believes staffing levels for DVOPs and LVERs should match the needs of the veterans' community in each state and not be based solely on the fiscal needs of the state government. Such services will continue to be crucial as today's active duty servicemembers, especially those returning from combat in Iraq and Afghanistan, transition into the civilian world. Education, vocational and entrepreneurial training and employment opportunities will enable these veterans to succeed in their future endeavors. Adequate funding will allow the programs to increase staffing to provide comprehensive case management job assistance to disabled and other eligible veterans.

Section 4103A, title 38 USC requires that all DVOP specialists shall be qualified veterans and preference be given to qualified disabled veterans in appointment to DVOP specialist positions. section 4104(a)(4), title 38 USC states:

> *"[I]n the appointment of local veterans' employment representatives on or after July 1, 1988, preference shall be given to qualified eligible veterans or eligible persons. Preference shall be accorded first to qualified service-connected disabled veterans; then, if no such disabled veteran is available, to qualified eligible veterans; and, if no such eligible veteran is available, then to qualified eligible persons."*

The American Legion believes that the military experience is essential to understanding the unique needs of the veteran and that all LVERs, as well as all DVOPs, should be veterans and should be additionally educated to be able to address the needs of veterans who desire entrepreneurial support.

The American Legion also supports legislation that will restore language to Chapter 41, title 38, USC, that require that half time DVOP/LVER positions be assigned only after approval of the DVET, and that the Secretary of Labor would be required to monitor all career centers that have veterans on staff assigned. PL 107–288 has eliminated the requirement that DOL/VETS review all workforce centers annually and this has minimized Federal oversight of the programs since the ASVET has drastically cut funds allocated for this activity and established a policy that only 10 percent of the centers operated under title 38, USC, will be reviewed, and PL 107–288 has removed the job descriptions of the DVOPs and LVERs from Title 38, USC, and given the states the ability to establish the duties and responsibilities, thus weakening the VETS program across the country by eliminating the language that required these staff positions provide services only to veterans.

Veterans returning from Afghanistan, Iraq and other tours of duty are not always coming back to a hero's welcome—at least from employers. The jobless rate for veterans between ages 18 to 24 was 12 percent in 2007, almost three times the national unemployment rate of 4.6 percent. Numerous national publications have reported veterans are having a more difficult time finding jobs than non-veterans. According to a recent national survey, one in five veterans said finding a job took 6 months or longer; one in 10 said it took more than a year. The employment market

is tougher for young veterans. This is a major key reason why the funding for the VETS program is so critical.

Veterans need proper training and tools to begin new careers after they leave military service. The VWIP account has only received $7.3 million in annual funding, which has allowed the program to operate in only 11 states. This is absolutely unacceptable. There are thousands of veterans available for work, but they lack marketable, technological skills, especially for those jobs that exist in the Information Age economy. The problem is clearly a lack of adequate funding for veterans who are the only participants in this program. The budget baseline needs to increase to allow VETS to train eligible veterans in all 50 states in FY 2010.

Make Transitional Assistance Program (TAP)/Disabled Transitional Assistance Program (DTAP) a Mandatory Program

The American Legion is deeply concerned with the timely manner that veterans, especially returning wartime veterans, transition into the civilian sector. Annually, for the past 6 years, approximately 300,000 servicemembers, 90,000 of them belonging to the National Guard and Reserve, enter the civilian sector each year.

DoD estimates that 68 percent of separating servicemembers attend the full TAP seminars and only 35 percent of the Reserve components attend. The American Legion believes this low attendance number is a disservice to all transitioning servicemembers, especially the Reserve component. Currently, numerous National Guard and Reserve troops have returned from the war in Iraq and Afghanistan only to encounter difficulties with their Federal and civilian employers at home, and the number of destroyed and bankrupt businesses due to military deployment is still being realized.

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

Any delay in reintegration into the civilian workforce can adversely affect a veteran's life. Every effort should be made to ensure that veterans are afforded all the opportunities that this great country can offer without delay.

The American Legion strongly supports the Transition Assistance Program and Disabled Transition Assistance Program. Additionally, The American Legion supports that DoD require all separating, active-duty servicemembers, including those from Reserve and National Guard units, be given an opportunity to participate in Transition Assistance Program and Disabled Transition Assistance Program training not more than 180 days prior to their separation or retirement from the Armed Forces.

The DoD Transition Assistance Program (TAP) was designed to help smooth the transition of military personnel (and family members) leaving active duty. TAP is a partnership among DoD, DOL, and VA. The program consists of four components:

1. DoD Preseparation Counseling;
2. DOL Employment Workshops;
3. VA Benefits Briefing; and
4. Disabled Transition Assistance Program (DTAP).

Once a servicemember has completed the four workshops above, they are eligible for one-on-one counseling and employment assistance training through their service. For demobilizing Guard and Reserve: DoD Preseparation Counseling, DOL Uniformed Services Employment and Reemployment Rights Act (USERRA) Briefing, VA Benefits Briefing, and VA DTAP Briefing are provided on major military installations by the Transition Assistance Offices.

A new Web site designed to help all veterans was recently launched on June 11, 2007. The "TurboTap" is intended to be a one-stop transition center but not to replace the face-to-face interaction and the assistance that the full programs can provide.

Transition Assistance Program (TAP) Employment Workshops are provided to transitioning servicemembers at most military installations in the United States as well as in eight overseas locations. The two and one-half day employment workshops help servicemembers prepare a plan for obtaining meaningful civilian employment when they leave the military. The workshop focuses on skills assessment, resume

writing, job counseling and assistance, interviewing and networking skills, labor market information, and familiarization with America's workforce investment system.

Studies have shown that servicemembers who participate in TAP employment workshops find their first civilian jobs 3 weeks earlier than veterans who do not participate in TAP. According to DOL—VETS, it is estimated that about 65 percent of servicemembers leaving active duty do attend a TAP workshop. VETS is vital in ensuring that every TAP participant leaves the session with a draft resume, a practice interview session, and having visited their state job board.

DOL—VETS program is critical in supporting veterans as they transition from the military and into the private sector, assisting veterans to be awarded federal employment using their earned veterans preference, and assisting veterans to achieve substantially gainful employment.

At the end of the Cold war, DoD dramatically downsized its personnel strength. In an attempt to assist separating servicemembers in making a successful transition back into the civilian workforce, Congress enacted PL 101–510 that authorized the creation of the TAP that provides separating servicemembers with 3 days of comprehensive training with emphasis on such topics as networking, how to conduct a job search, resume writing, career decisionmaking, interview techniques, as well as current occupational and labor market conditions.

VETS provide professional veterans' employment personnel, DVOPs and LVERs, to participate in the TAP program. Higher demands placed on LVERs to deliver TAP modules, in addition to their normal employment assistance programs, has the potential for weakening their overall capability.

To ensure that all veterans, both transitioning and those looking for employment assistance well past their discharge, receive the best care; the DOL–VETS program must be adequately funded. However, we feel that the current funding levels are inadequate.

On the contrary to the demands placed upon VETS, funding increases for VETS since 9/11 do not reflect the large increase in servicemembers requiring these services due to the Global War on Terror. In support of this fact, the inflation rate from January 2002 to January 2007 is 14.29 percent and yet for State Grants alone, funding has only increased a meek 1.19 percent ($158 million to $161 million).

More services and programs are needed and yet since 2002 the VETS program has only received a modest 4 percent-increase. Transition assistance, education, and employment are each a pillar of financial stability. They will prevent homelessness, afford the veteran to compete in the private sector, and allow our Nation's veterans to contribute their military skills and education to the civilian sector.

By placing veterans in suitable employment sooner, the country benefits from increased income tax revenue and reduced unemployment compensation payments, thus greatly offsetting the cost of TAP training. The necessity and severity of the situation is now.

The American Legion recommends $352 million to DOL–VETS for FY 2010.

MILITARY OCCUPATIONAL SPECIALTY TRANSITION (MOST) PROGRAM

The American Legion supports the new legislation, H.R. 6221 that will authorize $60 million for the next 10 years to fund the servicemembers' Occupational Conversion and Training Act (SMOCTA). SMOCTA is a training program developed in the early 1990's for those leaving military service with few or no job skills transferable to the civilian marketplace. SMOCTA has been changed to the Military Occupational Specialty Transition (MOST) program, but the language and intent of the program still applies.

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

Veterans eligible for assistance under MOST are those with a primary or secondary military occupational specialty that DoD has determined is not readily transferable to the civilian workforce or those veterans with a service-connected disability rating of 30 per cent or higher. MOST is a unique job training program because there is a job waiting for the newly trained veteran upon completion of training so that they can continue to contribute to the economic well-being of the Nation.

In March 1993, DoD, VA, and DOL signed a Memorandum of Understanding (MOU), which defined their roles and responsibilities in the implementation of SMOCTA and DoD provided funding for SMOCTA. The VA and DOL were responsible for administering the program. Many LVERs and DVOPs publicly praised the

effectiveness of this program because it successfully returned veterans to the civilian workforce.

The American Legion recommends reauthorization of SMOCTA (now MOST) and adequate funding for the program.

Employment

DVOPs provide outreach services and intensive employment services to meet the employment needs of eligible veterans, with priority to disabled veterans and special emphasis placed on those veterans most in need. LVERs conduct outreach to local employers to develop employment opportunities for veterans, and facilitate employment, training and placement services to veterans. In particular, many LVERs are the facilitators for the Transition Assistance Program employment workshops.

There are inadequate appropriations to several states because of policies and practices that cause these states to receive fewer positions and/or less funding. This procedure caused a deterioration of the available services provided to veterans in those states, and adversely impacts the level of services provided.

HOMELESSNESS (DOL—VETS)

The American Legion notes that there are approximately 154,000 homeless veterans on the street each night. This number, compounded with 300,000 servicemembers entering the private sector each year since 2001 with at least a third of them potentially suffering from mental illness, requires that intensive and numerous programs to prevent and assist homeless veterans are available.

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

The American Legion recommends $40 million for this highly successful grant program in FY 2010.

TRAINING

The National Veterans' Employment and Training Services Institute (NVTI) was established to ensure a high level of proficiency and training for staff that provide veterans employment services.

NVTI provides training to Federal and state government employment service providers in competency based training courses. Current law requires all DVOPs and LVERs to be trained within 3 years of hiring. We believe that these personnel should be trained within 1 year.

The American Legion recommends $6 million of funding for NVTI in FY 2010.

Veterans Workforce Investment Program (VWIP)

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

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

EMPLOYMENT RIGHTS AND VETERANS' PREFERENCE

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

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

Veterans' Preference is authorized by the Veterans' Preference Act of 1944. The Veterans' Employment Opportunity Act (VEOA) 1998 extended certain rights and

remedies to recently separated veterans. VETS were given the responsibility to investigate complaints filed by veterans who believe their Veterans' Preference rights have been violated and to conduct an extensive compliance assistance program.

Veterans' Preference is being unlawfully ignored by numerous agencies. Whereas figures show a decline in claims by veterans of this conflict compared to Gulf War I, the reality is that employment opportunities are not being broadcast. Federal agencies as well as subcontractors are required by law to notify OPM of job opportunities but more often than not these vacancies are never made available to the public. The VETS program investigates these claims and corrects unlawful practices.

The American Legion recommends funding of $61 million for Program Management that encompasses USERRA and VEOA in FY 2010.

The American Legion also supports the strongest Veterans' Preference laws possible at all levels of government. We believe that the evidence compiled in this report will show the current state of enforcing the Uniformed Services Employment and Reemployment Rights Act (USERRA) and Veterans' Preference laws to the Nation's veterans.

The American Legion is deeply concerned with the protection of the veteran and the prevention of illegal and egregious hiring practices. Currently, veterans are filing claims after the non-compliance employment event occurred and therefore may become financially disadvantaged. Concurrent measures and continuous oversight must be emplaced to protect veterans from unfair hiring practices, not just reactionary investigations.

The following paragraphs are the perceived steps taken by the Federal Government to protect veterans' employment and it demonstrates reactionary measures to assist veterans that may take months to resolve. Many veterans give up or do not file complaints because they must seek employment elsewhere or face serious financial difficulties.

The Office of Personnel Management (OPM) administers entitlement to Veterans' Preference in employment. DOL, through VETS, provides assistance to all persons having claims under USERRA. DOL is the enforcement authority for USERRA, and it processes all formal complaints of violations of the law. The veteran may then request that the Department of Justice (DoJ) litigate on their behalf but only after a certain period has passed.

The following excerpt is from the DoJ Web site (www.usdoj.gov):

> "If VETS is unsuccessful in resolving the complaint, the claimant may request that VETS refer the complaint to Office of Special Counsel (OSC). If the Special Counsel believes there is merit to the complaint, OSC will initiate an action before the Merit Systems Protection Board (MSPB) and appear on behalf of the claimant.
>
> "The DoJ is responsible for enforcing the provisions of the USERRA against state and local government employers and private employers. If the Department of Justice takes your case, it will serve as your attorney if you work for a private employer or a local government. If you work for a state government, the Department of Justice may bring a lawsuit in the name of the United States."

The DoJ Web site continues to state:

> "USERRA authorizes the Department of Justice Office of Special Counsel (OSC) to investigate alleged violations of the act by Federal Executive Agencies, and to prosecute meritorious claims before the Merit Systems Protection Board on behalf of the aggrieved person. Under the Veterans Employment Opportunities Act 1998 (VEOA), in order to seek corrective action, a preference eligible [veteran] is to file a written complaint with the U.S. Department of Labor, Veterans Employment and Training Service (VETS), within 60 days of the alleged violation. If the Secretary is unable to resolve a complaint within 60 days, the Secretary is to provide notification of an unsuccessful effort to resolve the complaint to the complainant."

The American Legion reiterates its position that protection of veterans' employment rights should be concurrent and continuous oversight must be emplaced to protect veterans from unfair hiring practices, not just reactionary investigations and lawsuits. We further state that the veteran must be protected at the onset of the hiring process, especially because corrective actions to remedy the veteran's plight are not guaranteed.

Finally, we recommend to this Committee that the DoJ provide a detailed description of their veterans' employment activities.

Veterans' Preference Cases	FY 2006	FY 2007
Cases Carried over from previous FY	67	29
Cases Opened	479	427
Total cases	546	456
Cases Closed	517	406
Cases carried to next FY	29	50

FY 2006

In 2006, VETS staff closed 1,377 USERRA complaints, recovering $2,346,142.04 in lost wages and benefits.

FY 2007

In 2007, VETS staff closed 1,200 USERRA complaints, recovering $1,886,572.95 in lost wages and benefits.

VETERAN AND SERVICE DISABLED VETERAN OWNED BUSINESSES

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

The impact of deployment on self-employed Reservists is tragic with a reported 40 percent of all businesses owned by veterans suffering financial losses and in some cases bankruptcies. Many small businesses have discovered they are unable to operate and suffer some form of financial loss when key employees (who are members of the Reserve component) are activated. The Congressional Budget Office in a report, "The Effects of Reserve Call-Ups on Civilian Employers," stated that it "expects that as many as 30,000 small businesses and 55,000 self-employed individuals may be more severely affected if their Reservist employee or owner is activated." The American Legion is a strong supporter of the "Hope at Home Act of 2007," which is a bipartisan bill that would not only require the Federal Government to close the pay gap between their Reserves and National Guard servicemember's civilian and military pay but it would also provide tax credits up to $30,000 for small businesses with servicemembers who are activated.

Additionally, the Office of Veterans' Business Development within the Small Business Administration (SBA) remains crippled and ineffective due to a token funding of $750,000 per year. This amount, which is less than the office supply budget for the SBA, is expected to support an entire Nation of veterans who are entrepreneurs. The American Legion feels that this pittance is an insult to American military veterans who are small businessowners; consequently, this undermines the spirit and intent of PL 106–50 and continues to be a source of embarrassment for this country.

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

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

THE NATIONAL VETERANS BUSINESS DEVELOPMENT CORPORATION

Congress enacted the Veterans Entrepreneurship (TVC) and Small Business Development Act 1999 (PL 106–50) to assist veterans and service-connected disabled veterans who own small businesses by creating the National Veterans Business Development Corporation. Presently, the objectives of PL 106–50 (as originally envi-

sioned) are not being met at the present time due to the scope of the mission, staffing and funding requirements.

The American Legion believes that with limited funding and staffing, TVC should not try to duplicate or replicate preexisting services such as those provided by the Small Business Development Centers (SBDC). The American Legion recommends that the resource-training centers that TVC is currently providing funding for be given to the jurisdiction of the SBA's Veterans' Development Office.

The SBA's Veterans' Development Office is presently funding five such centers around the country and should be given the additional three. In addition, the SBA office should take on the responsibility of partnering with military and VA hospitals, TAPs, State Department of Veterans Affairs, Procurement technical Assistance Centers, Military Family Support Centers, and VSOs to provide employment and entrepreneurship programs along with the addition of funding and necessary senior staff to oversee the implementation and development of such a program.

TVC would operate more effectively acting as a liaison with existing associations of small businessowners and, by working with SBA programs, ensure the involvement of private and successful military alumni from the business community to help support SBA's successful reintegration of veterans and Reserve component entrepreneurs into the private and public American marketplace.

The American Legion also supports restructuring of the organization by replacing the current Chief Executive Officer position with a congressionally appointed Director from the Senior Executive Service. That move would allow Congress greater oversight of expenditures and an enhanced ability to monitor performance. Restricting the role of the Board of Directors to fundraising, marketing and branding which will serve to increase small business opportunities to veterans along with relieving board members with the challenges of operating such a national outreach initiative, with only the guidance of the Chief Executive Officer.

The American Legion reiterates the SBA's Office of Veterans' Business Development should be the lead agency to ensure that veterans returning from Iraq and Afghanistan are provided with Entrepreneurial Development Assistance. Comprehensive training should be handled by the SBA and augmented by TVC's online training. Resource Training Centers should include DoD and VA faculties. Currently, many military families are suffering financial hardship while their loved ones are recuperating in military hospitals around the country. Many spouses leave their jobs to be with that disabled servicemember only to watch their finances deteriorate. Seamless transition in many cases is just a wishful thought; however, if business development training was offered to military members, a small home based business that is feasible could be the answer in guaranteeing a constant source of revenue for the family, in turn making them less dependent on the Federal Government.

The American Legion has encouraged Congress to require reasonable "set-asides" of Federal procurements and contract for businesses owned and operated by veterans. The American Legion supported legislation in the past that sought to add service-connected disabled veterans to the list of specified small business categories receiving 3 percent set-asides. PL 106–50, "The Veteran Entrepreneurship and Small Business Development Act of 1999," included veteran small businesses within Federal contracting and subcontracting goals for small businessowners and within goals for the participation of small businesses in Federal procurement contracts. It requires the head of each Federal agency to establish agency goals for the participation by small businesses owned and controlled by service-connected disabled veteran, within that agency's procurement contracts.

Agency compliance with PL 106–50 has been minimal with only two agencies self-reporting that they have met their goals (the Department of Veterans Affairs and the Small Business Administration). In 2004, President Bush issued Executive Order 13360 to strengthen opportunities in Federal contracting for service-disabled veteran-owned businesses.

Recommendations

1. Incorporate Executive Order 13360 into SBA Regulations and Standard Operating Procedures

The American Legion endorses these recommendations given from the "SBA Advisory Committee on Veterans Business Affairs" FY 2006 SBA report:

- "The SBA needs to reemphasize implementation of Executive Order 13360 and establish it as a Federal procurement priority across the entire Federal sector. Federal agencies need to be held accountable, by the SBA, for their implementing Executive Order 13360 and their progress toward the 3 percent-goal.

The SBA needs to establish a means to monitor agencies progress and where appropriate, establish a vehicle to report or otherwise identify those that are not in compliance, and pursue ongoing follow-up."

- "To achieve the SDVOSB procurement goal contained in Executive Order 13360, the SBA must identify all agencies affected by the Executive Order under the directive of Congress. Then the SBA should assist these agencies to develop a demonstrable, measured strategic plan and establish realistic reporting criteria. Once the information is received, disseminate this data to all agencies, Veterans Organizations and post on SBA Web site as a bellwether of program progress."

2. Change to Sole Source Contracting Methods

"To provide parity among special emphasis procurement programs the SBA should take immediate, appropriate steps to promulgate regulations to revise 13 CFR 125.20. The proposed revision would eliminate existing restrictions on the award of sole source contracts to SDVOSB such as the "Rule of Two". The change should mirror 13 CFR 124.508(c) which applies to 8 (a) Program participants and states—.In order to be eligible to receive a sole source 8 (a) contract, a firm must be current participant on the date of the award—Accordingly, adopting this language would eliminate all restrictions on sole source awards to SDVOSBs."

3. Develop a User Friendly Veteran Procurement Database

The American Legion also urges that the Federal Government and DoD utilize its available technology to create, fund and support a veteran procurement-spending database within the DoD that would finally bring veteran owned and service-disabled veteran owned businesses on equal footing with all other small business special interest groups when it comes to Federal procurement opportunities.

HOME LOAN GUARANTY PROGRAM

VA's Home Loan Guaranty program has been in effect since 1944 and has afforded approximately 18 million veterans the opportunity to purchase homes. The Home Loan programs offer veterans a centralized, affordable and accessible method of purchasing homes in return for their service to this Nation. The program has been so successful over past years that not only has the program paid for itself, but has also shown a profit in recent years. Administrative costs constitute a relatively small portion—less than 10 percent—of the total capital and operating costs. The predominant costs are claims costs and other costs associated with foreclosure and alternatives taken to avoid foreclosure. Each claim costs the Federal Government about $20,000. However, revenues that VA collects from different sources, including the funding fee that borrowers pay, property sales, and proceeds from acquired loans and vendee loans, offset this cost.

The VA funding fee is required by law and is designed to sustain the VA Home Loan Program by eliminating the need for appropriations from Congress. Congress is not required to appropriate funding for this program; however, because veterans must now 'buy' in to the program, it no longer serves the intent of helping veterans afford a home.

The fee, currently 2.15 percent on no-downpayment loans for a first-time use, is intended to enable the veteran who obtains a VA home loan to contribute toward the cost of this benefit, and thereby reduce the cost to taxpayers. The funding fee for second time users who do not make a downpayment is 3.3 percent. The idea of a higher fee for second time use is based on the fact that these veterans have already had a chance to use the benefit once, and also that prior users have had time to accumulate equity or save money toward a down payment.

The following persons are exempt from paying the funding fee:

- Veterans receiving VA compensation for service-connected disabilities.
- Veterans who would be entitled to receive compensation for service-connected disabilities if they did not receive retirement pay.
- Surviving spouses of veterans who died in service or from service-connected disabilities (whether or no tsuch surviving spouses are veterans with their own entitlement and whether or not they are using their own entitlement on the loan).

The funding fee makes the VA Home Loan program less beneficial than compared to a standard, private loan, in some aspects. The current rate for mortgages (July 2008) is 6.5 percent. The funding fee would be in addition to the rate given by the lender. A $300,000 loan would generate a fee in addition to any rate the veteran would achieve. The funding fee mandates the participant to buy in to the program; however that goes directly against the intention of the law, to provide veterans a resource for obtaining a home.

The American Legion believes that it is unfair for veterans to pay high funding fees of 2 to 3 percent, which can add approximately $3,000 to $11,000 for a first time buyer. The VA funding fee was initially enacted to defray the costs of the VA guaranteed home loan program. The current funding fee paid to VA to defray the cost of the home loan has had a negative effect on many veterans who choose not to participate in this highly beneficial program.

Therefore, The American Legion strongly recommends that the VA funding fee on home loans be reduced or eliminated for all veterans whether active duty, Reservist, or National Guard.

Specially Adaptive Housing

The American Legion is pleased to support the VA Secretary's efforts to improve the housing arrangements to better suit disabled veterans' needs, with specific emphasis on severe burn injuries. The American Legion additionally applauds efforts to assist disabled veterans to receive adaptive equipment for automobiles.

The American Legion conveys that specially adaptive housing should also include those veterans suffering from Traumatic Brain Injury (TBI), and other debilitating injuries. We are also concerned with the ambiguity of the term "severe" in that there are many different levels of injury where a severe injury to one individual may not be as severe to another.

HOMELESS VETERANS

The American Legion supports the efforts of public and private sector agencies and organizations with the resources necessary to aid homeless veterans and their families. The American Legion supports proposals that will provide medical, rehabilitative and employment assistance to homeless veterans and their families.

Homeless veteran programs should be granted full appropriations to provide supportive services such as, but not limited to outreach, health care, habilitation and rehabilitation, case management, daily living, personal financial planning, transportation, vocational counseling, employment and training, and education.

The American Legion applauds the VA, HUD, and the Senate Appropriations Committee for ensuring PL 110–161, the FY 2008 Consolidated Appropriations Act, included $75 million for the Department of Housing and Urban Development (HUD)—Veterans Affairs Supported Housing (VASH) program. This funding allowed HUD and VA to make up to 10,000 supportive incremental housing vouchers available to homeless veterans. Looking ahead to FY 2009 funding for veterans permanent housing, HUD has requested another $75 million for up to 10,000 additional vouchers for the HUD–VASH program. The American Legion urges the Appropriations Members to support this amount in new legislation, and to double that amount in FY 2010.

Veterans need a sustained coordinated effort that provides secure housing, nutritious meals, essential physical health care, substance abuse aftercare and mental health counseling, as well as personal development and empowerment. Veterans also need job assessment, training and placement assistance. The American Legion believes all programs to assist homeless veterans must focus on helping veterans reach their highest level of self-management.

Homeless Providers Grant and Per Diem Program Reauthorization

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem Program under the Homeless Veterans Comprehensive Service Programs Act of 1992, PL 102–590. The Grant and Per Diem Program is offered annually (as funding permits) by the VA to fund community agencies providing service to homeless veterans.

VA can provide grants and per diem payments to help public and nonprofit organizations establish and operate supportive housing and/or service centers for homeless veterans. Funds are available for assistance in the form of grants to provide transitional housing (up to 24 months) with supportive services, supportive services in a service center facility for homeless veterans not in conjunction with supportive housing, or to purchase vans.

The American Legion strongly supports increasing the funding level to $200 million annually for the Grant and Per Diem Program.

VBA has 20 full-time and 37 part-time homeless veteran outreach coordinators to enhance prompt claims for homeless and at-risk veterans. VBA identified and expedited more than 21,000 claims from homeless veterans since 2003. Approximately 44 percent of compensation claims and 77 percent of pension claims are approved annually.

Health Care for Homeless Veterans (HCHV) sites provide outreach, physical and psychiatric treatment, referrals, and case management to homeless veterans. HCHV

staffs assist over 60,000 homeless veterans each year and place homeless veterans into community-based facilities under contract to local VA medical facilities.

Domiciliary Care for Homeless Veterans Program (DCHV) operates 34 sites, with 1,833 dedicated domiciliary beds, providing time limited residential treatment with long-term physical, psychological, and rehabilitative counseling and services including aftercare. This program annually provides residential treatment to nearly 5,200 homeless veterans.

Veterans Industries/Compensated Work Therapy Program (VI/CWT) offers vocational and rehabilitative services, ranging from evaluation and counseling to participation in compensated work and vocational training. Since 1994 over 32,000 veterans have been successfully reintegrated into society as responsible members of the community through this program.

Compensated Work Therapy/Transitional Residence (CWT/TR) program operates in 64 community-based locations (with a total of 469 operational beds), provides residences to disadvantaged, at risk, and homeless veterans, while they participate in the VI/CWT. Nearly 6000 veterans have been housed under this program.

Homelessness impacts every community in the Nation. Approximately 200 community-based veterans' service organizations across the country have successfully reached homeless veterans through specialized programs. Veterans who participate in these programs have a higher chance of becoming productive citizens again.

A full continuum of care—housing, employment training and placement, health care, substance abuse treatment, legal aid, and follow-up case management—depends on many organizations working together to provide services and adequate funding. The availability of homeless veteran services, and continued community and government support for them, depends on vigilant advocacy and public education efforts on the local, state and Federal levels.

The FY 2007 Department of Veterans Affairs Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) report estimates that approximately 154,000 veterans are homeless at any point in time. Prior reports state that one out of every three homeless men sleeping in doorways, alleys or boxes in our cities and rural communities has put on a uniform and served this country. According to the February 2007 Homeless Assessment Report to Congress (U.S. Department of Housing and Urban Development 2007), veterans represent 19 percent of all homeless people in America.

For FY 2007, The VA Health Care for Homeless Veterans (HCHV) reports that 68,000 homeless veterans are enrolled in their programs. Community-based organizations are attempting to assist the overwhelming remainder of veterans who are homeless.

In addition to the complex set of factors affecting all homelessness (the extreme shortage of affordable housing, livable income, and access to health care), a large number of displaced and at-risk veterans live with lingering effects of Post Traumatic Stress Disorder (PTSD), substance abuse, and a lack of family and social support networks. Many times these veterans have mental health disorders related to their honorable service to their country, are unable to compensate for their condition. They unfortunately deteriorate to unrecognizable individuals compared to their pre-military experience.

Potential homeless veterans of Operation Iraq Freedom and Operation Enduring Freedom (OIF/OEF)

Some OIF/OEF veterans are at high risk of becoming homeless. Combat veterans of OIF/OEF and the Global War on Terror who need help—from mental health programs to housing, employment training and job placement assistance—are beginning to trickle into the Nation's community-based homeless veterans' service organizations. Already stressed by an increasing need for assistance by post-Vietnam Era veterans and strained budgets, homeless services providers are deeply concerned about the inevitable rising tide of combat veterans who will soon be requesting their support.

Since 9/11, nearly 800,000 American men and women have served or are serving in a war zone. Rotations of troops returning home from Iraq are now a common occurrence. Military analysts and government sources say the deployments and repatriation of combat veterans is unlike anything the Nation has experienced since the end of the Vietnam War.

The signs of an impending crisis are clearly seen in VA's own numbers. Under considerable pressure to stretch dollars, VA estimates it can provide assistance to about 100,000 homeless veterans each year, only 20 percent of the more than 500,000 who will need supportive services. Hundreds of community-based organizations nationwide struggle to provide assistance to as many of the other 80 percent as possible, but the need far exceeds available resources.

VA's HCHV reports 1,049 OIF/OEF era homeless veterans with an average age of 33 years young. HCHV further reports that nearly 65 percent of these homeless veterans experienced combat. Now receiving combat veterans from Iraq and Afghanistan daily, the VA is reporting that a high percentage of those casualties need treatment for mental health problems. That is consistent with studies conducted by VA and other agencies that conclude anywhere from 15 to more than 35 percent of combat veterans will experience some clinical degree of PTSD, depression or other psychosocial problems.

Homeless Women Veterans and Children

Homeless veterans' service providers' clients have historically been almost exclusively male. That is changing as more women veterans and women veterans with young children have sought help. Additionally, the approximately 200,000 female Iraq veterans are isolated during and after deployment making it difficult to find gender-specific peer-based support. Access to gender-appropriate care for these veterans is essential.

More women are engaging in combat roles in Iraq where there are no traditional frontlines. In the past 10 years, the number of homeless women veteran has tripled. In 2002, the VA began a study of women and PTSD. The study includes subjects whose PTSD resulted from stressors that were both military and non-military in nature. Preliminary research shows that women currently serving have much higher exposure to traumatic experiences, rape and assault prior to joining the military. Other reports show extremely high rates of sexual trauma while women are in the service (20–40 percent). Repeated exposure to traumatic stressors increases the likelihood of PTSD. Researchers also suspect that many women join the military, at least in part, to get away from abusive environments. Like the young veterans, these women may have no safe supportive environment to return to, adding yet more risk of homeless outcomes.

CHALENG sites continue to report increases in the number of homeless veterans with families (i.e., dependent children) being served at their programs. It reports that 98 sites (71 percent of all sites) reported a total of 1,038 homeless veteran families seen. This was a 5 percent-increase over the previous year's 989 homeless veteran families. (FY 2007 VA CHALENG report)

Homeless veteran service providers recognize that they will have to accommodate the needs of the changing homeless veteran population, including increasing numbers of women and veterans with dependents. Access to family housing through the distribution of the thousands of new section 8 vouchers that will be made available through the HUD–VASH program will offer an important new resource allowing VA staff to assist the veteran and her family.

The American Legion supports adequate funding for all domiciliary programs for all qualified veterans. More women veterans and women veterans with young children have sought help. Additionally, the approximately 200,000 female Iraq veterans are isolated during and after deployment making it difficult to find gender-specific, peer-based support. Access to gender-appropriate care for these veterans is essential.

SUMMARY

The American Legion appreciates the strong relationship we have developed with both Committees. With increasing military commitments worldwide, it is important that we work together to ensure that the services and programs offered through VA are available to the new generation of American servicemembers who are returning home.

The American Legion is fully committed to working with each of you to ensure that America's veterans receive the entitlements they have earned. Whether it is improved accessibility to health care, timely adjudication of disability claims, improved educational benefits or employment services, each and every aspect of these programs touches veterans from every generation. Together we can ensure that these programs remain productive, viable options for the men and women who have chosen to answer the Nation's call to arms.

Statement of Hon. Harry E. Mitchell,
a Representative in Congress from the State of Arizona

Chairman Filner, thank you for calling this hearing, and thank you Secretary Shinseki for your willingness to appear before the Committee again today. Thank you also to the Veterans Service Organizations for agreeing to testify.

The task of examining the Administration's Budget and crafting the Congressional Budget should be a little easier this year. For the first time in the history of *The Independent Budget*—which is drafted by veterans for veterans—the Administration's proposal has exceeded the requests made by the veteran community.

According to the Administration, the 11 percent-increase in discretionary funding is aimed at bringing 500,000 Priority 8 veterans into the VA health care system, ensuring that the new GI Bill is ready and active for the 2009 school year, and reaching out to veterans in need. Many of my constituents and colleagues have raised concerns about a proposal that would collect medical fees from veterans with service-connected disabilities, but with this exception, I believe the Administration's budget outline is headed in the right direction.

As the Administration finalizes the details of its budget proposal, I wish to highlight two issues that I hope will be addressed.

We are all troubled by a startling spike in traumatic brain injury and post-traumatic stress disorder. About one-fifth of all combat casualties include TBI, and roughly the same proportion of troops will develop PTSD after returning from combat. Recently, I met with a young veteran from Arizona who suffers from PTSD, and he has been through the ringer at the VA, trying to get the mental health care he needs. He is working as hard as he can to recover, but he's been through four or five jobs, a couple attempts at college, and he's fighting to keep his second marriage together. His long-term success is by no means assured, so we must assure him that the service and benefits he needs will be there when he needs them.

I also expect increased transparency as the VA drafts its Priority List of Pending State Home Construction Grant Applications for FY 2010. This year, two facilities in one state received approximately $140 million of the $175 million available nationwide. While some states may have more pressing needs than others, I hope that the rationale for budgeting these funds will be made clear in FY 2010.

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

MATERIAL SUBMITTED FOR THE RECORD

U.S. Department of Veterans Affairs
The Secretary of Veterans Affairs
Washington, DC
April 20, 2009

The Honorable Phil Roe
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Roe:

At the March 10, 2009, House Veterans' Affairs Committee hearing, you asked for the percentage of the budget going to care for World War II, Vietnam Veterans, and Veterans of other eras.

The Fiscal Year (FY) 2008 table below provides a breakdown of obligation-based cost by combat, excluding state home patients and Readjustment Counseling. Please note these figures only include costs for Veteran care; costs for other beneficiaries (such as CHAMPVA) are not included, but amount to approximately 1 percent of VA's health obligation-based cost. Also note Veterans may have served in multiple combat eras. However, 98 percent of Veterans have one period of service listed in their FY 2008 encounter records. The remaining Veterans have a period of service assigned consistent with their age.

Vietnam	46%	Desert Storm	6%
World War II	14%	OEF/OIF	3%
Korea	12%	Pre-Korea	1%
Post-Vietnam	12%	Other*	1%
Post-Korea	7%	TOTAL	100%

*Includes categories that do not fit within remaining definitive categories. For example, a few records from World War I Veterans are included among others.

Thank you for your and the Committee's support of our mission.

Sincerely,

Eric K. Shinseki

U.S. Department of Veterans Affairs
The Secretary of Veterans Affairs
Washington, DC
April 20, 2009

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman Filner:

At the March 10, 2009, House Veterans' Affairs Committee hearing when you made comments about a transformative approach to the claims backlog,

I responded that advocacy training can make a difference.

Since that time the Veterans Benefits Administration (VBA) is obtaining contractor support to assist in developing a Veteran-focused strategy for improving client satisfaction and service delivery. VBA's comprehensive approach includes collection and analysis of customer satisfaction and other data and information; internal assessments of VBA's client-services culture, processes, and issues; and development of training programs and other process improvements to increase client satisfaction.

I look forward to working with you and the Committee in our common effort to meet the needs of Veterans who deserve the best care we can provide.

Sincerely,

Eric K. Shinseki

Committee on Veterans' Affairs
Washington, DC
March 18, 2009

The Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki

In reference to our Committee hearing of March 10, 2009, I would appreciate your response to the enclosed additional questions for the record by close of business Wednesday, April 15, 2009.

It would be appreciated if you could provide your answers consecutively on letter size paper, single spaced. Please restate the question in its entirety before providing the answer.

Thank you for your cooperation in this matter.

Sincerely,

Steve Buyer
Ranking Republican Member

Questions for the Record
The Honorable Steve Buyer
Ranking Republican Member
House Veterans' Affairs Committee

March 10, 2009
U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2010

Question 1: I am concerned that the Administration's out-year funding projections could result in serious budget shortfalls for veterans' health care. Considering among other things health care inflation and increased workloads due to the restoration of health care eligibility for many priority 8 veterans, the drawdown in Iraq, and increased demand for VA health care from the economic downturn, please provide an explanation of how the funding levels were calculated for the VA in the out-years of FY 2011 through FY 2014.

Response: The 2010 Budget is the first step in meeting the Presidential initiative to increase VA's budget by $25 billion over the baseline over the next 5 years. The 2010 Budget includes a large increase for the Department of Veterans Affairs (VA) to invest in improved quality care and services. While the currently projected out-year estimates show more modest growth, the Department will continue to evaluate its resource requirements annually to ensure full consideration of its funding needs in the budget planning process.

Question 2: According to the budget information provided to the Committee for FY 2010, VA is expecting an unprecedented increase in collections. How does the Department anticipate reaching the goal? What efficiencies do you intend to establish to reach these new collection goals?

Response: The specific details of VA's projected collections estimate for 2010 are still being finalized and will not be available until the detailed 2010 budget documents are published. However, we are constantly improving businesses associated with collections. For example, the 2010 budget request makes investments in an accelerated implementation of the consolidated patient accounting centers, in critical training efforts for VA employees responsible for collections, and internal reviews to identify opportunities for improved collections efforts. Achieving the best results from our collections efforts is a priority, but VA understands that Congress shares that priority. The Department would welcome further discussions on how to continue improving VA's ability to increase collections.

Question 3: The stimulus provided over a billion dollars for non-recurring maintenance and energy projects at VHA. How much of the total funding will be allocated toward energy projects? Have the projects been identified? How many of these projects will include photovoltaic solar roofs?

Response: About $400 million of the $1 billion (40 percent) that Veterans Health Administration (VHA) received is allocated toward energy improvement and renewable energy projects. VA has identified these projects. The Department is conducting feasibility studies at multiple sites and will then select the most beneficial projects based on the study results. Regarding solar photovoltaic (PV) systems, VA is assessing 31 sites and will select up to 8 sites to implement a solar PV project. VA anticipates that most, if not all of these projects, will be rooftop solar PV systems.

Question 4: For many years VA and DoD have told the Committee that significant progress is being made to provide a seamless transition for our servicemembers. While progress has been made, many servicemember transitions are still not seamless. How does your budget reflect this priority and what help do you need from Congress and DoD to make this a reality?

Response: The seamless transition of servicemembers to civilian life is a priority for VA and the 2010 budget will ensure this remains a top priority. When the 2010 budget is released it will present specifics on how the Department will advance its efforts both internally and with the Department of Defense (DoD), to help ensure that active duty services members' transition to civilian life is smooth as possible. Some examples of key activities in support of the seamless transition goal are presented below:

Compensation & Pension: Based on the success of the Joint DoD/VA Disability Evaluation System (DES) pilot in the National Capital Region, VA and DoD agreed to expand the pilot to 20 additional sites across the Nation in 2009 to thoroughly test the new processes. Further expansion in 2010 is planned.

VA will continue the following activities which help provide a seamless transition for our servicemembers:

- Benefits delivery at discharge and quick start programs for those servicemembers who wish to file a claim while still on active duty.
- Expedited processing of initial and reopened claims from seriously and very seriously injured Veterans, as well as initial claims from all in-theater war Veterans and subsequent claims from Veterans claiming post traumatic stress disorder.
- Expanded outreach to newly discharged Veterans and Guard and Reserve personnel.

The Department will pursue information technology modernization efforts that support transition initiatives, including enhancements to VA and DoD data exchange as well as integration of technologies to enable Veterans and other claimants to interact with VA in the same manner as the best private-sector service businesses.

Updating VA schedule for rating disabilities (VASRD) to reflect the best medical information, and the signature conditions associated with new conflicts, is a priority. New rating criteria for the assessment of traumatic brain injury (TBI) became effective on October 23, 2008. The Veterans Benefits Administration (VBA) is processing claims from very seriously injured and seriously injured Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veterans on a first priority basis. VBA also conducts priority claims processing for all returning theater Veterans and when post traumatic stress disorder (PTSD) is first claimed by OEF/OIF Veterans.

Education: VA is conducting outreach activities to inform servicemembers and Veterans of the Post-9/11 GI Bill education benefit. As part of this outreach effort, VA identified approximately 2 million individuals who have been discharged, including recently discharged Veterans, with 30 days or more of service after September 10, 2001. These individuals will receive a letter that explains the Post-9/11 GI Bill and provides them with information on electing and applying for the education benefit. While these initial letters will be sent in April 2009, subsequent direct mailings containing education benefit information will be sent to individuals on active duty throughout fiscal 2010.

Insurance: The servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) provides critical transition support for severely injured servicemembers and their families. TSGLI provides for payment to servicemembers who suffer a traumatic injury that results in a qualifying loss in the program. It helps servicemembers and their families with financial burdens associated with recovering from a traumatic injury as they transition into civilian life. A premium of $1 per month is charged to each servicemember insured under SGLI. This premium covers the civilian incidence of such injuries. Any excess program costs above the premiums collected are paid by DoD. The administrative cost of processing TSGLI is covered under the administrative expenses of the Office of servicemembers' Group Life Insurance (OSGLI). For these reasons, TSGLI has no impact on Insurance's budget.

All discharged Veterans who had servicemembers' Group Life Insurance (SGLI) in the military receive a series of mailings advising them of their right to convert the SGLI coverage to Veterans' Group Life Insurance (VGLI). Since virtually all current servicemembers are enrolled in SGLI, virtually all new veterans are covered by these mailings. In addition, the Insurance Service staff conducts special outreach to recently separated servicemembers who have a military or VA disability rating of 50 percent or more. The purpose of this outreach (which is conducted by phone calls) is to ensure that separated servicemembers are aware of their eligibility for post-separation life insurance benefits, including the SGLI Disability Extension, VGLI, TSGLI, and Service-Disabled Veterans Insurance. The administrative costs of the mailing are paid by OSGLI, and there are minimal costs associated with the special outreach effort, so there is little impact on Insurance's budget.

Loan Guaranty: The Specially Adapted Housing (SAH) Program helps transitioning servicemembers and Veterans with certain permanent service connected disabilities adapt a home they already own, or buy or build a house and modify it to meet their disability-related needs. The Department will continue the SAH program which provides valuable assistance to severely disabled Veterans.

Vocational Rehabilitation & Employment: Vocational Rehabilitation & Employment helps transitioning servicemembers through two programs: Chapter 36, Educational and Vocational (Ed/Voc) counseling and Coming Home to Work (CHTW). Ed/Voc counseling is available to servicemembers during the 6-month period prior to discharge and to Veterans during the 1-year period following discharge. Ed/Voc counseling services include academic and career counseling. VA will continue to provide appropriate Education and Vocational Rehabilitation counseling services to Veterans to help ease their transition from active military service to civilian life.

The CHTW program is a cooperative effort with DoD that provides opportunities for servicemembers and OEF/OIF Veterans to obtain work experience, develop skills needed to transition to civilian employment, determine potential career opportunities, and return to suitable, gainful employment. There is a CHTW coordinator in each of the 57 VA regional offices, with 13 of these positions being designated as unique, full-time positions to support this effort. The remaining 44 regional office positions are filled by vocational rehabilitation counselors who provide assistance as a collateral duty.

Benefits Executive Council: VA gets support from DoD through the Benefits Executive Council (BEC), the official forum for senior level interaction between the VBA and DoD. VBA's program offices regularly report transition-related activities to the BEC. The transition-related activities are included in the budget of the appropriate program office.

Outreach: The Wounded Warrior Act (the FY 2008 National Defense Authorization Act, Public Law 110–181) called for joint outreach efforts to recovering servicemembers, Veterans, and their families. As a result, web-based applications, assistance centers, and direct outreach activities were developed.

The web-based National Resource Directory provides information on services and resources available through: national, state and local government agencies; Veterans' benefit, service, or advocacy organizations; professional provider associations; community and faith-based or non-profit organizations; academic institutions; and employers and philanthropic activities of business and industry. The Directory was developed jointly and is currently co-managed by DoD, VA, and the Department of Labor.

The Yellow Ribbon Reintegration Program provides National Guard and Reserve members and their families with information about services throughout the entire deployment cycle. VA participates with representation on the advisory board and assignment of a VA liaison within the program office.

A compensation and benefits handbook was co-developed by DoD and VA to help servicemembers and their families navigate the DoD and VA systems. The handbook is available electronically or in book format.

Information Technology as an Enabler: DoD and VA have taken the first crucial steps in creating a Joint Virtual Lifetime Electronic Record (VLER), as announced by President Obama on April 9, 2009. Both Secretaries are dedicated to ensuring strong executive oversight with specific attention to the Interagency Program Office, mandated by NDAA 2008, on behalf of VA and DoD, to provide oversight for VA–DoD data sharing initiatives. The emerging vision for the VLER initiative is for all current and future servicemembers, Veterans, and eligible family members to have a VLER that will encapsulate all data necessary to uniquely identify them and ensure the delivery of care and benefits for which they are eligible. This proactive delivery begins upon oath of military service and continues beyond death to survivor benefits.

DoD and VA will develop workgroups to define the common services used by information processes in both Departments as well as the common functional processes within services unique to each Department. Joint DoD/VA efforts have already begun to define the data and business processes for this effort. The result will be an unprecedented unified data sharing between the two Departments.

A My*e*Benefits portal, currently under development, will provide individualized information upon login for all servicemembers and Veterans.

Committee on Veterans' Affairs
Washington, DC
March 23, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010" on March 10, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 5, 2009.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Questions for the Record
The Honorable Bob Filner
Chairman
House Committee on Veterans' Affairs
March 10, 2009
U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2010

Question 1: The proposed 5-year discretionary budget increases for VA are relatively modest in the out-years, providing for an increase of about $1.5 billion, or 3 percent, in each of the out-years. This compares to the 10 percent-increase proposed in the FY 2010 budget. This year marks a sharp departure from prior budgets such as last year's budget submission which proposed cutting VA by $20 billion over 5 years. In light of criticism from some quarters that these modest increases do not accurately reflect the funding needs of the VA in out-years, can you explain how these estimates were developed?

Response: The 2010 Budget is the first step in meeting the Presidential initiative to increase the Department of Veterans Affairs' (VA) budget by $25 billion over the baseline over the next 5 years. The 2010 Budget includes a large increase for the Department to invest in improved quality care and services. While the currently projected out-year estimates show more modest growth, the Department will continue to evaluate its resource requirements annually to ensure full consideration of its funding needs in the budget planning process.

Question 2(a): VA has seen record funding increases for medical care over the last few years and your budget request would seem to accommodate another record increase. While VA has enjoyed these record increases, the Committee has heard concerns raised by some local medical facilities that suggest these facilities are not seeing these increased resources in their budgets. Does this suggest a flaw in the current resource allocation system, or how VISN budgets are handled?

Response: The concerns expressed early in the fiscal year (FY) by the Veterans Integrated Service Networks (VISN) and medical centers were a matter of timing. The funds allocated by the Veterans Equitable Resource Allocation (VERA) process were released to the field within 2 weeks of enactment of the FY 2009 appropriation. However, a significant amount of centrally managed funding was not included in that initial allocation, including funding for prosthetics, clinical trainees, and State Veterans homes. In addition, funding for two new congressional initiatives, $250 million for rural health and $543 million for expanded enrollment of Priority Group 8 Veterans, required planning, analysis and preparation prior to allocation. The vast majority of these funds were allocated by January 2009. VA is committed to ensuring that sufficient funds reach critical points of care in a timely manner.

Question 2(b): What plans does VA have to better control and account for health care spending while maintaining some level of flexibility to respond to local needs?

Response: VA conducts monthly performance reviews of all its activities, including actual execution of budgets as compared to plans. In addition, the Veterans Health Administration (VHA) National Leadership Board, through its subordinate finance committee, reviews funding requirements and budget execution data in detail at least twice each month. A portion of the annual VHA appropriations are held in unallocated reserve each year, and are used at the discretion of the Under Secretary of Health to address emerging funding requirements from the field, as well as to provide funding for innovative proposals to improve health care services for our Nation's Veterans.

Question 3: The budget seems to include a proposal to shift the mandatory funding for contract examinations for disability compensation eligibility to the discretionary side of the budget, specifically the General Operating Expenses account. Can you explain to the Committee the details of this proposal and the reasons for it and assure the Committee that this will not place an undue strain on the account that funds the claims processing system?

Response: The proposed transfer of funding from the compensation and pension mandatory funding account to the General Operating Expense (GOE) account is based on an analysis of the spending. Specifically, the spending for medical examinations supports providing benefits, but is not itself a payment of benefits to Veterans. As a result, funding for these examinations more appropriately belongs in the discretionary operational account, GOE.

Managing contract examination presents unique challenges whether funded from the mandatory or discretionary accounts. Sufficient funding for the examinations clearly must be provided to the Department. Moreover, Veterans Benefit Administration (VBA) already manages some contracted examinations through discretionary funding because an existing contract with MES Solutions is paid from that account. The current legislative authority for the MES Solutions contract, without further Congressional action to extend it, will expire at the end of 2010.

VA is committed to the sound budgeting and management practices required to provide for the needs of our Veterans with regard to contract examinations. VA analyzed three key factors before recommending this migration of funding source. The first and most critical factor is that use of contractors typically means a loss or lessening of capacity for examinations through internal sources as our medical centers refocus resources to provide for more acute and chronic patient care. Second, if the need for examinations or the mix of examinations is underestimated or the requested funding is not provided, VA's ability to provide needed examinations in a timely manner may be adversely affected. New legislation, new presumptive conditions, new outreach efforts, or new case law may result in an unanticipated increased caseload. Finally, the growth in the cost of examinations, as with health care generally, could exceed the budgeted discretionary funding increase. However, these factors are inherent across the core services that VA provides for Veterans. We are monitoring for precisely these kinds of events so that we will not be caught off guard, and will be able to adjust funding strategies as necessary.

Question 4(a): The budget highlights investments in better technology to deliver services and benefits to Veterans. There have been concerns over the adequacy of previous VA budget requests for IT spending and the speed with which the VA was reforming its efforts. Can you provide an update to the Committee as to the Department's efforts in this area and whether you feel confident that when the IT account level is established it will be sufficient to meet the requirements mandated by Congress?

Response: VA's goal is to build modern information technology (IT) systems that will move us into the 21st century, enabling the delivery of the highest quality

health care and services to our Veterans. This can only be done with a modern IT infrastructure, a high performing IT workforce, and a state-of-the-art information system in health care and benefits that will be flexible enough to meet both existing and emerging service delivery requirements. With the FY 2010 IT funding request, VA will develop an interagency interoperability plan with the Department of Defense (DoD), with the goal of improving patient safety and care; expedite benefit claims processing; automate the educational benefits assistance system to handle the expanded benefits passed in the Post 9/11 Veterans Educational Assistance Act of 2008; continue to develop financial and logistics integrated technology as the next generation core financial management system; and strengthen our IT workforce as well as our aging and fragile IT infrastructure.

The budget increase we are requesting for FY 2010 recognizes that IT touches all aspects of VA operations. IT provides standard equipment of desktop computers, laptops, printers, phone systems, network connections through regional servers, which hold the vital information of our Veterans. The Office of Information and Technology supports a workforce of 286,000 employees VA-wide who directly or indirectly serve 23 million Veterans and their families. Our nationwide health care system is comprised of 153 medical facilities, 755 community-based outpatient clinics, and 232 vet centers. Our benefits delivery system for compensation, pension, housing loan guaranty, education and insurance benefits support 55 regional offices nationwide. Our burial system automates all necessary processes for interments efficiently and effectively throughout 128 national cemeteries, and provides headstones and markers worldwide. Our backbone corporate financial management system provides steady and reliable data and performs financial processing needed to monitor funds, and financially report our operations throughout VA.

Question 4(b): Should the Committee expect the need for continued large investments in this area, and if so, how can the Committee be assured that such increases will truly accomplish the mission at hand?

Response: Transformational change of this scope and breadth is always a challenge; however, we believe the FY 2010 funding request supports a full budget requirement to right-size the IT budget request and avoids transferring funds, as was the case over the last 2 years. Congress approved the reprogramming of funds for FY 2008 and 2009 from the Medical Care and General Operating Expenses accounts. These transfers to our budget were needed to meet the demands of an aging IT infrastructure, the investment in 21st century legacy systems, and to ensure staffing a full workforce to support those current and future systems.

The Honorable Michael Michaud

Question 1: During your testimony on March 10, you testified that, "the number of patients who served in OEF/OIF will rise to over 419,000 in 2010." According to some VSO estimates, this number significantly undercounts the amount of Iraq and Afghanistan war Veterans who will seek VA treatment and services. How did VA come by this estimate?

Response: Starting with the 2007 enrollee health care projection model (EHCPM), VHA has used a future force deployment scenario developed by the Congressional Budget Office (CBO) to estimate future Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veterans. Based on this scenario, VHA created a separate model that projects OEF/OIF total Veteran population, enrollment, patients, utilization and expenditures.

The model recognizes the 5-year period of enrollment eligibility for combat Veterans. In the beginning of the eligibility period, the enrollment rates for OEF/OIF Veterans are assumed to be higher relative to other Veteran populations. As time passes, enrollment becomes more similar to that of other Veteran cohorts.

In addition, the model reflects the fact that OEF/OIF enrollees have significantly different VA health care utilization patterns than non-OEF/OIF enrollees. In particular:

- OEF/OIF enrollees are expected to need more than eight times the number of post-traumatic stress disorder (PTSD) residential rehab services than non-OEF/OIF enrollees;
- OEF/OIF enrollees have an increased need for dental services, physical medicine, prosthetics, and outpatient psychiatric and substance abuse treatment; but
- On the other hand, experience indicates that OEF/OIF enrollees seek about half as much inpatient acute surgery care from VA as non-OEF/OIF enrollees.

VA recognizes projecting demand for health care services for OEF/OIF Veterans has been challenging because many unknowns will influence the number and type of services that VA will need to provide OEF/OIF enrollees. For example, VA cannot project the duration of the conflict, when OEF/OIF Veterans will be demobilized, or the ultimate total OEF/OIF force strength at this time.

The Honorable Joe Donnelly

Question 1(a): Mr. Secretary, ensuring our Nation's Veterans have access to the health care they earned is clearly a top priority, and the VA budget requested by the President reflects that. However, many Veterans across the country, including in my district, are forced to drive hours each way to get specialty, diagnostic or recurrent care. While the budget does not get into specifics, do you anticipate a considerable amount of funding to go toward enhancing and expanding the health care services provided at some of the smaller VA health clinics?

Response: VHA engages in continuous strategic evaluation of its health care delivery system and expands services based upon analysis of the enrolled Veteran population and the projected demand for health care services. VHA uses access guidelines to achieve one of its primary goals of providing high quality health care to Veterans in their communities.

The primary strategic goal of VISN 11 is to improve access to VA health care for Veterans, and adequate funding is available to accomplish that goal. The VISN strategy is following a dual course of action to improve access by expanding the network of community-based outpatient clinics (CBOC) available for Veterans, and identifying and locating in existing VA medical center (VAMC) and CBOC sites, services used by Veterans.

In Indiana, VISN 11 has reviewed the health care needs of Veterans in the Fort Wayne and South Bend areas and determined that an expanded array of services can be justified in both those cities. As recently announced, VISN 11 will be developing a construction project to expand the ambulatory services at the Fort Wayne VAMC and increase the specialized services on site. At the same time, services will be expanded at the South Bend CBOC site to include specialty care for which Veterans now have to travel to Fort Wayne.

Question 1(b): Also, how will VA determine which clinics and areas should receive expanded or enhanced VA health care services?

Response: Expansion of services is based on local Veteran populations and demand for services. VA has established access guidelines for primary care, acute care, and tertiary care, and VA uses those standards to determine service delivery methods and ensure that access to care is available close to home.

Committee on Veterans' Affairs
Washington, DC
March 23, 2009

Carl Blake
National Legislative Director
Paralyzed Veterans of America
801 18th Street, NW
Washington, DC 20006

Dear Carl:

In reference to our Full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010" on March 10, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 5, 2009.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Committee on Veterans' Affairs
Washington, DC
March 23, 2009

Kerry Baker
Assistant National Legislative Director
Disabled American Veterans
807 Maine Avenue, SW
Washington, DC 20024

Dear Kerry:

In reference to our Full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010" on March 10, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 5, 2009.

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Sincerely,

BOB FILNER
Chairman

Committee on Veterans' Affairs
Washington, DC
March 23, 2009

Dennis Cullinan
National Legislative Director
Veterans of Foreign Wars of the United States
200 Maryland Avenue, NE
Washington, DC 20002–5724

Dear Dennis:

In reference to our Full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010" on March 10, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 5, 2009.

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Sincerely,

BOB FILNER
Chairman

Committee on Veterans' Affairs
Washington, DC
March 23, 2009

Raymond C. Kelley
Legislative Specialist
AMVETS
4647 Forbes Boulevard
Lanham, MD 20706

Dear Ray:

In reference to our Full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010" on March 10, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 5, 2009.

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Sincerely,

BOB FILNER
Chairman

The Independent Budget
Washington, DC
April 30, 2009

Honorable Bob Filner
Chairman
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Filner:

On behalf of *The Independent Budget*, we would like to thank you for the opportunity to present our views on the FY 2010 budget for the Department of Veterans' Affairs (VA). We appreciate the Committee recommending a substantial budget for the VA in its recently submitted Views and Estimates. We also look forward to working with the Committee to move your advance appropriations legislation. Only through cooperation between the veterans' service organizations and the Members of the Committee can we hope to attain a sufficient, timely, and predictable budget for the VA.

We have included with our letter a response to each of the questions that you presented following the hearing on March 10, 2009. Thank you very much.

Sincerely,

Raymond C. Kelley
National Legislative Director
AMVETS

Joseph A. Violante
National Legislative Director
Disabled American Veterans

Carl Blake
National Legislative Director
Paralyzed Veterans of America

Dennis Cullinan
National Legislative Director
Veterans of Foreign Wars of the United States

Question 1: The FY 2010 *Independent Budget* was released prior to the enactment of the American Recovery and Reinvestment Act of 2009 on February 17, 2008. The law provides $1.4 billion in resources for the VA, including funding for Medical Facilities; Grants for State Extended Care Facilities; National Cemetery

Administration; claims processing for VBA; and the Office of Inspector General. In light of the resources newly made available to the VA, do the VSOs recommend any modifications to the FY 2010 *Independent Budget* request?

Response: *The Independent Budget* is pleased that the "American Recovery and Reinvestment Act of 2009" (also the Stimulus bill) included a substantial amount of funding for veterans programs. The legislation identified areas of significant need within the VA system, particularly as it relates to infrastructure needs. While we were disappointed that additional funding was not provided for major and minor construction in the Stimulus bill, we recognize that the funding that was provided will be critically important to the VA going forward. It is also important to note that we do not believe the funding provided in the Stimulus bill should impact our recommendations for the VA. We have been told that the VA intends to spend that funding in the current fiscal year; therefore, the funding needs for FY 2010 will still remain.

Question 2: *The Independent Budget* argues that amounts estimated for medical collections should be fully appropriated and is silent as to how medical collections should be used by the VA. Does you organization support or oppose the current collections program? If opposed, should Congress scrap the current Priority Group system and not differentiate between service-connected and non-service-connected veterans? If you support the current program but believe that these funds should be appropriated, how does your organization specifically propose to spend this nearly $3 billion amount, or 5 percent of current VA medical care budget?

Response: Principally, the co-authors of *The Independent Budget* do not support the current collections program. Historically, the purpose of collections has not had a direct bearing on the utilization of such funds throughout the evolution of what is now the Medical Care Collections Fund (MCCF). When the VA collection authority was initially established in 1986 to seek reimbursement from third-party health insurers, collections were meant to be utilized as a deficit reduction tool. It then evolved into a tool to offset VA's health care budget in 1997, and expanded to become a medical care utilization tool in 1999 by allowing VA to increase cost-sharing on veterans. In doing so however, such funds were supposed to be used to reduce medical care waiting times and to reduce the burden of cost sharing on veterans for medications and prosthetics. In 2003, MCCF was created to consolidate revenue accounts, thus increasing the total amount of collections available to further offset VA's health care budget.

While the purpose and utilization of collections has evolved we continue to hold the belief that collections supplement the cost of providing health care. Veterans' health care should not be dependent upon an uncertain funding mechanism like medical care collections. However, we realize that political considerations will not allow for the policy by which *The Independent Budget* for FY 2010 believes funding for VA health care services should be provided. In the meantime, we cannot openly oppose the use of collections to provide for medical care services so long as the total of appropriated dollars and actual collected dollars meets the funding levels that we believe are necessary to operate the VA health care system.

Moreover, we are not suggesting that we do not believe that medical care collections are "real dollars." It is simply meant to reflect our belief that funding for Department of Veterans Affairs (VA) health care programs should be provided in full with Federally appropriated dollars. Our budget recommendations this year reflect this policy position that we have long supported. The Administration, year-after-year, chooses to include medical care collections as part of its overall funding authority for Medical Services. In the past, the VA did a very poor job of meeting collections estimates that it formulated its operating budget on. We will not deny that in recent years, the VA has done a much better job of meeting its collections estimates. However, we remain concerned about a process that is grounded in so much uncertainty, especially in light of the fact that shortages between what the VA estimated it would collect and what it actually collected have never been funded. As such, we believe that the cost of medical care services should be provided for entirely through direct appropriations.

As to the question about the Priority Group enrollment structure, we do not support any suggestion to abolish this system. The Priority Group system is not simply a tool to distinguish between who pays for their care and who does not. The system also establishes priority for care should there be a funding shortfall that may result in restrictions to care, much like what happened to new Priority Group 8 veterans in 2003. Additionally, the existing Priority Group system establishes varying degrees of care available to veterans, most notably access to nursing home care and other long-term care services.

As for spending the additional funding, we believe that this money could be reinvested in various programs that are part of the Veterans Health Administration (VHA) or the entire VA. First and foremost, we believe that a large portion of the money collected can be devoted to capital investment projects. The VA has not adequately addressed the long list of projects identified by the Capital Asset Realignment for Enhanced Service (CARES) process. Moreover, as explained in the Construction section of *The Independent Budget*, the VA should be reinvesting five to 7 percent in its capital infrastructure each year. However, the VA currently only reinvests about 2 percent.

We also remain concerned that the VA falls well below the requirement for long-term care capacity (defined as average daily census) as mandated by P.L. 106–117, the "Millennium Health Care Act." A portion of the money achieved through medical care collections could be used to correct this deficiency. Additionally, the VA could invest this money in State Extended Care facilities which support the VA long-term care program. The VA could also use these additional resources to address gaps that currently exist. For instance, VA currently offers no assisted living services to any Priority Group of veterans. And yet, this is certainly a model of non-institutional care that can benefit many veterans as well as their spouses. This type of service is also something that the newest generation of disabled veterans is clamoring for. There is also a broad range of community services including expanded home-based care such as homemaker services and attendant care (services not currently authorized) that could be provided with these additional dollars. These services would maximize independence and preclude institutional care for both disabled and aging veterans.

We also believe this money could be used to properly staff the Office of Rural Health so that it can better fulfill its mission. *The Independent Budget* believes that this new office has not lived up to the expectations placed on it. However, the VA has not set this office up for success. It is telling that the VA devoted only $1 million and one new full-time employee (FTE) to this office in FY 2009. This brought the Office of Rural Health up to three FTE. This is wholly unacceptable, particularly given the fact that rural health care access might be the single biggest health care issue facing the VHA.

Finally, we would suggest some of the resources generated through medical care collections could be used to make the VA more competitive in the market for hiring critical staff. The VA is at a significant competitive disadvantage when trying to hiring certain health care professionals. This is particularly true of nurses, rehabilitation specialists, and specialized care doctors.

Question 3: The Administration has vowed to pore over the budgets of every Federal Department and Agency line-by-line to make sure that taxpayer dollars are spent wisely. The Administration has also signaled that veterans' funding will be a high priority. In light of this need for fiscal restraint, which programs and operations of the VA provide the most cost-effective service to veterans and which programs and services do you believe we should look closely at to see if it can be reformed to provide better service at a lower cost?

Response: *The Independent Budget* would like to emphasize our ongoing concern that the biggest factor in creating inefficient spending of resources by the Department of Veterans Affairs (VA) is the late approval of appropriations and insufficient budgets in previous years. As we have pointed out many times, late passage of the VA's appropriations bill has become the rule, not the exception. In fact, in 19 of the previous 22 years, the VA's appropriations bill was not approved prior to the start of the fiscal year on October 1. Moreover, while in the past couple of years Congress has provided very significant increases in resources for the VA, we believe that previous fiscal years were marked by marginal increases and even flat-line budgets. This uncertainty about when and how much funding will be provided hinders the ability of VA officials to efficiently plan and responsibly manage VA health care.

The Independent Budget would also like to point to the management of Medical Care Collections. Once again, while the VA has gotten much better at meeting collections estimates in recent years, in the past collection rates were terrible. Moreover, considering the fact that the operating budget of the VA is based on collections estimates, it is completely unacceptable that even one dollar of a given fiscal year's estimate not be collected, since this has a direct impact on the ability of the VA to provide care. As long as part of the operations of the VA health care system are reliant on uncertain collections outcomes, the system itself will be placed at a disadvantage.

We also believe that the Fee-for-Service program needs to be reevaluated as well. Non-VA purchased care may be provided to eligible veterans from non-VA health care providers when VA medical facilities are incapable of providing necessary care;

when VA medical facilities are geographically inaccessible to a veteran for necessary care; when a medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of care; and for certain specialty examinations to assist VA in adjudicating disability claims.

As you know, many of the veterans' service organizations (VSO) have complained about the application of fee basis care in order to meet the needs of veterans in rural settings. However, this concern can be taken a step further. Veterans eligible for fee basis care are sometimes unable to secure treatment from a community provider because of VA's lower payment, less than full payment, and delayed payment for medical services. In fact, as stated in *The Independent Budget* for FY 2010, we are "especially concerned that service-connected disabled veterans who are authorized to use non-VA care are at times required by the only provider in their community to pay for their care up front." We would encourage the Committee to seriously examine the Fee-for-Service program so as to affect real improvements to this service. With a properly run fee basis care program, the VA can better meet the health care needs of many veterans, particularly those veterans living in rural communities.

As an example of a cost-effective program within the VA, we would point to the operations of the Prosthetics and Sensory Aids program. Because the prosthetics activities of the entire VA are managed through a centralized funding structure, the program's leadership is better able to monitor and adjust the budgetary needs of the service. Over years of budget shortfalls, many of the VA hospitals had been forced to hold down costs by cutting spending. This delayed provision of wheelchairs, artificial limbs, and other prosthetic devices, which was unacceptable. As a result, the VA established a policy that all funds for prosthetics would be controlled from the VA Prosthetic Service in the Central Office and that no prescription for prosthetics would fail to be filled or delayed because of a lack of funds.

Committee on Veterans' Affairs
Washington, DC
March 23, 2009

Paul Sullivan
Executive Director
Veterans for Common Sense
P.O. Box 15514
Washington, DC 20003

Dear Paul:

In reference to our Full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010" on March 10, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 5, 2009.

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Sincerely,

BOB FILNER
Chairman

Committee on Veterans' Affairs
U.S. House of Representatives
Post-Hearing Questions from the Honorable Bob Filner
March 10, 2009
Hearing on the U.S. Department of Veterans Affairs
Budget Request for Fiscal Year 2010

Question: The Administration has vowed to pore over the budgets of every Federal Department and Agency line-by-line to make sure that taxpayer dollars are spent wisely. The Administration has also signaled that veterans' funding will be a high priority. In light of this need for fiscal restraint, which programs and operations of the VA provide the most cost-effective service to veterans and which programs and services do you believe we should look closely at to see if t can be reformed to provide better service at a lower cost?

Response: We are very pleased the Administration has signaled that funding for the Department of Veterans Affairs (VA) is a "high priority."

VCS respectfully disagrees with the implied premise of the question that Congress should limit oversight of VA programs based only on VA's limited ability to measure cost effectiveness.

Here is a description of a meeting 11 years ago that describes how using only the financial cost of a bill or a program to discuss and decide the legitimacy of medical care and benefits for veterans is wrong because it is incomplete:

> *During an advocacy meeting to discuss the "Persian Gulf Veterans Act 1998," a legislative aide told me that the financial cost of providing medical care and benefits to the hundreds of thousands of our ill Gulf War veterans would be prohibitive. Therefore, he said, the legislator opposed the bill due to the high cost—he did not want to spend billions of dollars on health care and disability benefits for our ill Gulf War veterans sickened by multiple toxic exposures during deployment to Southwest Asia during Desert Shield and Desert Storm.*
>
> *I asked the aide if the legislator supported unlimited funding for the military to fight and win wars. The aide quickly responded that the legislator absolutely supported unlimited appropriations for our military, especially during war. During our conversation, we both agreed our number one national security asset is our servicemembers who support and defend our Constitution.*
>
> *I asked the aide this question: If our Nation has an unlimited budget for bullets, bombs, and bayonets for our military, and since care for our veterans is part of the cost of fighting wars, why then do we not have an unlimited budget for hospital beds and disability benefits for our most important national security asset—our disabled veterans who fought in and survived combat?* ***The legislative aide became speechless and then abruptly left the room without answering.***

In addition to our social contract that guides VA to take care of our veterans who gave up the best years of our lives defending our Constitution, Congress should follow the example of the burn unit at the San Antonio Military Medical Center (SAMMC) in Texas.

The highly dedicated and exceptionally motivated medical staff at Brooke Army Medical Center, part of SAMMC, spare no expense treating Iraq and Afghanistan war casualties. Expensive skin grafts are provided immediately without question and without regard to financial cost. Nurses provide 24/7 medical care to each wounded warrior. Medical professionals with expertise evaluating and treating burns are frequently flown to Texas to provide the best available current technology and treatments. In our view, this is the correct policy, as everything possible is done to save lives.

VCS believes VA must have an equal standard—mandatory full funding for VA health care. If we only count the lives lost and funds spent on the battlefield for arms in order to determine the human and financial costs of war, then we are counting only those things that are easily counted, and we are ignoring those items that truly count—the quality of life for disabled veterans (and their families) sent to war in our name who return home, often in great need of assistance.

While VA often suffered from inefficiency, poor leadership, poor training, chronic underfunding, chronic understaffing, complex rules, and adversarial bureaucratic red tape, especially during the last Administration, VA still usually provides high-quality assistance, albeit sometimes with significant delays. VCS believes manda-

tory full funding, strong leadership, and streamlined policies will assist VA with evolving and improving the delivery of health care and benefits to our veterans. VCS thanks VA for continuing to move forward under the current Administration's new leaders and additional funding.

VCS is not familiar with every program administered by VA, so our answer about specific VA programs is limited to the areas with which we are most familiar. Here is a list of a seven areas VCS finds critical. Many of these need significant and immediate improvement to meet a sustained increased in demand caused by the current economic crisis and the continuation of two simultaneous wars in Iraq and Afghanistan:

1. **Medical Research.** At a time of unprecedented demand for health care related to highly toxic dioxin (agent orange) exposures associated with the Vietnam War, VA has a moral and legal obligation to fund scientific research immediately in order to better understand the adverse health outcomes of toxic exposures and to develop desperately needed treatments for veterans and our families. Our Vietnam War and Gulf War veterans fought valiantly for answers and health care after their return, yet VA took decades to respond adequately. While research for toxic exposures during those wars remains important, VA must immediately begin pro-actively collecting data, monitoring veterans, and researching the impact of Iraq War and Afghanistan War toxic exposures, starting with toxic exposures surrounding the enormous burn pit near Balad, Iraq. By starting medical research now, we have a rare window of opportunity to avoid prior VA mistakes that caused delays in medical care and benefits for our Atomic veterans, Vietnam War veterans, and Gulf War veterans.
2. **Benefits Delivery at Discharge (BDD).** This new and expanding program is highly successful and efficient because it places Veterans Benefits Administration (VBA) employees at military installations who can expeditiously collect and review service and medical records before discharge, thus saving VA staff months, and of10 years, of searching for misplaced military records, especially for post traumatic stress disorder claims. The government Accountability Office (GAO) and several Congressional hearings have validated the success of this essential program. Therefore, VCS recommends significantly expanding this essential program so that as many servicemembers as possible have the opportunity to participate in BDD, especially National Guard and Reserve servicemembers who are usually excluded. During the March 10, 2009, hearing, VCS provided Congress with our modest proposal to expand VA's BDD and bring VA to our veterans with one-stop shopping during and after military service.
3. **Readjustment Counseling Service's "Vet Centers."** This seasoned and expanding program is also highly successful and efficient because it places Veterans Health Administration (VHA) mental health professionals in store front locations easily accessed by deployed veterans seeking readjustment counseling. Several GAO reports about Vet Centers have repeatedly shown this program to be among the most successful entry points for veterans seeking mental health care services. The low overhead of small store front offices makes these points of care highly cost-effective. Therefore, VCS recommends significantly expanding this program so that more veterans can utilize equally valuable Vet Center counseling in addition to VHA out-patient and in-patient care provided at VHA medical centers. VCS advocates placing Vet Centers on or near military installations to meet the mental health care crisis among our returning servicemembers as soon as possible, when treatment is least expensive and most effective. Vet Centers should also be expanded to provide counseling for servicemembers' and veterans' families.
4. **Mental Health.** This includes VA's Suicide Prevention programs, anti-stigma programs, and the National Center for Post Traumatic Stress Disorder (NCPTSD). Specifically, VA has not provided consistent and timely oversight of VA's Mental Health Strategic Plan. Although there are some pilot programs, VA has yet to fully implement outreach and anti-stigma campaigns. On a positive note, VA is now working closely with DoD on the issue of suicide prevention. Unfortunately, while prior VA leaders have often attempted to under-fund the NCPTSD during a time of record demand for VA mental health care, we are pleased that Congress consistently provided more funds for NCPTSD than requested by the Administration. Based on VA's internal reports documenting increased health care use, VCS estimates as many as 400,000 total new mental health patients from the Iraq and Afghanistan wars by the end of 2013, out

of one million estimated new VA patients from the two wars. Therefore, VCS recommends increasing all facets of VA's mental health care programs to develop processes designed at early identification, intervention, and treatment of war-related mental health conditions. We believe ramping up programs now for existing and returning servicemembers, when treatment is least expensive and most effective, is crucial. Increases should be made for Suicide Prevention Coordinators and Local Recovery Coordinators to make sure there is a coordinated effort between VA's many different mental health programs.

5. **Office of the Actuary.** This office could and should provide VA leaders with far greater amounts of accurate, consistent, transparent, and timely information for use in VA planning, policy development, and long-term budgeting. A critical role of VA's Office of the Actuary is to collaborate with other federal agencies, especially the Department of Defense (DoD) and the Census Bureau, on the collection of data on veterans for planning purposes. However, due to a lack of robust and timely data for several years, VA leaders made several critical decisions without complete information, resulting in dramatic multi-billion dollar budget shortfalls. Poor data played a key role in the large numbers of veteran patients and claimants waiting unreasonable amounts of time for VA assistance. Therefore, VCS recommends that VA's Office of the Actuary be significantly expanded to include more DoD, Census Bureau, VHA, and VBA subject matter experts. VHA requires better data to monitor and prepare for health care use demand. Similarly, VBA requires better data to monitor and prepare for disability claim activity. VHA and VBA must work more closely together to identify veterans using VHA yet not VBA, and vice-versa, in order to understand what drives health care and claim demand. At a time when Congress is ready to provide VHA with advanced funding (and possibly mandatory full funding), Congress should take a thorough and deliberate look at VA's limited ability to prepare for and use the money Congress appropriates. This becomes even more vital with the extension of free medical care, from 2 years to five years, for deployed Iraq and Afghanistan war veterans.
6. **Office of Seamless Transition (STO) and related offices.** These offices perform vital roles within VA assisting veterans, collecting data, and developing policies to assist servicemembers with seamlessly transitioning from the military into civilian life as veterans. The lack of single office with a single leader and streamlined processes have significantly hampered VA's ability to provide prompt and high-quality services to the tidal wave of returning Iraq and Afghanistan war veterans. The lack of consistent data about individual servicemembers (such as service and medical records) as well as data about the entire cohort of all servicemembers (that would include demographic and deployment data for planning purposes) has created significant challenges in meeting the needs of our returning veterans in an efficient manner. The office would realize a much higher effectiveness if it was fully staffed, fully funded, and led by an executive who interacted with DoD and the Department of Labor. VA is currently unable to meet the needs of the existing one million current war veterans, and the situation may deteriorate significantly as the remaining one million servicemembers who have deployed or are deployed prepare for discharge. Therefore, VCS recommends that VA develop a more robust and efficient STO to meet the current and growing need of our returning Iraq and Afghanistan war veterans.
7. **Information Technology (IT).** This VA office provides vital hardware, software, and communications within VA and to the outside world essential to the success of nearly every VA program—from applications, claims processing, medical records, e-mail, and the Internet, to name a few. VCS recommends modernizing VA's computer equipment and computer programs as well as using new technologies to assist veterans and beneficiaries with learning about and applying for VA benefits and so that VA is more transparent and interactive for veterans, family members, VA staff, journalists, elected officials, and the public. VCS lists VA's IT efforts based on recent challenges veterans faced applying for the new Post-9/11 GI Bill education benefits, an outstanding VA program we strongly support.

Committee on Veterans' Affairs
Washington, DC
March 23, 2009

Paul Rieckhoff
Executive Director and Founder
Iraq and Afghanistan Veterans of America
770 Broadway, 2nd Floor
New York, NY 10003

Dear Paul:

In reference to our Full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010" on March 10, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 5, 2009.

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Sincerely,

BOB FILNER
Chairman

Response from Iraq and Afghanistan Veterans of America

Committee on Veterans' Affairs
U.S. House of Representatives

Post-Hearing Questions from the Honorable Bob Filner

March 10, 2009

Hearing on the U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2010

Question: The Administration has vowed to pore over the budget of every Federal Department and Agency line-by-line to make sure that taxpayer dollars are spent wisely. The Administration has also signaled that veterans' funding will be a high priority. In light of this need for fiscal restraint, which programs and operations of the VA provide the most cost-effective service to veterans and which programs and services do you believe we should look closely at to see if it can be reformed to provide better service at a lower cost?

Response: Thank you for the opportunity to address this issue. IAVA believes that the introduction of OIF/OEF outreach coordinators is a highly successful and cost-efficient program. These coordinators, themselves veterans of Iraq and Afghanistan, are for many returning servicemembers the first point of contact with the VA. They provide an invaluable personal connection that helps overcome the many bureaucratic hurdles facing those seeking out support from the VA. These outreach coordinators make up a crucial element of the excellent Vet Centers, which have been proven for decades to be a low-cost, high-impact answer to the mental health needs of combat veterans. We wholeheartedly support the continuation and expansion of this and other VA outreach programs.

In our legislative agenda, IAVA has called for a reformed and streamlined VA budget. If the VA were to know their health care budget a year in advance, we would see an end to the waste and inefficiency brought about by poor planning. For instance, VA hospitals frequently delay needed repairs while they are shifting funding to other accounts to cover shortfalls. In the meantime, many of those infrastructure problems are worsening and growing more expensive to repair. When hospitals are operating under a continuing budget resolution, they are forced to ration care, delaying appointments while patients get sicker and their care becomes more expensive. No one at the VA wants these problems to persist, but without action by Con-

gress and the President to appropriate VA funding in advance, these inefficiencies will continue to unabated.

Committee on Veterans' Affairs
Washington, DC
March 23, 2009

Richard F. Weidman
Executive Director for Policy and Government Affairs
Vietnam Veterans of American
8605 Cameron Street, Suite 400
Silver Spring, MD 20910

Dear Rick:

In reference to our Full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010" on March 10, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 5, 2009.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Vietnam Veterans of America
Silver Spring, MD
May 18, 2009

The Honorable Bob Filner
Chairman
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC.

Dear Chairman Filner:

In response to your questions following the hearing on the Budget Request for FY 2010 for the Department of Veterans Affairs, Vietnam Veterans of America (VVA) offers the following:

Which programs and operations of the VA provide the most cost-effective service?

- The *Vet Centers*, since their inception, are the most well-run—and cost-effective—entities within the VA. They are the only VA service that can treat families as well as the veteran.
- Preventive health programs run at different VA Medical Centers certainly are cost-effective: they prevent far more costlier treatments for health conditions that develop later on. We want to cite the programs run by Dr. Lawrence Deyton and his staff at the VA Central Office, and the programs run by Dr. Victor Wahby, both of which help reduce illness.

Which programs and operations need to be reformed to provide better, less costly service?

- One out of ten VA health care dollars are expended for so-called "fee-basis" care for services that either a VAMC or CBOC are unable to provide in a timely manner or can be performed locally and save a veteran, usually living in a rural or remote area, hours of travel. In an attempt to get a handle on this, the VA

is engaged in a pilot program in four VISNs called "Project HERO." This endeavor is worth an oversight hearing. We believe it is resulting in less health care for more money.

- Pharmacy Service—the formulary is much too restrictive (and much more restrictive than either DoD or Medicare) on the theory that they are going to save a lot of money on medications. However, they often save pennies and spend big dollars because they scrimp on medications that could have prevented very costly acute care in-patient stays. The method of evaluating pharmacists needs to be dramatically changed from how much in "savings" they produce in comparison with the national average (which becomes a "race to the bottom") to how much did what they do in cooperation with the medical staff at a given VA Medical Center to promote healing and wellness, and reduce in-patient acute care stays in the hospital, and/or to prevent secondary conditions from developing. VVA will be coming out with a paper on this issue in the next 2 months.
- The VA needs to develop a comprehensive "wellness program" that brings together nutrition, the "get Fit for Life" program, the "MOVE' program, the "My Health-e-Vet" program, and other initiatives into an integrated model that is directly linked into primary care at each VAMC, OC, or CBOC. Only by putting a major and imaginative comprehensive effort together can VA reduce incidence and severity of chronic diseases and create a sustainable model for VA health care.

Mr. Chairman, VVA hopes these answers prove to be useful to you in your deliberations. Again I wish to thank you for allowing VVA to present our views to you on these vital veterans' issues.

Sincerely,

Richard F. Weidman
Executive Director for Policy and Government Affairs

Committee on Veterans' Affairs
Washington, DC.
March 23, 2009

Steve Robertson
The American Legion
Director, National Legislative Commission
1608 K Street, NW
Washington, DC 20006

Dear Steve:

In reference to our Full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010" on March 10, 2009, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 5, 2009.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

The American Legion
Washington, DC.
March 26, 2009

Honorable Bob Filner, Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon Office Building
Washington, DC 20515–6335

Dear Chairman Filner:

Thank you again for allowing The American Legion to testify at the March 10 hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2010." This letter is in response to your Post-Hearing Question:

> ***The Administration has vowed to pore over the budgets of every Federal Department and Agency line-by-line to make sure that taxpayer dollars are spent wisely. The Administration has also signaled that veterans' funding will be a high priority. In light of this need for fiscal restraint, which programs and operations of the VA provide the most cost-effective service to veterans and which programs and services do you believe we should look closely at to see if it can be reformed to provide better service at a lower cost?***

Mr. Chairman, with all due respect, The American Legion has worked closely with both the Department of Veterans Affairs and Congress for many, many years. Clearly, The American Legion has never hesitated to praise programs and operations that provide the most cost-effective service to veterans nor identified programs and operations that needed immediate attention and reform.

Each and every program and operation is an earned benefit due to honorable military service. Fortunately, this grateful Nation continues to strive toward meeting the needs of America's veterans and their family members. Without question, the Veterans Health Administration (VHA) continues to serve as the role model for the rest of the health care industry. Its achievements in that industry truly illustrate a solid return on investment dollars. From the electronic medical records to the medical research to the patient safety to the customer satisfaction, VHA is peerless within and outside the Federal Government.

The American Legion still believes there is much room for improvement in two significant areas within VHA, that of mental health and long-term care. The American Legion believes that due to the high cost of these specialized services, they have been neglected by VHA leadership. During the Capital Assets Realignment for Enhanced Services (CARES) process, VA did not address these two critical areas of concentration. Therefore, a situation now exists where there exists a growing demand for both mental health care services and long-term care that VHA is not properly prepared to meet and the veterans' community is underserved.

With the newest generation of wartime veterans and the aging veterans' community turning to VHA for timely access to quality health care, both of these areas of specialized service need to be closely monitored and addressed via congressional oversight. "Take a number and we'll get back to you" is absolutely unacceptable.

The challenges facing the Veterans Benefits Administration remain although The American Legion remains optimistic. Newly hired claims adjudicators must be properly trained and, more importantly, retained. VBA leadership must develop an aggressive short- and long-term strategy to recruit, train, and retain proficient claims processors and adjudicators. The American Legion continues to support the recruitment, training, and retention of service-connected disabled veterans in this career field, especially those going through VA's Vocational Rehabilitation Program.

With regards to construction projects, both major and minor, The American Legion supported many of the CARES recommendations, but has waited patiently for the aggressive funding to put those recommendations into structures.

State Extended Care Facilities Grant Program remains a valuable resource for the Department of Veterans Affairs; however, The American Legion still believes VA should increase the amount of per diem paid to these facilities, especially in light of the current economic downturn and the increased fiscal pressures state legislatures continue to face.

The National Cemetery Administration continues to provide the veterans' community with cemeteries that reflect the appreciation of a grateful Nation toward those that served in the Armed Forces and their family members.

Thank you for your continued commitment to America's veterans and their families.

Sincerely,

Steve Robertson, Director
National Legislative Commission

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
20	Anchorage	AK	At Large	Renovate Warehouse Space to Meet VA Requirements	$300,000	$—	$300,000
20	Anchorage	AK	At Large	Renovate Space for Clinical Programs, Building 1.	$200,000	$—	$200,000
***NCA**	***Fort Richardson***	***AK***	***At Large***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
***NCA**	***Sitka***	***AK***	***At Large***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
				Total—Alaska	**$600,000**	**$—**	**$600,000**
7	Montgomery	AL	3	Renovate Inpatient Area to be Residential Environment	$2,500,000	$—	$2,500,000
7	Montgomery	AL	3	Renovate and Modernize the EKG Unit	$220,000	$—	$220,000
7	Montgomery	AL	3	Upgrade Sprinkler and Fire Alarm System	$164,000	$—	$164,000
7	Montgomery	AL	3	Modernize Nursing Home	$1,783,513	$283,513	$1,500,000
***7**	***Montgomery***	***AL***	***3***	***Renovate Restrooms with water conservation measures***	***$998,330***	***$90,800***	***$907,530***
7	Tuscaloosa	AL	7	Upgrade Cabling and Telephone Closets	$4,980,000	$480,000	$4,500,000
7	Birmingham	AL	7	Upgrade Research Labs 4 & 5 Floors	$925,000	$—	$925,000

7	Birmingham	AL	7	Renovate Critical Care Unit	$829,927	$129,927	$700,000
7	Tuscaloosa	AL	7	Modernize Halls and Floors	$500,000	$—	$500,000
***7**	***Tuscaloosa***	***AL***	***7***	***Replace Windows***	***$905,000***	***$—***	***$905,000***
***7**	***Birmingham***	***AL***	***7***	***Replace Windows***	***$1,512,907***	***$126,988***	***$1,385,919***
7	Tuscaloosa	AL	7	Replace Elevators	$705,000	$54,000	$651,000
7	Birmingham	AL	7	Renovate Surgical Intensive Care Unit	$1,700,000	$200,000	$1,500,000
7	Tuscaloosa	AL	7	Upgrade Quality Management and Pharmacy	$1,072,041	$200,000	$872,041
				Total—Alabama	**$18,795,718**	**$1,565,228**	**$17,230,490**
16	North Little Rock	AR	2	Electrical Upgrade in Building 102 for facility Computer Center	$750,000	$—	$750,000
***16**	***North Little Rock***	***AR***	***2***	***Replace Boiler Plant***	***$3,200,000***	***$—***	***$3,200,000***
16	North Little Rock	AR	2	Renovate/Repair Elevators	$4,000,000	$—	$4,000,000
***16**	***Little Rock***	***AR***	***2***	***Replace air Handling Equipment, Phase 2***	***$4,000,000***	***$—***	***$4,000,000***
16	Fayetteville	AR	3	Pave Gravel Parking Lot	$98,000	$—	$98,000
16	Fayetteville	AR	3	Construct Security Control Center	$252,000	$—	$252,000
16	Fayetteville	AR	3	Upgrade Lightning Protection Systems	$190,000	$—	$190,000
16	Fayetteville	AR	3	Repair/Replace Existing Columns in Building 1, 2, 3, and 4	$390,000	$—	$390,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
***16**	***Fayetteville***	***AR***	***3***	***Upgrade Air Conditioning System in Building 2 for Dietetics***	***$1,500,000***	***$—***	***$1,500,000***
				Total—Arkansas	**$14,380,000**	**$—**	**$14,380,000**
18	Prescott	AZ	1	Fire and Life Safety/Security Improvements	$546,125	$76,125	$470,000
18	Prescott	AZ	1	Repair Building 14 Exterior	$750,000	$—	$750,000
18	Prescott	AZ	1	Replace Elevator Controls, Phase 1	$785,000	$110,000	$675,000
18	Prescott	AZ	1	Upgrade/Repair Elevators in Building 14 and 107	$720,000	$—	$720,000
18	Prescott	AZ	1	Repair Foundation and Drainage System for Building	$750,000	$—	$750,000
18	Prescott	AZ	1	Upgrade/Replace Fire Alarm System	$1,400,000	$—	$1,400,000
18	Prescott	AZ	1	Repair/Replace Roofing Building 17	$450,000	$10,000	$440,000
***18**	***Prescott***	***AZ***	***1***	***Implement Selected Conservation Measures[1]***	***$1,142,857***	***$—***	***$1,142,857***
***18**	***Prescott***	***AZ***	***1***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***

18	***Phoenix***	***AZ***	***4***	***Replace/Upgrade Patient Ward Windows and Doors in Building 1***	***$600,000***	***$—***	***$600,000***
18	Phoenix	AZ	4	Replace Building 1 and 16 Drain, Sewer, and Water Lines, Phase 5	$2,200,000	$200,000	$2,000,000
18	Phoenix	AZ	4	Automatic Transfer Switch Replacement	$1,600,000	$—	$1,600,000
****18***	***Phoenix***	***AZ***	***4***	***Renovate Supply, Processing and Distribution to provide for proper humidity control***	***$750,000***	***$—***	***$750,000***
18	Phoenix	AZ	4	Renovate 6th Floor for Motivating Overweight Veterans Everywhere (MOVE) Program	$600,000	$—	$600,000
18	Phoenix	AZ	4	Bldg 1 & 16 Drain/Water Sewer	$750,000	$—	$75,000
18	Phoenix	AZ	4	Replace/Upgrade Electrical Distribution Equipment, Phase 4	$2,750,000	$—	$275,000
18	Phoenix	AZ	4	Provide Backup Power per Regulation, Phase 3	$750,000	$—	$75,000
18	Phoenix	AZ	4	Replace/Upgrade Electrical Distribution System, Phase 3	$3,500,000	$750,000	$2,750,000
18	Phoenix	AZ	4	Environment of Care Corrections	$550,000	$—	$550,000
****18***	***Phoenix***	***AZ***	***4***	***Implement Selected Conservation Measures[1]***	***$1,142,857***	***$—***	***$1,142,857***
18	Tucson	AZ	7	Fire and Life Safety Corrections	$757,950	$257,950	$500,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
18	Tucson	AZ	7	Install Fire Sprinklers in Building 3	$407,434	$57,434	$350,000
18	Tucson	AZ	7	Renovate Restrooms for Patient Privacy in Building 60	$750,000	$—	$750,000
18	Tucson	AZ	7	Renovate Building 60 for Polytrauma Staff and Programs	$350,000	$—	$350,000
***18**	***Tucson***	***AZ***	***7***	***Implement Selected Conservation Measures[1]***	***$1,142,857***	***$—***	***$1,142,857***
				Total—Arizona	**$25,155,080**	**$1,461,509**	**$19,868,571**
***21**	***Sacramento (Mather)***	***CA***	***3***	***Evaluate Feasibility of Direct Geothermal[1]***	***$342,857***	***$—***	***$342,857***
***21**	***Sacramento (Mather)***	***CA***	***3***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
***21**	***Sacramento (McClellan)***	***CA***	***3***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
***21**	***Vallejo***	***CA***	***7***	***Evaluate Feasibility of Direct Geothermal[1]***	***$342,857***	***$—***	***$342,857***
***21**	***Martinez (OPC)***	***CA***	***7***	***Evaluate Feasibility of Direct Geothermal[1]***	***$342,857***	***$—***	***$342,857***

21	***Vallejo***	***CA***	***7***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
****21***	***Martinez***	***CA***	***7***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
****21***	***San Francisco***	***CA***	***8***	***Renovate Building 9 and 10 to correct Heating Deficiencies***	***$400,000***	***$—***	***$400,000***
21	San Francisco	CA	8	Replace/Upgrade Building 8 Elevator	$425,000	$—	$425,000
21	San Francisco	CA	8	Campus Wide Elevator Study	$225,000	$—	$225,000
21	San Francisco	CA	8	Repair/Upgrade Water Tower Utility System	$2,000,000	$—	$2,000,000
21	San Francisco	CA	8	Review American Disability Act Compliance, and Pedestrian & Traffic Flow	$365,000	$—	$365,000
21	Livermore	CA	10	Renovate for the Installation of New Patient Lift Equipment	$479,000	$—	$479,000
21	Livermore	CA	10	Renovate Building 26 Water Tank	$650,099	$—	$650,099
21	Livermore	CA	10	Repair Below Grade Storm Drainage	$25,000	$4,026	$20,974
21	Livermore	CA	10	Remediate Asbestos from Building Exterior Walls and Lead Paint from Bridge	$250,099	$—	$250,099
21	San Francisco	CA	10	Renovate for Pharmacy Relocation	$2,000,000	$—	$2,000,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
21	San Francisco	CA	10	Renovate for Parking Behind Building 11	$300,000	$—	$300,000
21	San Francisco	CA	10	Install Utilities Behind Building 11	$425,000	$—	$425,000
***21**	***San Francisco***	***CA***	***10***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$410,000***
***21**	***San Francisco***	***CA***	***10***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
***21**	***San Francisco***	***CA***	***10***	***Evaluate Feasibility of Direct Geothermal[1]***	***$342,857***	***$—***	***$342,857***
***NCA**	***Dixon***	***CA***	***10***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
***NCA**	***San Bruno***	***CA***	***12***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
21	Martinez	CA	13	Renovate/Update Fire Sprinkler and Life Safety Compliance, Building 29	$200,000	$—	$200,000
21	Palo Alto	CA	14	Renovate for Life Safety and Egress Compliance per Regulation	$30,000	$10,942	$19,058

21	Palo Alto	CA	14	Review Facility for Fire and Life Safety Compliance	$10,800	$—	$10,800
21	Palo Alto	CA	14	Install Fire Sprinkler Control Valve Signs	$15,099	$—	$15,099
21	Palo Alto	CA	14	Renovate for the Installation of New Patient Lift Equipment	$508,000	$—	$508,000
21	Menlo Park	CA	14	Repair/Upgrade Loop Road, Phase 1A	$929,000	$—	$929,000
***21**	***Menlo Park**	***CA**	***14**	***Replace Air Handlers, Building 322**	***$230,000**	***$—**	***$230,000**
21	Menlo Park	CA	14	Renovate for Auto Shop and Engineering Storage	$650,099	$—	$150,000
***21**	***Menlo Park**	***CA**	***14**	***Replace Exhaust Units**	***$2,000,099**	***$—**	***$2,000,099**
21	Menlo Park	CA	14	Loop Road—Design, Phase 3	$335,975	$—	$335,975
21	Palo Alto	CA	14	Demolition of Building 23	$660,000	$—	$660,000
21	Menlo Park	CA	14	Expand Storm Drains	$1,813,740	$613,740	$1,200,000
21	Palo Alto	CA	14	Replace Roof	$131,084	$—	$131,084
21	Menlo Park	CA	14	Renovate Interior Floor Covering for all buildings	$485,520	$—	$485,520
***21**	***Menlo Park**	***CA**	***14**	***Replace Condensing Units**	***$384,672**	***$—**	***$384,672**
***21**	***Palo Alto**	***CA**	***14**	***Renovate Interior Lighting**	***$249,854**	***$—**	***$249,854**
21	Palo Alto	CA	14	Replace Vinyl Floor Covering	$75,000	$—	$75,000
***21**	***Palo Alto**	***CA**	***14**	***Renovation of Exterior Windows**	***$4,728**	***$—**	***$4,728**

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
21	Menlo Park	CA	14	Loop Road, Phase 1B Construction Parking Lot	$1,700,000	$—	$1,700,000
***21**	***Menlo Park***	***CA***	***14***	***Replace Exhaust Units, Building 324, Phase 2***	***$1,000,099***	***$—***	***$1,000,099***
21	Menlo Park	CA	14	Loop Road, Phase 2 Road and Parking Construction	$2,800,000	$—	$2,800,000
21	Palo Alto	CA	14	Demolition of Building 23	$350,099	$—	$350,099
21	Palo Alto	CA	14	Renovate Clinic B Bathrooms for American Disability Act Compliance	$250,000	$—	$250,000
21	Palo Alto	CA	14	Renovate for 64-slice CT & Relocate Ultrasound	$800,099	$50,099	$750,000
***21**	***Menlo Park***	***CA***	***14***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
***21**	***Seaside***	***CA***	***17***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
21	Fresno	CA	20	Remediate all known asbestos on station	$2,200,000	$—	$2,200,000
***21**	***Fresno***	***CA***	***20***	***Replace Steam Boilers***	***$1,570,000***	***$—***	***$1,570,000***
***21**	***Fresno***	***CA***	***20***	***Replace Cooling Tower 1 & 2***	***$1,600,000***	***$—***	***$1,600,000***

21	***Fresno***	***CA***	***20***	***Replace Heating, Ventilation and Air Conditioning, Buildings 10, 11, 12, 13, 14***	***$2,750,000***	***$—***	***$2,750,000***
21	Fresno	CA	20	Repairs/ Replace Sidewalks	$1,100,000	$—	$1,100,000
21	Fresno	CA	20	Repair/Upgrade Sidewalks and Parking	$1,900,000	$—	$1,900,000
****22***	***Sepulveda***	***CA***	***27***	***Replace Heating, Ventilation and Air Conditioning System for Building B103, Animal Research***	***$1,125,000***	***$—***	***$1,125,000***
22	Sepulveda	CA	27	Repair Roads and Parking, Phase 1	$1,113,919	$—	$1,113,919
22	Sepulveda	CA	27	Repair Irrigation System	$881,000	$—	$881,000
****22***	***Sepulveda (ACC)***	***CA***	***27***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
****22***	***Sepulveda (Vet Center)***	***CA***	***27***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
22	W. Los Angeles	CA	30	Renovate Operating Rooms, Building 500	$1,553,500	$—	$1,553,500
22	W. Los Angeles	CA	30	Replace Roofs Building 218 and Building 507	$1,050,000	$—	$1,050,000
22	W. Los Angeles	CA	30	Renovate Patient Bathrooms for Handicap Access	$1,175,000	$—	$1,175,000
22	W. Los Angeles	CA	30	Renovate Nuclear Medicine for USP–823 Compliance	$693,200	$—	$693,200

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
22	W. Los Angeles	CA	30	Renovate to provide adequate drainage at Loading Dock, Building 508	$722,000	$—	$722,000
22	W. Los Angeles	CA	30	Renovate Building 158, various systems	$3,025,000	$—	$3,025,000
22	W. Los Angeles	CA	30	Replace Nurse Call System, Building 500	$1,100,000	$—	$1,100,000
***22**	***W. Los Angeles***	***CA***	***30***	***Retrofit Steam Piping, North Campus Phase 6***	***$1,225,000***	***$—***	***$1,225,000***
22	W. Los Angeles	CA	30	Renovate Radiology/Nuclear Medicine, Building 500	$1,035,390	$—	$1,035,390
22	W. Los Angeles	CA	30	Retrofit Sewer System for Main Hospital Building, Phase 4	$1,792,000	$—	$1,792,000
22	W. Los Angeles	CA	30	Retrofit Sewer System for Main Hospital Building, Phase 5	$1,792,000	$—	$1,792,000
22	W. Los Angeles	CA	30	Replace Galvanized Piping in Building 212	$1,493,100	$—	$1,493,100
***22**	***W. Los Angeles***	***CA***	***30***	***Renovate Restrooms and Correct Accessibility Deficiencies***	***$1,230,000***	***$—***	***$1,230,000***
22	W. Los Angeles	CA	30	Retrofit Sewer System for Main Hospital, Phase 6	$1,792,000	$—	$1,792,000

22	***Los Angeles***	***CA***	***30***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
****NCA***	***Los Angeles***	***CA***	***30***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
22	Loma Linda	CA	41	Renovate Isolation Rooms	$1,500,000	$—	$1,500,000
22	Loma Linda	CA	41	Renovate Nursing Home Care Unit	$600,000	$—	$600,000
22	Loma Linda	CA	41	Renovate Laboratory	$1,300,000	$—	$1,300,000
22	Loma Linda	CA	41	Purchase Additional Emergency Generator to meet load requirements	$5,000,000	$—	$5,000,000
****NCA***	***Riverside***	***CA***	***44***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
22	Long Beach	CA	46	Replace/Repair Main Sewer Line	$2,000,000	$—	$2,000,000
22	Long Beach	CA	46	Renovate Spinal Cord Injury Unit	$500,000	$—	$500,000
22	Long Beach	CA	46	Renovate Interior Finishes, Building 126	$800,000	$—	$800,000
22	Long Beach	CA	46	Site Install Emergency Management Generator	$5,500,000	$—	$5,500,000
22	Long Beach	CA	46	Renovate/Relocate Gait Lab	$1,100,000	$—	$1,100,000
22	Long Beach	CA	46	Replace Electrical Equipment in Building 126, Phase 2	$2,200,000	$—	$2,200,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
22	Long Beach	CA	46	Replace Sanitation Piping, Phase 2, Building 216	$2,000,000	$—	$2,000,000
22	Long Beach	CA	46	Repair/Replace Fire Pump System	$165,000	$—	$165,000
22	Long Beach	CA	46	Repair/Resurface Roads and Parking, Phase 1	$3,000,000	$—	$3,000,000
***NCA**	***San Diego***	***CA***	***52***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
***22**	***San Diego***	***CA***	***53***	***Upgrade Supply, Processing and Distribution Heating, Ventilation and Air Conditioning Systems***	***$835,000***	***$—***	***$835,000***
***22**	***San Diego***	***CA***	***53***	***Upgrade Heating, Ventilation and Air Conditioning for Operating Rooms***	***$2,125,000***	***$—***	***$2,125,000***
22	San Diego	CA	53	Renovate Emergency Room	$2,022,402	$—	$2,022,402
22	San Diego	CA	53	Emergency Generator Switchboard	$2,275,000	$—	$2,275,000
22	San Diego	CA	53	Renovate/Expand Prosthetics	$150,000	$—	$150,000
22	San Diego	CA	53	Renovate administrative space for Social Work and OEF/OIF	$2,150,000	$—	$2,150,000

22	***San Diego***	***CA***	***53***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
				Total—California	**$93,880,105**	**$678,807**	**$92,701,199**
19	***Denver***	***CO***	***1***	***Repair/Upgrade Heating, Ventilation and Air Conditioning in Sub-Basement of Building 1***	***$600,000***	***$55,000***	***$545,000***
19	***Denver***	***CO***	***1***	***Repair/Replace Heating, Ventilation and Air Conditioning Components in Buildings 19 and 21***	***$750,000***	***$70,000***	***$680,000***
19	Denver	CO	1	Replace Piping in Building 1	$750,000	$70,000	$680,000
19	Denver	CO	1	Replace/Upgrade Exterior Finishes and Windows	$660,000	$60,000	$600,000
19	***Denver***	***CO***	***1***	***Improve Heating, Ventilation and Air Conditioning System for Energy Reduction***	***$550,000***	***$50,000***	***$500,000***
19	***Denver***	***CO***	***1***	***Replace/Upgrade Heating Piping in Building 1***	***$1,355,000***	***$55,000***	***$1,300,000***
19	***Denver***	***CO***	***1***	***Repair Steam System Building 1***	***$387,000***	***$37,000***	***$350,000***
19	Grand Junction	CO	3	Replace Site Underground Electrical Feeds, Phase 2	$750,000	$75,000	$675,000
19	***Grand Junction***	***CO***	***3***	***Replace Air Handling Unit***	***$750,000***	***$70,000***	***$680,000***
19	***Grand Junction***	***CO***	***3***	***Replace Air Handling Unit, Building 5***	***$750,000***	***$75,000***	***$675,000***

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
19	Grand Junction	CO	3	Renovate for Employee Locker Rooms and Patient/Visitor Restrooms	$750,000	$75,000	$675,000
****19***	***Grand Junction***	***CO***	***3***	***Install Solar Photovoltaic Array System, Phase 1***	***$750,000***	***$75,000***	***$675,000***
				Total—Colorado	**$8,802,000**	**$767,000**	**$8,035,000**
1	Newington	CT	1	Correct Life Safety Deficiencies	$557,000	$—	$557,000
1	Newington	CT	1	Repair and Replace Roofs, Phase 3	$732,075	$—	$732,075
****1***	***West Haven***	***CT***	***3***	***Repair and Replace the Chilled Water Insulation***	***$1,087,000***	***$—***	***$1,087,000***
1	West Haven	CT	3	Renovate for Construction of Semi-Private and Private Inpatient Units	$8,841,000	$1,098,000	$7,743,000
				Total—Connecticut	**$11,217,075**	**$1,098,000**	**$10,119,075**
****5***	***Washington***	***DC***	***At Large***	***Replace Chiller in Main Hospital***	***$2,500,000***	***$—***	***$2,500,000***
5	Washington	DC	At Large	Renovate Pharmacy	$3,000,000	$—	$3,000,000
5	Washington	DC	At Large	Renovate Area for Installation of Cat Scanner	$560,000	$—	$560,000
5	Washington	DC	At Large	Renovate Radiology	$3,250,000	$—	$3,250,000

5	Washington	DC	At Large	Upgrade Dental Area	$1,000,000	$—	$1,000,000
5	Washington	DC	At Large	Renovate the Research Animal Facility	$750,000	$—	$750,000
5	Washington	DC	At Large	Replace the Sprinkler System	$1,000,000	$—	$1,000,000
***5**	***Washington***	***DC***	***At Large***	***Implement Selected Conservation Measures[1]***	***$3,333,333***	***$—***	***$3,333,333***
				Total—District of Columbia	**$15,393,333**	**$—**	**$5,393,333**
***4**	***Wilmington***	***DE***	***At Large***	***Upgrade and Replace the Heating, Ventilation and Air Conditioning***	***$2,200,000***	***$—***	***$2,200,000***
4	Wilmington	DE	At Large	Upgrade Secondary Electrical Distribution System	$2,750,000	$—	$2,750,000
4	Wilmington	DE	At Large	Replace Elevator	$450,000	$—	$450,000
***4**	***Wilmington***	***DE***	***At Large***	***Upgrade and Replace Boiler Plant Equipment***	***$466,440***	***$—***	***$466,440***
***4**	***Wilmington***	***DE***	***At Large***	***Upgrade Heating, Ventilation and Air Conditioning System***	***$2,200,000***	***$—***	***$2,200,000***
				Total—Delaware	**$8,066,440**	**$—**	**$8,066,440**
***8**	***Lake City***	***FL***	***4***	***Replace Air Handling Units***	***$450,458***	***$—***	***$450,458***
***8**	***Lake City***	***FL***	***4***	***Replace Chiller***	***$550,000***	***$—***	***$550,000***
8	Lake City	FL	4	Replace Electrical Switches	$500,000	$—	$500,000
***8**	***Lake City***	***FL***	***4***	***Repair and Upgrade Operating Room Heating, Ventilation and Air Conditioning***	***$409,091***	***$—***	***$409,091***

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
8	Gainesville	FL	6	Relocate and Renovate for Vascular Lab	$285,000	$—	$285,000
8	Gainesville	FL	6	Construct an Intensive Care Step Down Unit	$830,000	$—	$830,000
8	Gainesville	FL	6	Upgrade Physical Security	$450,000	$—	$450,000
8	Gainesville	FL	6	Replace Finishes	$400,000	$—	$400,000
8	Gainesville	FL	6	Repair and Upgrade Electrical Distribution System	$2,260,000	$—	$2,260,000
8	Orlando	FL	8	Construct New Medical Gas Bldg	$250,000	$—	$250,000
8	Orlando	FL	8	Study for Electrical Distribution System	$150,000	$—	$150,000
***8**	***Orlando***	***FL***	***8***	***Upgrade Heating, Ventilation and Air Conditioning Controls***	***$350,000***	***$—***	***$350,000***
***8**	***Orlando***	***FL***	***8***	***Replace Steam Pipes***	***$700,000***	***$—***	***$700,000***
***8**	***Orlando***	***FL***	***8***	***Upgrade Operating Room Heating, Ventilation and Air Conditioning***	***$350,000***	***$—***	***$350,000***
8	Orlando	FL	8	Renovate and Upgrade Operating Room	$500,000	$—	$500,000
***8**	***Orlando***	***FL***	***8***	***Repair Steam Traps***	***$195,000***	***$—***	***$195,000***

8	Orlando	FL	8	Upgrade and Renovate Operating Room Finishes	$605,000	$—	$605,000
8	Orlando	FL	8	Renovate for Supply, Processing and Distribution Cart Lift	$350,000	$—	$350,000
8	Orlando	FL	8	Repair and Upgrade Fire Alarm System	$625,000	$—	$625,000
***8**	***Orlando***	***FL***	***8***	***Upgrade and Replace Heating, Ventilation and Air Conditioning Controls***	***$500,000***	***$—***	***$500,000***
***8**	***Orlando***	***FL***	***8***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
8	Bay Pines	FL	10	Renovate Area for MRI Install	$726,715	$—	$726,715
8	Bay Pines	FL	10	Renovate Kitchen	$1,477,357	$—	$1,477,357
***8**	***Bay Pines***	***FL***	***10***	***Replace and Upgrade Heating, Ventilation and Air Conditioning Systems***	***$2,758,419***	***$—***	***$2,758,419***
***8**	***Bay Pines***	***FL***	***10***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
8	Tampa	FL	11	Renovate Area for Electro Physiology Lab	$1,000,000	$—	$1,000,000
8	Tampa	FL	11	Renovate Area for Electro Physiology Lab Recovery	$1,650,000	$—	$1,650,000
***8**	***Tampa***	***FL***	***11***	***Upgrade Windows for Hurricane Hardening***	***$1,250,000***	***$—***	***$1,250,000***
8	Tampa	FL	11	Renovate Area for Install of Gamma Camera	$750,000	$—	$750,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
8	***Tampa***	***FL***	***11***	***Replace Research Exhaust Fan***	***$750,000***	***$—***	***$750,000***
8	Tampa	FL	11	Renovate and Modernize for American Disability Act Compliance	$700,000	$—	$700,000
8	***Tampa***	***FL***	***11***	***Repair and Replace Steam Pipe System***	***$250,000***	***$—***	***$250,000***
8	***Tampa***	***FL***	***11***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
8	***Orlando***	***FL***	***15***	***Upgrade Operating Room Heating, Ventilation and Air Conditioning***	***$350,000***	***$—***	***$350,000***
8	Miami	FL	18	Repair Hallways for Life Safety	$1,210,053	$—	$1,210,053
8	Miami	FL	18	Upgrade and Repair Electrical Distribution System	$330,674	$—	$330,674
8	Miami	FL	18	Study Fire and Smoke Damper	$300,244	$—	$300,244
8	***Miami***	***FL***	***18***	***Replace Chilled Water Valves***	***$834,334***	***$—***	***$834,334***
8	Miami	FL	18	Upgrade Community Living Center Elevators	$892,914	$—	$892,914

8	***Miami***	***FL***	***18***	***Upgrade Restrooms***	***$4,214,923***	***$—***	***$4,214,923***
8	***Miami***	***FL***	***18***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
8	***W. Palm Beach***	***FL***	***22***	***Construct Cooling Tower Walls***	***$267,777***	***$—***	***$267,777***
8	W. Palm Beach	FL	22	Install Hurricane Shutters	$112,713	$—	$112,713
8	W. Palm Beach	FL	22	Replace and Upgrade Fire Alarm System	$3,479,189	$—	$3,479,189
8	***W. Palm Beach***	***FL***	***22***	***Modernize Patient Bathrooms***	***$497,402***	***$—***	***$497,402***
8	W. Palm Beach	FL	22	Upgrade Electrical Distribution System	$444,463	$—	$444,463
				Total—Florida	**$34,996,726**	**$—**	**$34,996,726**
7	Dublin	GA	3	Replace Sanitary Sewer Lines	$610,308	$30,828	$579,480
7	***Dublin***	***GA***	***3***	***Replace and Upgrade Air Handling Equipment***	***$834,747***	***$89,437***	***$745,310***
7	Dublin	GA	3	Renovate for Inpatient Ward	$877,500	$90,000	$787,500
7	Dublin	GA	3	Renovate for IT Space	$753,750	$110,000	$643,750
7	***Dublin***	***GA***	***3***	***Implement Ground Source Heat Pumps[1]***	***$2,152,000***	***$—***	***$2,152,000***
7	Atlanta	GA	5	Modernize Community Living Center	$2,631,463	$—	$2,631,463
7	Atlanta	GA	5	Renovate Mental Health	$490,000	$—	$490,000
7	Atlanta	GA	5	Upgrade and Replace Plumbing Systems	$2,200,000	$200,000	$2,000,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
7	Atlanta	GA	5	Renovate Histology Lab	$806,469	$170,512	$635,957
7	Atlanta	GA	5	Upgrade and Expand Emergency Department	$1,766,856	$137,005	$1,629,851
***7**	***Augusta***	***GA***	***10***	***Replace and Upgrade Heating, Ventilation and Air Conditioning System***	***$548,550***	***$50,000***	***$498,550***
7	Augusta	GA	12	Renovate Area for Position Electron Transformation/Cat Scanner	$1,000,000	$—	$1,000,000
7	Augusta	GA	12	Renovate and Modernize Inpatient Wards	$1,400,000	$—	$1,400,000
				Total—Georgia	**$16,071,643**	**$877,782**	**$15,193,861**
***21**	***Honolulu***	***HI***	***1***	***Repair/Clean Ductwork***	***$275,000***	***$—***	***$275,000***
***21**	***Honolulu***	***HI***	***1***	***Upgrade for Direct Digital Control for Heating, Ventilation and Air Conditioning on E-Wing***	***$275,000***	***$—***	***$275,000***
***21**	***Honolulu***	***HI***	***1***	***Replace Air Conditioning Condensing and Air Handling Roof Unit***	***$250,000***	***$—***	***$250,000***
***NCA**	***Honolulu***	***HI***	***1***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
				Total—Hawaii	**$850,000**	**$—**	**$850,000**

23	***Iowa City***	***IA***	***2***	***Energy Upgrades to Heating, Ventilation and Air Conditioning System, Building 40 & 41***	***$660,000***	***$—***	***$660,000***
23	Iowa City	IA	2	Replace Roof for Building 7/ Repair Roof Building 1	$220,000	$—	$220,000
23	Iowa City	IA	2	Update/Renovate Interior Finishes Building 1, Phase I	$480,000	$—	$480,000
23	Iowa City	IA	2	Renovate Inpatient Medical/ Surgical Ward 7E	$2,280,000	$—	$2,280,000
23	Des Moines	IA	3	Correct Electrical Deficiencies, Phase 5	$1,020,000	$—	$1,020,000
****23***	***Des Moines***	***IA***	***3***	***Renovate Basement of Building 3 for Heating, Ventilation and Air Conditioning***	***$1,100,000***	***$—***	***$1,100,000***
23	Des Moines	IA	3	Renovate Cardiac Cath Special Procedure Patient Prep and Recovery Rooms	$100,000	$—	$100,000
****23***	***Des Moines***	***IA***	***3***	***Relocate/Upgrade Air Intake for Primary Care***	***$115,000***	***$—***	***$115,000***
23	Des Moines	IA	3	Renovate/Install Dental Suction System in Clinical Annex Building	$115,000	$—	$115,000
23	Des Moines	IA	3	Renovate Education Space in Building 3	$280,000	$—	$280,000
23	Des Moines	IA	3	Renovate for additional storage	$280,000	$—	$280,000
23	Des Moines	IA	3	Replace/Repair Steps for Building 3	$300,000	$—	$300,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
23	Des Moines	IA	3	Renovate/Repair Loading Dock	$300,000	$—	$300,000
23	Des Moines	IA	3	Renovation for the Installation of New Patient Lift Equipment	$200,000	$—	$200,000
23	Des Moines	IA	3	Joint Commission on Accreditation of Health care Organizations Pre-Survey Inspection	$240,201	$—	$240,201
				Total—Iowa	**$7,690,201**	**$—**	**$7,690,201**
20	Boise	ID	2	Replace Underground Electrical System and Generators	$1,820,000	$—	$1,820,000
20	Boise	ID	2	Upgrade/Replace Electrical System and Emergency Generators	$2,040,000	$—	$2,040,000
20	Boise	ID	2	Replace Electrical Systems	$1,090,000	$—	$1,090,000
20	Boise	ID	2	Renovate 1st and 2nd Floors for Clinical Care, Building 110	$800,000	$—	$800,000
***20**	**Boise**	**ID**	**2**	**Evaluate Feasibility of Direct Geothermal[1]**	**$342,857**	**$—**	**$342,857**
				Total—Idaho	**$6,092,857**	**$—**	**$6,092,857**

12	Chicago (WS)	IL	7	Install American Disability Act Automatic Fixtures in Bathroom	$350,000	$—	$350,000
12	Hines	IL	7	Replace Electrical Distribution System	$8,000,000	$—	$8,000,000
***12**	***Chicago (WS)**	***IL**	***7**	***Replace Ductwork**	***$172,862**	***$—**	***$172,862**
12	Hines	IL	7	Replace Water Main Lines	$1,550,000	$—	$1,550,000
12	Chicago (WS)	IL	7	Design to Enclose Building	$35,000	$—	$35,000
12	Hines	IL	7	Upgrade and Repair Medical Gas System	$8,000,000	$—	$8,000,000
***12**	***Chicago (WS)**	***IL**	***7**	***Install Ventilation in Dialysis**	***$700,509**	***$—**	***$700,509**
12	Chicago (WS)	IL	7	Relocate Psychology Suite	$150,000	$—	$150,000
12	Chicago (WS)	IL	7	Repair Exterior Masonry	$564,200	$—	$564,200
12	Chicago (WS)	IL	7	Install New Electrical Cables	$772,878	$—	$772,878
12	Hines	IL	7	Replace Roof	$1,220,000	$—	$1,220,000
12	Hines	IL	7	Remodel Physical Rehab/Extended Care	$6,000,000	$—	$6,000,000
***12**	***Chicago (WS)**	***IL**	***7**	***Replace Air Handling Units**	***$251,300**	***$—**	***$251,300**
12	Hines	IL	7	Reconfigure Fire Dampers	$400,000	$—	$400,000
***12**	***Hines**	***IL**	***7**	***Replace Boiler Plant Controls**	***$85,000**	***$—**	***$85,000**
***12**	***Hines**	***IL**	***7**	***Install Boiler Flue Gas Analyzers**	***$110,000**	***$—**	***$110,000**
12	Hines	IL	7	Upgrade Tank Lining	$60,000	$—	$60,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
12	Hines	IL	7	Install Natural Gas Emergency Shutdown Valves	$50,000	$—	$50,000
***12**	***Hines***	***IL***	***7***	***Replace Heating, Ventilation and Air Conditioning System***	***$200,000***	***$—***	***$200,000***
***12**	***Hines***	***IL***	***7***	***Upgrade and Repair Condensate Return Lines***	***$125,000***	***$—***	***$125,000***
12	Hines	IL	7	Relocate Prosthetics, Neurology, and Rehab Clinic	$4,000,000	$—	$4,000,000
12	Chicago (WS)	IL	7	Renovate Area for Install of Gamma Camera	$241,000	$—	$241,000
12	North Chicago	IL	10	Replace Electrical Sub-Station	$2,180,000	$—	$2,180,000
***12**	***North Chicago***	***IL***	***10***	***Upgrade Street Lights***	***$1,200,000***	***$—***	***$1,200,000***
***12**	***North Chicago***	***IL***	***10***	***Replace Windows***	***$2,850,000***	***$—***	***$2,850,000***
12	North Chicago	IL	10	Repair and Replace Roads and Sidewalks	$500,000	$—	$500,000
12	North Chicago	IL	10	Repair Drainage System	$1,500,000	$—	$1,500,000
12	North Chicago	IL	10	Expand Phone Switch Room	$50,000	$—	$50,000
12	North Chicago	IL	10	Demolish Porch	$95,000	$—	$95,000
12	North Chicago	IL	10	Upgrade Site for American Disability Act Compliance	$750,000	$—	$750,000

12	North Chicago	IL	10	Renovate Education Spaces	$120,000	$—	$120,000
12	North Chicago	IL	10	Upgrade Electrical Distribution System	$575,000	$—	$575,000
12	North Chicago	IL	10	Abate Asbestos	$750,000	$—	$750,000
12	North Chicago	IL	10	Renovate and Modernize Showers	$82,000	$—	$82,000
15	Marion	IL	12	Water Tower Renovation—FCA Corrections	$148,000	$—	$148,000
15	Marion	IL	12	Mold Abatement & Water Intrusion Prevention—FCA Corrections	$3,416,000	$496,000	$2,920,000
15	Marion	IL	12	South Periphery Road Relocation	$336,000	$—	$336,000
***15**	***Marion**	***IL**	***12**	***Chiller Plant Addition**	***$1,097,600**	***$117,600**	***$980,000**
15	Marion	IL	12	Relocate Generator and Electrical	$952,000	$—	$952,000
15	Marion	IL	12	Repair and Recondition Building 15 Exterior	$530,000	$—	$530,000
15	Marion	IL	12	Renovate Halls and Replace Exit Doors in Building 43	$500,000	$—	$500,000
***11**	***Danville**	***IL**	***15**	***Replace Central Boiler Plant**	***$12,000,000**	***$—**	***$12,000,000**
11	Danville	IL	15	Replace Elevator Cabs & Controls	$1,500,000	$—	$1,500,000
				Total—Illinois	**$64,169,349**	**$613,600**	**$63,555,749**
***11**	***Indianapolis**	***IN**	***7**	***Install New Chiller**	***$2,100,000**	***$—**	***$2,100,000**
11	Indianapolis	IN	7	Upgrade Nurse Call System	$1,870,000	$—	$1,870,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
11	Indianapolis	IN	7	Resurface Parking Lots	$896,000	$—	$896,000
				Total—Indiana	**$4,866,000**	**$—**	**$4,866,000**
15	Leavenworth	KS	2	Building 21 Fire Safety Upgrades—FCA Correction	$380,000	$30,000	$350,000
15	Topeka	KS	2	Renovate Radiology Department—FCA Corrections	$90,000	$—	$90,000
15	Leavenworth	KS	2	Repair Concrete Sidewalks	$100,000	$—	$100,000
15	Topeka	KS	2	Replace Roof Eyebrows—FCA Corrections	$750,000	$—	$750,000
15	Topeka	KS	2	Tuck point and Repair Roof of Building 1	$1,100,000	$100,000	$1,000,000
15	Leavenworth	KS	2	Renovate Pharmacy to meet ventilation requirements	$330,000	$30,000	$300,000
****15***	***Leavenworth***	***KS***	***2***	***Replace Windows in Buildings 88, 89, 90, and 91, Phase 1***	***$1,000,000***	***$—***	***$1,000,000***
15	Wichita	KS	4	Correct Electrical Deficiencies	$4,600,000	$—	$4,600,000
15	Wichita	KS	4	Replace Roofs on Buildings 5–7, 10–13, 19	$1,080,000	$80,000	$1,000,000
				Total—Kansas	**$9,430,000**	**$240,000**	**$9,190,000**
****9***	***Louisville***	***KY***	***3***	***Replace Boilers***	***$2,413,000***	***$259,000***	***$2,154,000***

9	Louisville	KY	3	Renovate Mental Health	$2,170,560	$232,560	$1,938,000
9	Louisville	KY	3	Replace Sewer Lines	$250,000	$—	$250,000
***9**	***Louisville***	***KY***	***3***	***Repair and Replace Street Lighting***	***$184,000***	***$—***	***$184,000***
10	Ft. Thomas	KY	4	Renovate for Traumatic Brain Injury and Post-Traumatic Stress Disorder Program	$1,591,000	$—	$1,591,000
9	Lexington	KY	6	Upgrade and Replace Electrical Distribution System	$2,100,000	$190,000	$1,910,000
9	Lexington	KY	6	Construct Additional Parking	$1,650,000	$100,000	$1,550,000
9	Lexington	KY	6	Upgrade and Repair Electrical Distribution System	$770,000	$70,000	$700,000
9	Lexington	KY	6	Renovate Clinics	$719,000	$55,000	$664,000
9	Lexington	KY	6	Renovate Police Dispatch	$550,000	$50,000	$500,000
				Total—Kentucky	**$12,397,560**	**$956,560**	**$11,441,000**
***16**	***New Orleans***	***LA***	***2***	***Repair/Upgrade Energy Management System***	***$750,000***	***$—***	***$750,000***
***16**	***Shreveport***	***LA***	***4***	***Replace Kitchen Exhaust***	***$500,000***	***$—***	***$500,000***
16	Shreveport	LA	4	Renovate/Upgrade Operating Room—FCA Corrections	$5,200,000	$—	$5,200,000
***16**	***Shreveport***	***LA***	***4***	***Replace Fan Coils to meet Heating, Ventilation and Air Conditioning requirements***	$550,000	$—	$550,000
16	Alexandria	LA	5	Renovate Kitchen and Lobby of Building 9 for Mental Health Program Offices	$324,000	$—	$324,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
16	***Alexandria***	***LA***	***5***	***Recondition Boiler #1***	***$246,000***	***$—***	***$246,000***
16	Alexandria	LA	5	Renovate/Upgrade Canteen Dining Area	$300,000	$—	$300,000
16	***Alexandria***	***LA***	***5***	***Renovate Heating, Ventilation and Air Conditioning in Laboratory, Building 7***	***$395,000***	***$—***	***$395,000***
				Total—Louisiana	**$8,265,000**	**$—**	**$8,265,000**
1	***Northampton***	***MA***	***2***	***Upgrade Supply, Processing and Distribution Heating, Ventilation and Air Conditioning & Sterilizer***	***$1,596,000***	***$196,000***	***$1,400,000***
1	Northampton	MA	2	Repair and Upgrade Fire Protection System	$3,310,000	$250,000	$3,060,000
1	Northampton	MA	2	Correct American Disability Act Building Access Deficiencies	$550,000	$50,000	$500,000
1	Leeds	MA	2	Correct American Disability Act Building Deficiencies	$839,000	$39,000	$800,000
1	Bedford	MA	6	Renovate Inpatient Psychiatric Wards	$7,165,000	$—	$7,165,000

1	***Bedford***	***MA***	***6***	***Upgrade Heating, Ventilation and Air Conditioning, Animal Research Facility***	***$765,000***	***$—***	***$765,000***
1	Bedford	MA	6	Replace and Upgrade Electrical Distribution System	$4,033,000	$—	$4,033,000
1	Bedford	MA	6	Renovate Nursing Home Care Unit into a Community Living Center	$721,000	$—	$721,000
1	Brockton	MA	9	Replace Fire Alarm System	$3,525,000	$—	$3,525,000
1	***West Roxbury***	***MA***	***9***	***Upgrade Supply, Processing and Distribution Heating, Ventilation and Air Conditioning System***	***$975,000***	***$85,000***	***$890,000***
1	***West Roxbury***	***MA***	***9***	***Replace and Upgrade Air Handling Equipment, Phase 2***	***$1,339,000***	***$120,000***	***$1,219,000***
				Total—Massachusetts	**$24,818,000**	**$740,000**	**$24,078,000**
5	Perry Point	MD	1	Upgrade and Replace Electrical Distribution System	$1,870,000	$—	$1,870,000
5	***Perry Point***	***MD***	***1***	***Replace and Upgrade Heating, Ventilation and Air Conditioning***	***$450,000***	***$—***	***$450,000***
5	Perry Point	MD	1	Upgrade the Patient Security System	$3,750,000	$—	$3,750,000
5	Perry Point	MD	1	Replace Roof	$548,000	$—	$548,000
5	***Perry Point***	***MD***	***1***	***Replace Chilled Water Line***	***$150,000***	***$—***	***$150,000***
5	Perry Point	MD	1	Replace Elevator and Shaft	$550,000	$—	$50,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
5	***Perry Point***	***MD***	***1***	***Replace Windows***	***$150,000***	***$—***	***$150,000***
5	Perry Point	MD	1	Replace Elevators	$90,000	$—	$90,000
5	Perry Point	MD	1	Upgrade Security for the Chemical Storage Area	$25,000	$—	$25,000
5	Perry Point	MD	1	Replace Dock Leveler Bldg 11W	$20,000	$—	$20,000
5	Perry Point	MD	1	Upgrade and Replace Fire & Safety Systems	$475,000	$—	$475,000
5	Perry Point	MD	1	Repair Roads and Sidewalks	$1,375,000	$—	$1,375,000
5	***Perry Point***	***MD***	***1***	***Repair and Upgrade Heating, Ventilation and Air Conditioning Systems***	***$1,540,000***	***$—***	***$1,540,000***
5	Perry Point	MD	1	Replace Exterior for Buildings 4H and 5H	$1,000,000	$—	$1,000,000
5	Perry Point	MD	1	Replace Exterior for Buildings 11H, 15H and 17H	$1,909,000	$—	$1,909,000
5	***Perry Point***	***MD***	***1***	***Implement Selected Conservation Measures[1]***	***$3,333,333***	***$—***	***$3,333,333***
5	***Baltimore***	***MD***	***7***	***Replace Steam Traps***	***$200,000***	***$—***	***$200,000***
5	Baltimore	MD	7	Upgrade and Repair Electrical Distribution System	$200,000	$—	$200,000
5	Loch Raven	MD	7	Replace Fire Alarm System	$300,000	$—	$300,000

5	Baltimore	MD	7	Construct Entrance Vestibule Parking Garage P1	$90,000	$—	$90,000
5	Baltimore	MD	7	Install Security Door 6A Mental Health	$40,000	$—	$40,000
***5**	***Baltimore***	***MD***	***7***	***Upgrade Acquisitions and Materials Management Service Heating, Ventilation and Air Conditioning Controls***	***$250,000***	***$—***	***$250,000***
5	Loch Raven	MD	7	Study and Provide Recommendations for Loch Raven Drainage	$100,000	$—	$100,000
5	Loch Raven	MD	7	Replace Dock Leveler	$20,000	$—	$20,000
5	Loch Raven	MD	7	Construct a Low Vision Clinic	$100,000	$—	$100,000
5	Baltimore	MD	7	Renovate Canteen Food Court	$525,000	$—	$525,000
5	Loch Raven	MD	7	Relocate Campus Main Telephone Feed Bldg 4	$50,000	$—	$50,000
5	Baltimore	MD	7	Repair Roofs	$450,000	$—	$450,000
5	Baltimore	MD	7	Upgrade and Repair Electrical Distribution System	$750,000	$—	$750,000
				Total—Maryland	**$20,310,333**	**$—**	**$19,810,333**
***1**	***Togus***	***ME***	***1***	***Construct Private Bathrooms and Showers for Inpatient Wards in Building 200***	***$7,386,493***	***$696,000***	***$6,690,493***
1	Togus	ME	1	Repair and Upgrade Building 200 and Building 200E Façade	$4,400,000	$—	$400,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
***1**	***Augusta***	***ME***	***1***	***Construct a Renewably Fueled Cogeneration System[1]***	***$6,201,531***	***$31,531***	***$6,170,000***
				Total—Maine	**$17,988,024**	**$727,531**	**$13,260,493**
12	Iron Mountain	MI	1	Upgrade Electrical Distribution & Generator	$765,000	$—	$765,000
12	Iron Mountain	MI	1	Replace Fire Pump	$130,000	$—	$130,000
***12**	***Iron Mountain***	***MI***	***1***	***Replace Heating, Ventilation and Air Conditioning Telephone Room***	***$532,000***	***$—***	***$532,000***
12	Iron Mountain	MI	1	Replace Kitchen Coolers/ Freezers	$50,000	$—	$50,000
12	Iron Mountain	MI	1	Construct Additional Parking and Utilities	$400,000	$—	$400,000
12	Iron Mountain	MI	1	Repair Exterior Masonry	$350,000	$—	$350,000
12	Iron Mountain	MI	1	Repair Sidewalks	$40,000	$—	$40,000
12	Iron Mountain	MI	1	Renovate and Modernize Outpatient Lobby	$40,000	$—	$40,000
***12**	***Iron Mountain***	***MI***	***1***	***Replace Chiller***	***$350,000***	***$—***	***$350,000***

11	Saginaw	MI	5	Upgrade Primary Electrical Distribution System	$1,950,000	$—	$1,950,000
11	Saginaw	MI	5	Upgrade and Expand Electrical Closets	$2,263,000	$—	$2,263,000
***11**	***Saginaw***	***MI***	***5***	***Replace Heating, Ventilation and Air Conditioning System***	***$4,606,224***	***$—***	***$4,606,224***
11	Battle Creek	MI	7	Replace Roads, Curbs, Gutter	$1,124,000	$—	$1,124,000
11	Detroit	MI	13	Renovate for Mental Health	$4,950,000	$—	$4,950,000
11	Ann Arbor	MI	15	Renovate Inpatient and Outpatient Pharmacy	$2,500,000	$—	$2,500,000
11	Ann Arbor	MI	15	Renovate and Modernize Urgent Care	$2,500,000	$—	$2,500,000
11	Ann Arbor	MI	15	Upgrade Emergency Room	$1,500,000	$—	$1,500,000
				Total—Michigan	**$24,050,224**	**$—**	**$24,050,224**
***23**	***Minneapolis***	***MN***	***5***	***Repair/Upgrade Mechanical Systems***	***$100,000***	***$—***	***$100,000***
23	Minneapolis	MN	5	Eyewash Upgrade ph. II	$500,000	$—	$500,000
23	Minneapolis	MN	5	Install Carpet, Mental Health	$225,000	$—	$225,000
23	Minneapolis	MN	5	Pneumatic Tube Expansion	$200,000	$—	$200,000
23	Minneapolis	MN	5	Replace Automatic Transfer Switch—Medical Intensive Care Unit	$35,000	$—	$35,000
23	Minneapolis	MN	5	Renovate for the Installation of Operating Room Boom to support equipment	$150,000	$—	$150,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
23	***Minneapolis***	***MN***	***5***	***Replace Chilled Water Valves Ph. 2***	***$250,000***	***$—***	***$250,000***
23	***Minneapolis***	***MN***	***5***	***Replace/Repair Screens/ Vents—Building 49 and 70***	***$100,000***	***$—***	***$100,000***
23	Minneapolis	MN	5	Upgrade Waste Anesthesia Gas System	$50,000	$—	$50,000
23	***Minneapolis***	***MN***	***5***	***Replace Condensate Return Piping, Ph. 1***	***$250,000***	***$—***	***$250,000***
23	***Minneapolis***	***MN***	***5***	***Replace Automatic Faucets***	***$40,000***	***$—***	***$40,000***
23	Minneapolis	MN	5	Telephone Switch Room Upgrades	$150,000	$—	$150,000
23	Minneapolis	MN	5	Replace Carpet—General	$425,000	$—	$425,000
23	Minneapolis	MN	5	Parking Lot and Road Upgrade	$1,100,000	$—	$1,100,000
23	Minneapolis	MN	5	Install Security System for IT closets	$250,000	$—	$250,000
23	Minneapolis	MN	5	Construct Hospice Unit, Building 70	$200,000	$—	$200,000
23	Minneapolis	MN	5	Ward Renovation	$200,000	$—	$200,000
23	Minneapolis	MN	5	Life Safety Assessment	$60,000	$—	$60,000

23	Minneapolis	MN	5	Design Ramp Snow Melt System for Building 70 and Loading Dock	$250,000	$—	$250,000
23	Minneapolis	MN	5	Design Transfer Switch Replacement	$120,000	$—	$120,000
***23**	***Minneapolis***	***MN***	***5***	***Replace Chiller #2 at Energy Center***	***$1,200,000***	***$—***	***$1,200,000***
23	Minneapolis	MN	5	Renovate Building 70 for Patient Privacy	$350,000	$—	$350,000
***23**	***Minneapolis***	***MN***	***5***	***Communication Closet A/C Upgrades***	***$300,000***	***$—***	***$300,000***
23	Minneapolis	MN	5	Extended Care Center Renovation, Ph. 1	$450,000	$—	$450,000
***23**	***Minneapolis***	***MN***	***5***	***Replace Heating, Ventilation and Air Conditioning Coils ph. I***	***$300,000***	***$—***	***$300,000***
23	Minneapolis	MN	5	Elevator upgrades ph. II	$1,700,000	$—	$1,700,000
23	Minneapolis	MN	5	Replace Water Booster Pumps	$250,000	$—	$250,000
23	Minneapolis	MN	5	Renovate for Provider Consultation Area	$220,000	$—	$220,000
***23**	***St. Cloud***	***MN***	***6***	***Install Heating, Ventilation and Air Conditioning System in Basement Building 29***	***$775,000***	***$—***	***$775,000***
23	St. Cloud	MN	6	Renovate for Rehab Services	$750,000	$—	$750,000
23	St. Cloud	MN	6	Replace Carpet in Domiciliary, Building 2	$180,000	$—	$180,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
23	St. Cloud	MN	6	Repair/Upgrade Roads throughout Campus, Phase 8	$1,365,000	$—	$1,365,000
23	St. Cloud	MN	6	Repair/Upgrade Nurse Call System in Building 48, 49, 50 and 51	$650,000	$—	$650,000
***23**	***St. Cloud***	***MN***	***6***	***Install Metering for Electrical, Steam and Gas Lines***	***$240,000***	***$—***	***$240,000***
23	St. Cloud	MN	6	Upgrade/Renovate Supply, Processing and Distribution	$1,300,000	$—	$1,300,000
***23**	***St. Cloud***	***MN***	***6***	***Upgrade Ground Source Heat Pumps***	***$1,952,000***	***$—***	***$1,952,000***
				Total—Minnesota	**$16,637,000**	**$—**	**$16,637,000**
15	St. Louis	MO	3	Correct Sprinkler Deficiencies	$1,411,000	$138,600	$1,272,400
15	St. Louis	MO	3	Emergency Power for Building 60 Main Kitchen	$1,359,000	$146,000	$1,213,000
15	St. Louis	MO	3	Correct Secondary Power Deficiencies, Phase II	$1,723,000	$—	$1,723,000
15	St. Louis	MO	3	Replace Public Address System, Building 1	$2,000,000	$180,000	$1,820,000
15	St. Louis	MO	3	Renovate Existing Clinics	$4,570,000	$500,000	$4,070,000

15	Kansas City	MO	5	Renovate Building 2—FCA Corrections	$2,189,710	$189,710	$2,000,000
15	Kansas City	MO	5	Site prep for install of new Cook/Chill Equipment in Kitchen	$580,000	$—	$580,000
15	Kansas City	MO	5	Upgrade Emergency Power Building 1—FCA Correction	$3,900,000	$—	$3,900,000
15	Kansas City	MO	5	Renovate Mental Health Building	$900,000	$—	$900,000
15	Columbia	MO	9	Elevator Replacement/Renovation	$1,320,000	$—	$1,320,000
15	Columbia	MO	9	Renovate Research	$1,200,000	$—	$1,200,000
15	Columbia	MO	9	Renovate and Relocate Specialty Care to 6th Floor	$500,000	$50,000	$450,000
***15**	***Columbia***	***MO***	***9***	***Replace Exhaust Fans—FCA Corrections***	***$1,650,000***	***$—***	***$1,650,000***
15	Columbia	MO	9	Renovate Pathology Labs	$2,000,000	$—	$2,000,000
				Total—Missouri	**$25,302,710**	**$1,204,310**	**$24,098,400**
16	Jackson	MS	3	Provide Back-Up Generator Capacity	$4,700,000	$—	$4,700,000
***16**	***Jackson***	***MS***	***3***	***Replace Medical Center Windows—Phase 1***	***$2,000,000***	***$—***	***$2,000,000***
16	Jackson	MS	3	Clean and Recoat portions of Existing Room on Building 1 & 7	$300,000	$—	$300,000
16	Biloxi	MS	4	Replace Elevators in Building 2 &19	$1,300,000	$—	$1,300,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
16	Biloxi	MS	4	Repair/Replace Elevators and Dumbwaiters in Building 1&3	$2,200,000	$—	$2,200,000
16	Biloxi	MS	4	Replace Building 5 Roof & Update Exterior finish	$1,120,000	$—	$1,120,000
16	Biloxi	MS	4	Renovate/Upgrade Building 17 Interior for American Disability Act accessibility	$820,000	$—	$820,000
				Total—Mississippi	**$12,440,000**	**$—**	**$12,440,000**
19	Helena	MT	At Large	Repair Mechanical Deficiencies	$705,000	$55,000	$650,000
****19***	***Helena***	***MT***	***At Large***	***Convert Building 154 to Low Pressure Steam***	***$750,000***	***$70,000***	***$680,000***
19	Helena	MT	At Large	Repair/Replace Masonry in Stairwells—FCA Corrections	$550,000	$50,000	$500,000
19	Helena	MT	At Large	Remediate Lead Based Paint	$750,000	$50,000	$700,000
19	Helena	MT	At Large	Remediate Lead Based Paint	$750,000	$50,000	$700,000
****19***	***Helena***	***MT***	***At Large***	***Implement Energy Conservation Measures per regulation***	***$750,000***	***$70,000***	***$680,000***
****19***	***Fort Harrison***	***MT***	***At Large***	***Evaluate Feasibility of Direct Geothermal[1]***	***$342,857***	***$—***	***$342,857***
				Total—Montana	**$4,597,857**	**$345,000**	**$4,252,857**

6	***Durham***	***NC***	***4***	***Replace Air Handling Units***	***$3,700,000***	***$—***	***$3,700,000***
6	Durham	NC	4	Upgrade and Install New Electrical Distribution Systems	$4,730,000	$—	$4,730,000
6	Durham	NC	4	Renovate and Expand Physical Therapy and Occupational Therapy	$800,000	$—	$800,000
6	Durham	NC	4	Resurface Roads and Parking Lots	$1,150,000	$—	$1,150,000
6	Fayetteville	NC	7	Upgrade Women's Clinic	$925,000	$—	$925,000
6	Fayetteville	NC	7	Replace Elevators	$600,000	$—	$600,000
6	Fayetteville	NC	7	Upgrade Kitchen	$700,000	$—	$700,000
6	Fayetteville	NC	7	Upgrade Elevator	$700,000	$—	$700,000
6	Asheville	NC	11	Repair Dom Water System	$878,000	$—	$878,000
6	Asheville	NC	11	Repair and Replace Exterior	$560,000	$—	$560,000
6	Asheville	NC	11	Renovate for a Community Living Center	$420,000	$—	$420,000
6	Asheville	NC	11	Renovate Emergency Department, Phase I	$910,000	$—	$910,000
6	***Asheville***	***NC***	***11***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
6	Salisbury	NC	12	Upgrade Elevators	$1,800,000	$—	$1,800,000
6	***Salisbury***	***NC***	***12***	***Upgrade and Replace Heating, Ventilation and Air Conditioning System***	***$1,873,250***	***$—***	***$1,873,250***
6	Salisbury	NC	12	Replace Water Pipes	$857,250	$—	$857,250

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
6	Salisbury	NC	12	Modernize Patient Areas	$1,210,500	$—	$1,210,500
				Total—North Carolina	**$21,864,000**	**$—**	**$21,864,000**
23	Fargo	ND	At Large	Renovate Administrative Space for Clinical Ambulatory Care Exam Rooms and Support Space	$1,901,855	$—	$1,901,855
*23	Fargo	ND	At Large	Replace/Upgrade Chiller Compressors	$370,000	$—	$370,000
23	Fargo	ND	At Large	Repair/Replace Sidewalk at Medical Center	$260,000	$—	$260,000
23	Fargo	ND	At Large	Renovate Inpatient Pharmacy	$734,375	$—	$734,375
				Total—North Dakota	**$3,266,230**	**$—**	**$3,266,230**
23	Omaha	NE	1	Repair/Replace Roofs Buildings 12, 24 and 45	$300,000	$—	$300,000
23	Omaha	NE	1	Repair/Upgrade Main Fire Alarm Panel	$500,000	$—	$500,000
23	***Omaha***	***NE***	***1***	***Repair/Update Condensate Pipes and Pumps***	***$125,000***	***$—***	***$125,000***
23	***Omaha***	***NE***	***1***	***Replace/Update Water Softeners for Boilers and Domestic Water Systems***	***$150,000***	***$—***	***$150,000***

23	Omaha	NE	2	Remodel Operating Room/ Post Anesthesia Care Unit	$2,520,000	$—	$2,520,000
23	Omaha	NE	2	Renovate Radiology for Position Electron Transformation (PET) CT Install	$1,920,000	$—	$1,920,000
23	Omaha	NE	2	Renovate for New Coolers and Freezers	$225,000	$—	$225,000
***23**	***Omaha***	***NE***	***2***	***Repair/Replace Steam Condensate Lines, Tanks and Pumps***	***$300,000***	***$—***	***$300,000***
***23**	***Omaha***	***NE***	***3***	***Replace Air Handlers for Laboratory Space***	***$500,000***	***$—***	***$500,000***
23	Omaha	NE	3	Replace Electrical Distribution System	$750,000	$—	$750,000
23	Omaha	NE	3	Replace/Upgrade Domestic Hot Water Heaters	$210,000	$—	$210,000
				Total—Nebraska	**$7,500,000**	**$—**	**$7,500,000**
1	Manchester	NH	1	Correct Corrosion and Upgrade Water Tower	$1,111,500	$95,000	$1,016,500
1	Manchester	NH	1	Renovate for Mental Health and Primary Care	$585,000	$50,000	$535,000
				Total—New Hampshire	**$1,696,500**	**$145,000**	**$1,551,500**
***4**	***Cape May***	***NJ***	***2***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
***NCA**	***Salem***	***NJ***	***2***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
4	***Fort Dix***	***NJ***	***3***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
NCA	***Beverly***	***NJ***	***3***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
3	East Orange	NJ	10	Repave Parking Lots and Roads	$2,500,000	$—	$2,500,000
3	Lyons	NJ	10	Repair and Upgrade the Storm Water System	$2,500,000	$—	$2,500,000
3	East Orange	NJ	10	Install Access Security System	$850,000	$—	$850,000
3	East Orange	NJ	10	Renovate and Modernize the Inpatient Ward Halls and Floors	$500,000	$—	$500,000
3	***East Orange***	***NJ***	***10***	***Upgrade Heating, Ventilation and Air Conditioning for Cardiac Cath Lab***	***$275,000***	***$—***	***$275,000***
3	East Orange	NJ	10	Upgrade Pharmacy to 797 Code Compliance	$207,000	$—	$207,000
3	East Orange	NJ	10	Renovate Nuclear Medicine for New Gama Cameras	$715,000	$—	$715,000
3	East Orange	NJ	10	Renovate the Ear, Nose and Throat Clinic	$330,000	$—	$330,000

3	East Orange	NJ	10	Renovate and Modernize Inpatient Wards	$2,500,000	$—	$2,500,000
***3**	***East Orange***	***NJ***	***10***	***Upgrade Heating, Ventilation and Air Conditioning & Plumbing Systems***	***$2,500,000***	***$—***	***$2,500,000***
3	Lyons	NJ	11	Repair Structural Deficiencies in Building	$385,000	$—	$385,000
3	Lyons	NJ	11	Upgrade Security Project	$1,200,000	$—	$1,200,000
				Total—New Jersey	**$14,502,000**	**$—**	**$14,502,000**
18	Albuquerque	NM	1	Renovate Operating Room #2	$500,000	$—	$500,000
18	Albuquerque	NM	1	Pave Overflow Patient Parking Lot	$345,000	$20,000	$325,000
18	Albuquerque	NM	1	Replace Fuel Storage Tanks for Emergency Generators in Buildings 1, 3, and 10.	$713,000	$73,000	$640,000
***18**	***Albuquerque***	***NM***	***1***	***Repair/Upgrade Steam and Condensate systems, Phase I***	***$775,000***	***$75,000***	***$700,000***
18	Albuquerque	NM	1	Renovate 3rd Floor of Building 3 for Telehealth	$449,065	$49,065	$400,000
***18**	***Albuquerque***	***NM***	***1***	***Renovate Operating Room and Supply, Processing and Distribution in Building 41***	***$600,000***	***$—***	***$60,000***
18	Albuquerque	NM	1	Renovate Primary Care Area, Building 41	$750,000	$—	$75,000
18	Albuquerque	NM	1	Building 41, Handicap Accessible Parking	$500,000	$—	$500,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
18	***Albuquerque***	***NM***	***1***	***Repair Chilled Water Loop Piping***	***$750,000***	***$—***	***$75,000***
18	Albuquerque	NM	1	Correct Fire and Life Safety Deficiencies	$600,000	$—	$60,000
18	***Albuquerque***	***NM***	***1***	***Implement Selected Conservation Measures[1]***	***$1,142,857***	***$—***	***$1,142,857***
18	***Albuquerque***	***NM***	***1***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
				Total—New Mexico	**$7,134,922**	**$217,065**	**$4,487,857**
21	Reno	NV	2	Install Sprinklers, Building 1, Phase 3	$350,000	$—	$350,000
21	Reno	NV	2	Install Sprinklers, Building 1A	$300,000	$—	$300,000
21	Reno	NV	2	Install Sprinklers, Building 1, Phase 2	$350,000	$—	$350,000
21	Reno	NV	2	Upgrade Elevators in Building 1D and Dietetics	$1,200,000	$—	$1,200,000
21	Reno	NV	2	Renovate Community Living Center, Phase 2	$650,000	$—	$650,000
21	***Reno***	***NV***	***2***	***Replace/Upgrade Air Handling Units Building 10***	***$400,000***	***$—***	***$400,000***

21	***Reno***	***NV***	***2***	***Replace/Upgrade Heating, Ventilation and Air Conditioning Control System, Building 12***	***$400,000***	***$—***	***$400,000***
21	***Reno***	***NV***	***2***	***Replace Heating, Ventilation and Air Conditioning Control System, Buildings 10 & 1D***	***$400,000***	***$—***	***$400,000***
21	Reno	NV	2	Replace Sidewalks Facility Wide	$110,000	$—	$110,000
21	Reno	NV	2	Replace Flooring for Various Buildings	$150,000	$—	$150,000
21	Reno	NV	2	Renovate for Urgent Care Center and Police Service	$975,000	$—	$975,000
21	Reno	NV	2	Replace Sewer Line, Building 1	$225,000	$—	$225,000
				Total—Nevada	**$5,510,000**	**$—**	**$5,510,000**
3	Northport	NY	2	Renovate and Relocate Warehouse	$1,300,000	$—	$1,300,000
3	Northport	NY	2	Renovate and Modernize Supply, Processing and Distribution	$1,800,000	$—	$1,800,000
3	Northport	NY	2	Renovate Research Wet Labs	$865,000	$—	$865,000
3	Northport	NY	2	Upgrade Research Dry Labs to current American Association for Accreditation of Laboratory Animal Care standards	$865,000	$—	$865,000
****3***	***Northport***	***NY***	***2***	***Replace Windows***	***$1,500,000***	***$—***	***$1,500,000***
3	Northport	NY	2	Install Sprinkler System	$1,100,000	$—	$1,100,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
3	Northport	NY	2	Renovate Research	$500,000	$—	$500,000
3	Northport	NY	2	Relocate Sleep Lab	$550,000	$—	$550,000
***3**	***Northport***	***NY***	***2***	***Replace Outdoor Lighting Cables***	***$500,000***	***$—***	***$500,000***
3	Northport	NY	2	Renovate Pathology and Lab	$500,000	$—	$500,000
***3**	***Northport***	***NY***	***2***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
3	Bronx	NY	6	Renovate and Modernize for Geriatric Research, Education and Clinical Center (GRECC) and Geriatric Primary Care	$740,000	$—	$740,000
3	St Albans	NY	6	Replace Boiler Plant Roof	$400,000	$—	$400,000
***3**	***St Albans***	***NY***	***6***	***Replace and Upgrade Heating, Ventilation and Air Conditioning Components and Controls***	***$650,000***	***$—***	***$650,000***
3	St Albans	NY	6	Install New Medical Gas Systems	$550,000	$—	$550,000
***3**	***St Albans***	***NY***	***6***	***Upgrade Light Fixtures to Energy Efficient Fixtures***	***$600,000***	***$—***	***$600,000***
***3**	***St Albans***	***NY***	***6***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***

3	***Castle Point***	***NY***	***13***	***Repair and Upgrade Boilers***	***$1,750,000***	***$—***	***$1,750,000***
3	***Brooklyn***	***NY***	***13***	***Replace Light Fixtures and Upgrade Heating, Ventilation and Air Conditioning Components for Energy Efficiency***	***$600,000***	***$—***	***$600,000***
3	Brooklyn	NY	13	Upgrade the Electrical Distribution System	$600,000	$—	$600,000
3	***Brooklyn***	***NY***	***13***	***Upgrade Heating, Ventilation and Air Conditioning System***	***$395,000***	***$—***	***$395,000***
3	Brooklyn	NY	13	Replace and Upgrade Main Water Line	$400,000	$—	$400,000
3	***Brooklyn***	***NY***	***13***	***Upgrade Ventilation System in Building 1***	***$350,000***	***$—***	***$350,000***
3	Brooklyn	NY	13	Replace Sprinkler System	$155,000	$—	$155,000
3	Brooklyn	NY	13	Renovate Radiology	$657,000	$—	$657,000
3	Brooklyn	NY	13	Repair and Replace Sidewalks, Parking Lots & Roads	$495,000	$—	$495,000
3	Brooklyn	NY	13	Repair Elevators	$375,000	$—	$375,000
3	Brooklyn	NY	13	Replace Roof on Building 91	$350,000	$—	$350,000
3	***St Albans***	***NY***	***13***	***Upgrade the Heating, Ventilation and Air Conditioning System***	***$395,000***	***$—***	***$395,000***
3	***St Albans***	***NY***	***13***	***Upgrade Bathrooms***	***$605,000***	***$—***	***$605,000***
3	Brooklyn	NY	13	Abate Asbestos	$45,000	$—	$45,000
3	***Brooklyn***	***NY***	***13***	***Replace and Upgrade Light Fixtures***	***$445,000***	***$—***	***$445,000***

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
3	Brooklyn	NY	13	Renovate Supply, Processing and Distribution	$7,125,000	$—	$7,125,000
3	New York City	NY	14	Upgrade and Modernize GI Lab	$3,750,000	$175,000	$3,575,000
***3**	***Northport***	***NY***	***14***	***Renovate and Upgrade Heating, Ventilation and Air Conditioning for Supply, Processing and Distribution and Pharmacy Storage***	***$500,000***	***$—***	***$500,000***
3	New York City	NY	14	Replace Generators, Ph 2	$4,755,383	$—	4,755,383
***3**	***New York City***	***NY***	***14***	***Replace and Upgrade Heating, Ventilation and Air Conditioning Equipment***	***$1,623,800***	***$—***	***$1,623,800***
3	New York City	NY	14	Repair Parking Lot and Sidewalks	$850,000	$—	$850,000
***3**	***New York City***	***NY***	***14***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
***3**	***Bronx***	***NY***	***16***	***Replace and Upgrade the Heating, Ventilation and Air Conditioning & Controls***	***$1,348,000***	***$180,000***	***$1,168,000***
3	Brooklyn	NY	16	Replace and Upgrade the Dumbwaiter	$475,000	$—	$475,000

3	***Bronx***	***NY***	***16***	***Upgrade Boiler Controls***	***$224,000***	***$—***	***$224,000***
3	Bronx	NY	16	Upgrade Emergency Electrical, Ph 2	$3,620,000	$120,000	$3,500,000
3	Bronx	NY	16	Replace Mechanical Room Floor	$627,000	$—	$627,000
3	Montrose	NY	19	Renovate for Patient Dining Area	$3,300,000	$—	$3,300,000
3	Castle Point	NY	19	Repair Exterior of Building to Tuck-Point and Seal Masonry	$1,900,000	$—	$1,900,000
3	***Montrose***	***NY***	***19***	***Replace Steam Lines, Phase 2***	***$3,450,000***	***$—***	***$3,450,000***
3	Castle Point	NY	19	Renovate for a Modern Community Living Center	$510,000	$—	$510,000
3	***Castle Point***	***NY***	***19***	***Replace Fan Coils, Phase 1***	***$850,000***	***$—***	***$850,000***
3	Castle Point	NY	19	Replace Roofs on Buildings 8 & 9	$1,000,000	$—	$1,000,000
3	Castle Point	NY	19	Replace Water Main Lines	$2,500,000	$—	$2,500,000
3	***Castle Point***	***NY***	***19***	***Replace Steam Traps***	***$475,000***	***$—***	***$475,000***
3	***Castle Point***	***NY***	***19***	***Install Wind Turbine***	***$80,000***	***$—***	***$80,000***
3	***Castle Point***	***NY***	***19***	***Install Utility Metering***	***$380,000***	***$40,000***	***$340,000***
3	Castle Point	NY	19	Replace Medical Gas Systems in Patient Rooms	$525,000	$—	$525,000
2	Albany	NY	21	Abate Asbestos in Sub Basement, Phase 2	$5,400,000	$—	$5,400,000
2	Albany	NY	21	Renovate and Upgrade Dental Suite	$3,700,000	$—	$3,700,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
2	Albany	NY	21	Renovate and Expand Prosthetics	$1,050,000	$—	$1,050,000
***2**	***Albany***	***NY***	***21***	***Replace Windows***	***$1,100,000***	***$100,000***	***$1,000,000***
2	Albany	NY	21	Repair Warehouse Loading Docks	$350,000	$—	$350,000
2	Albany	NY	21	Renovate Post Anesthesia Care Unit	$997,500	$—	$997,500
2	Albany	NY	21	Remove Incinerator	$900,000	$—	$900,000
2	Albany	NY	21	Demolish Buildings 6, 7, 11 and 35	$900,000	$—	$900,000
***2**	***Albany***	***NY***	***21***	***Implement Selected Conservation Measures[1]***	***$2,400,000***	***$—***	***$2,400,000***
2	Rome	NY	24	Renovate and Modernize the Outpatient Clinic, Phase 2	$250,000	$—	$250,000
***2**	***Rome***	***NY***	***24***	***Replace and Upgrade Air Handling Unit's***	***$775,000***	***$—***	***$775,000***
2	Syracuse	NY	25	Renovate 8th Floor for Community Living Center, Phase 2	$200,000	$—	$200,000
2	Syracuse	NY	25	Replace Roofs	$250,000	$—	$250,000
2	Syracuse	NY	25	Provide Emergency Power to Bldg 16	$100,000	$—	$100,000

2	Syracuse	NY	25	Renovate for Cardiology Suite	$335,000	$—	$335,000
2	Syracuse	NY	25	Renovate Outpatient Exam Rooms	$570,000	$—	$570,000
2	Syracuse	NY	25	Upgrade Electrical Panel Boards	$635,000	$—	$635,000
2	Syracuse	NY	25	Upgrade the Electrical Distribution System by Adding a Power Monitoring System	$190,000	$—	$190,000
2	***Syracuse***	***NY***	***25***	***Replace Existing Chillers***	***$2,000,000***	***$—***	***$2,000,000***
2	***Syracuse***	***NY***	***25***	***Upgrade Light Fixtures to Energy Efficient Fixtures***	***$580,000***	***$—***	***$580,000***
2	***Syracuse***	***NY***	***25***	***Implement Selected Conservation Measures[1]***	***$2,400,000***	***$—***	***$2,400,000***
2	Batavia	NY	26	Repair and Remove Boiler Plant Bunker	$560,000	$—	$560,000
2	Batavia	NY	26	Repair Stairs in front of Building 2	$500,000	$—	$500,000
2	Batavia	NY	26	Renovate Primary Care for Patient Privacy	$150,000	$—	$150,000
2	***Batavia***	***NY***	***26***	***Implement Selected Conservation Measures[1]***	***$2,400,000***	***$—***	***$2,400,000***
2	Buffalo	NY	28	Construct Private Inpatient Wards	$3,600,000	$—	$3,600,000
2	Buffalo	NY	28	Repave Parking Lot for Patients	$700,000	$—	$700,000
2	Buffalo	NY	28	Expand Dialysis Clinic	$750,000	$—	$750,000
2	Buffalo	NY	28	Replace Domestic Water Booster Pumps	$560,000	$—	$560,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
2	Buffalo	NY	28	Repair Warehouse Roof	$425,000	$—	$425,000
***2**	***Buffalo***	***NY***	***28***	***Implement Selected Conservation Measures[1]***	***$2,400,000***	***$—***	***$2,400,000***
***2**	***Buffalo***	***NY***	***28***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
***2**	***Bath***	***NY***	***29***	***Replace Heating, Ventilation and Air Conditioning in Building 92***	***$1,956,000***	***$106,000***	***$1,850,000***
***2**	***Bath***	***NY***	***29***	***Replace Window Heating, Ventilation and Air Conditioning units with Central Air for Bldg 33***	***$1,084,000***	***$174,000***	***$910,000***
2	Bath	NY	29	Replace Elevator in Bldg 33	$350,000	$—	$350,000
2	Canandaigua	NY	29	Design for a new Fire Alarm System	$75,000	$—	$75,000
2	Bath	NY	29	Replace and Upgrade the Electric Distribution System in Bldg 41	$300,000	$40,000	$260,000
***2**	***Bath***	***NY***	***29***	***Replace and Upgrade Heating, Ventilation and Air Conditioning in Bldg 39***	***$200,000***	***$20,000***	***$180,000***

2	Canandaigua	NY	29	Upgrade and Modernize Patient Corridors in Buildings 3 and 8	$200,000	$—	$200,000
2	Bath	NY	29	Replace and Upgrade the Electrical Distribution System	$2,500,000	$250,000	$2,250,000
2	Bath	NY	29	Renovate for Women's Health Center	$250,000	$—	$250,000
2	Canandaigua	NY	29	Replace and Upgrade the Panic Alarm System	$450,000	$—	$450,000
***2**	***Bath***	***NY***	***29***	***Upgrade and Replace the Heating, Ventilation and Air Conditioning and Fire Suppression System***	***$750,000***	***$—***	***$750,000***
2	Canandaigua	NY	29	Replace Sanitary Sewer, B–36 & B–12	$250,000	$—	$250,000
2	Bath	NY	29	Relocate the Hospice and Gero-Pyschiatric Unit	$750,000	$—	$750,000
2	Bath	NY	29	Replace Main Drainage System for Bldg 76	$1,800,000	$30,000	$1,770,000
2	Canandaigua	NY	29	Upgrade and Repair Fuel Tanks	$200,000	$—	$200,000
***2**	***Canandaigua***	***NY***	***29***	***Implement Selected Conservation Measures[1]***	***$2,400,000***	***$—***	***$2,400,000***
***2**	***Bath***	***NY***	***29***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
				Total—New York	**$110,797,683**	**$1,235,000**	**$109,562,683**
	Cincinnati	OH	1	Expand Cath Lab	$2,200,000	$—	$2,200,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
10	Cincinnati	OH	1	Upgrade and Repair Exterior Façade	$1,100,000	$—	$1,100,000
***10**	***Cincinnati***	***OH***	***1***	***Implement Selected Conservation Measures[1]***	***$2,500,000***	***$—***	***$2,500,000***
10	Dayton	OH	3	Renovate Nursing Home Care Unit into a Community Living Center	$2,750,000	$—	$2,750,000
10	Dayton	OH	3	Renovate Domiciliary	$1,100,000	$—	$1,100,000
***10**	***Dayton***	***OH***	***3***	***Implement Selected Conservation Measures[1]***	***$2,500,000***	***$—***	***$2,500,000***
***10**	***Chillicothe***	***OH***	***7***	***Repair Steam Lines***	***$2,500,000***	***$—***	***$2,500,000***
10	Chillicothe	OH	7	Replace Elevators	$1,200,000	$—	$1,200,000
10	Chillicothe	OH	7	Renovate Physical Therapy	$1,200,000	$—	$1,200,000
10	Chillicothe	OH	7	Renovate Basement	$680,000	$—	$680,000
***10**	***Chillicothe***	***OH***	***7***	***Implement Selected Conservation Measures[1]***	***$2,500,000***	***$—***	***$2,500,000***
10	Cleveland	OH	11	Renovate Surgery	$8,500,000	$—	$8,500,000
10	Cleveland	OH	11	Renovate Elevator Lobby and Main Lobby	$4,913,331	$—	$4,913,331
10	Cleveland	OH	11	Renovate Canteen and Education	$3,500,000	$—	$3,500,000

10	***Cleveland***	***OH***	***11***	***Implement Selected Conservation Measures[1]***	***$2,500,000***	***$—***	***$2,500,000***
				Total—Ohio	**$39,643,331**	**$—**	**$39,643,331**
16	Muskogee	OK	2	Expand Parking Lot 12	$550,000	$—	$550,000
16	Muskogee	OK	2	Replace Generators 26 & 46	$1,815,000	$—	$1,815,000
16	Muskogee	OK	2	Expand Parking Lot 14	$330,000	$—	$330,000
16	Muskogee	OK	2	Repair/Resurface Roads and Parking	$699,000	$—	$699,000
16	***Oklahoma City***	***OK***	***5***	***Replace Morgue Heating, Ventilation and Air Conditioning***	***$80,000***	***$—***	***$80,000***
16	Oklahoma City	OK	5	Renovate for Primary Care Clinics	$530,000	$—	$530,000
16	Oklahoma City	OK	5	Renovate for Medical Record Storage	$264,000	$—	$264,000
16	Oklahoma City	OK	5	Renovate Police Training Room	$276,000	$—	$276,000
16	***Oklahoma City***	***OK***	***5***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
				Total—Oklahoma	**$4,554,000**	**$—**	**$4,554,000**
20	***Portland***	***OR***	***1***	***Install New Chiller for Ambulatory Surgery***	***$100,000***	***$—***	***$100,000***
20	Portland	OR	1	Renovate Lab	$465,000	$—	$465,000
20	Portland	OR	1	Remodel Surgical Waiting Area	$110,000	$—	$110,000
20	Portland	OR	1	Remodel Patient Exam Rooms	$290,000	$—	$290,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
20	Portland	OR	1	Renovate for installation of New SPEC CT	$100,000	$—	$100,000
20	Portland	OR	1	Building 100 Expansion Survey for Clinical Care	$25,000	$—	$25,000
20	Portland	OR	1	Renovate Primary Care Space for Women's Clinic, Building 103	$250,000	$—	$250,000
20	Portland	OR	1	Upgrade/Repair Paging System, Phase 2	$473,223	$—	$473,223
20	Portland	OR	1	Upgrade Nitrogen Farm per Regulation	$95,726	$—	$95,726
20	Portland	OR	1	Repair Safety Deficiencies	$100,000	$—	$100,000
20	Portland	OR	1	Renovate for the installation of Hi-Tech/Hi-Cost Equipment	$150,000	$—	$150,000
20	Portland	OR	1	Construct Retaining Wall for Building 16 Parking Lot	$225,000	$—	$225,000
20	Portland	OR	1	Renovate Basement of Building 16 for additional Exit	$225,000	$—	$225,000
20	Portland	OR	1	Install Distributed Antenna, Building 100, Phase 1	$287,889	$—	$287,889
20	Portland	OR	1	Install New PIV Door Locking System per Regulation	$300,000	$—	$300,000

20	Portland	OR	1	Renovate Operating Room	$580,000	$—	$580,000
20	White City	OR	2	Repair/Resurface Main Roadways—FCA Correction	$1,203,000	$93,000	$1,110,000
20	White City	OR	2	Renovate Building 212	$495,000	$—	$495,000
***20**	***White City***	***OR***	***2***	***Renovate Restrooms***	***$225,000***	***$—***	***$225,000***
20	Roseburg	OR	4	Renovate/Relocate Alzheimer Unit, Building 81	$265,000	$—	$265,000
20	Roseburg	OR	4	Upgrade Medical Gas System, Phase 2	$335,000	$—	$335,000
20	Roseburg	OR	4	Repair/Upgrade Nurse Call System for Patient Safety	$475,000	$125,000	$350,000
20	Roseburg	OR	4	Repair/Replace Sewer and Storm Lines	$410,000	$40,000	$370,000
20	Roseburg	OR	4	Install Security Upgrades for Surgery	$163,000	$20,000	$143,000
20	Roseburg	OR	4	Install Elevator Handrail and Replace Roof, Building 1 Elevator Tower	$55,500	$—	$55,500
				Total—Oregon	**$7,403,338**	**$278,000**	**$7,125,338**
4	Philadelphia	PA	1	Renovate Emergency Department	$4,750,000	$—	$4,750,000
4	Philadelphia	PA	1	Construct a New Computer Room	$250,000	$—	$250,000
***4**	***Philadelphia***	***PA***	***1***	***Upgrade the Boiler Plant Controls***	***$466,440***	***$—***	***$466,440***
4	Coatesville	PA	1	Renovate Pharmacy	$1,740,000	$40,000	$1,700,000
4	Philadelphia	PA	1	Upgrade Behavioral Health Clinic	$1,150,000	$—	$1,150,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
4	***Coatesville***	***PA***	***1***	***Upgrade Boiler Plant Controls***	***$410,000***	***$—***	***$410,000***
4	Coatesville	PA	1	Upgrade and Replace Electrical Distribution System	$1,750,000	$—	$1,750,000
4	Philadelphia	PA	1	Renovate and Modernize the Dental Lab	$35,000	$—	$35,000
4	***Erie***	***PA***	***3***	***Correct Boiler Plant Deficiencies***	***$466,440***	***$—***	***$466,440***
4	Butler	PA	3	Upgrade and Renovate the Electrical Distribution Panels	$2,556,000	$—	$2,556,000
4	***Butler***	***PA***	***3***	***Replace Boilers***	***$400,000***	***$—***	***$400,000***
4	Butler	PA	3	Improve Site Drainage	$1,500,000	$—	$1,500,000
4	Butler	PA	3	Replace and Upgrade Electrical Distribution System	$2,500,000	$—	$2,500,000
4	Butler	PA	3	Renovate Supply, Processing and Distribution for ETO Sterilizer Installation	$126,000	$—	$126,000
4	***Butler***	***PA***	***3***	***Replace Windows***	***$200,000***	***$—***	***$200,000***
4	Butler	PA	3	Assess the Water Tower Renovation Needs	$50,000	$—	$50,000
4	Butler	PA	3	Renovate for Diagnostics	$4,300,000	$—	$4,300,000

4	Pittsburgh	PA	4	Upgrade Emergency Power Distribution	$6,901,950	$—	$6,901,950
4	Pittsburgh	PA	4	Renovate Surgical Intensive Care Unit	$2,400,000	$—	$2,400,000
4	Pittsburgh	PA	4	Replace Main Plumbing System	$2,200,000	$—	$2,200,000
4	Altoona	PA	9	Upgrade and Replace Electrical Distribution System	$1,470,000	$—	$1,470,000
4	Altoona	PA	9	Upgrade and Replace Security Systems	$330,000	$—	$330,000
***4**	***Altoona***	***PA***	***9***	***Upgrade Heating, Ventilation and Air Conditioning Deficiencies***	***$51,000***	***$—***	***$51,000***
4	Altoona	PA	9	Renovate and Modernize Outpatient Areas for American Disability Act Compliance	$110,000	$—	$110,000
4	Altoona	PA	9	Renovate Canteen	$825,000	$—	$825,000
4	Wilkes-Barre	PA	10	Renovate the Cath Lab	$315,000	$—	$315,000
4	Lebanon	PA	17	Construct New Consolidated Rehabilitation Services	$4,100,000	$—	$4,100,000
4	Lebanon	PA	17	Renovate Patient Check-in and Appointment Area	$3,300,000	$—	$3,300,000
***4**	***Lebanon***	***PA***	***17***	***Install Chiller***	***$250,000***	***$—***	***$250,000***
4	Lebanon	PA	17	Renovate Bathrooms for American Disability Act Compliance	$1,570,000	$—	$1,570,000
				Total—Pennsylvania	**$46,472,830**	**$40,000**	**$46,432,830**
8	San Juan	PR	At Large	Renovate Outpatient Care	$1,432,043	$—	$1,432,043

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
8	San Juan	PR	At Large	Repair and Upgrade Electrical Substation	$3,640,403	$—	$3,640,403
8	San Juan	PR	At Large	Install New Emergency Generator	$1,303,682	$—	$1,303,682
8	San Juan	PR	At Large	Install Oxygen System	$172,104	$—	$172,104
***8**	***San Juan***	***PR***	***At Large***	***Replace Cooling Towers***	***$383,741***	***$—***	***$383,741***
8	San Juan	PR	At Large	Replace Community Living Center Elevators	$390,390	$—	$390,390
8	San Juan	PR	At Large	Study to Address Life Safety Issues on Main Water Distribution System	$126,500	$—	$126,500
8	San Juan	PR	At Large	Replace Sanitary System	$419,812	$—	$419,812
***8**	***San Juan***	***PR***	***At Large***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
				Total—Puerto Rico	**$7,878,675**	**$—**	**$7,878,675**
***1**	***Providence***	***RI***	***1***	***Add Heating, Ventilation and Air Conditioning for Inpatient Wards***	***$2,375,000***	***$225,000***	***$2,150,000***
1	Providence	RI	1	Repair and Upgrade Electrical Wiring, Phase 1	$1,650,000	$—	$1,650,000
1	Providence	RI	1	Repair and Replace the Exterior Façade	$5,600,000	$—	$5,600,000

1	***Providence***	***RI***	***1***	***Convert High Pressure Steam Boilers to Low Pressure Steam Boilers, Phase 2***	***$2,350,000***	***$200,000***	***$2,150,000***
				Total—Rhode Island	**$11,975,000**	**$425,000**	**$11,550,000**
7	Charleston	SC	1	Renovate Specialty Clinic	$2,037,047	$—	$2,037,047
7	Columbia	SC	2	Renovate for Handicap Access	$917,605	$—	$917,605
7	Columbia	SC	2	Renovate for Primary Care	$1,700,000	$200,000	$1,500,000
				Total—South Carolina	**$4,654,652**	**$200,000**	**$4,454,652**
23	Sioux Falls	SD	At Large	Elevator Upgrade	$1,200,000	$—	$1,200,000
23	Sioux Falls	SD	At Large	Renovate Pharmacy Consultation Rooms	$502,476	$—	$502,476
23	Sioux Falls	SD	At Large	Renovate Dental Suites	$326,181	$—	$326,181
23	Sioux Falls	SD	At Large	Construct Lead Lined Wall	$90,000	$—	$90,000
23	Sioux Falls	SD	At Large	Tuck-Pointing Study	$40,000	$—	$40,000
23	Sioux Falls	SD	At Large	Renovate for Mental Health Space	$110,000	$—	$110,000
23	Sioux Falls	SD	At Large	Renovate/Upgrade Acute Patient Care Area	$500,000	$—	$500,000
23	Ft. Meade	SD	At Large	Renovate Quality Management Space in Building 148	$275,000	$—	$275,000
23	Ft. Meade	SD	At Large	Renovate/Upgrade Existing Police Office	$225,000	$—	$225,000
****23***	***Ft. Meade***	***SD***	***At Large***	***Replace IRM A/C Systems***	***$200,000***	***$—***	***$200,000***
23	Ft. Meade	SD	At Large	Upgrade Security Systems for Medical Center	$460,000	$—	$460,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
23	Ft. Meade	SD	At Large	Renovate Supply, Processing and Distribution	$150,000	$—	$150,000
23	Ft. Meade	SD	At Large	Replace Corridor Floor Tile	$300,000	$—	$300,000
23	Ft. Meade	SD	At Large	Renovate Nursing Home Care Unit	$200,000	$—	$200,000
23	Ft. Meade	SD	At Large	Repair Historic Buildings on Campus	$200,000	$—	$200,000
****23***	***Ft. Meade***	***SD***	***At Large***	***Replace Hospital Windows***	***$250,000***	***$—***	***$250,000***
****23***	***Ft. Meade***	***SD***	***At Large***	***Heating, Ventilation and Air Conditioning Repairs Building 113 and 148***	***$50,000***	***$—***	***$50,000***
23	Ft. Meade	SD	At Large	Replace/Update Hospital Interior Finishes	$50,000	$—	$50,000
23	Ft. Meade	SD	At Large	Renovate Mental Health Outpatient Clinic, Phase 4	$450,000	$—	$450,000
23	Ht Springs	SD	At Large	Remodel Primary Care for Patient Privacy	$665,000	$—	$665,000
****23***	***Ht Springs***	***SD***	***At Large***	***Replace Heating, Ventilation and Air Conditioning System Building 4***	***$610,000***	***$—***	***$610,000***
23	Ht Springs	SD	At Large	Road Replacement, Phase 1	$400,000	$—	$400,000
****23***	***Ht Springs***	***SD***	***At Large***	***Replace Boiler 2***	***$100,000***	***$—***	***$100,000***

23	***Ht Springs***	***SD***	***At Large***	***Replace Hospital Steam Lines and Regulators***	***$40,000***	***$—***	***$40,000***
23	Ht Springs	SD	At Large	Repair/Upgrade Water Line for Quarters	$110,000	$—	$110,000
				Total—South Dakota	**$7,503,657**	**$—**	**$7,503,657**
***EN**	***TBD***	***TBD***	***TBD***	***Construct a Solar Photovoltaic System at up to 8 Locations[1]***	***$1,486,000***	***$—***	***$1,486,000***
***EN**	***TBD***	***TBD***	***TBD***	***Construct Wind Turbines for up to 6 Locations[1]***	***$6,000,000***	***$—***	***$6,000,000***
***EN**	***TBD***	***TBD***	***TBD***	***Implement Direct Geothermal at up to 5 Sites***	***$5,000,000***	***$—***	***$5,000,000***
***EN**	***TBD***	***TBD***	***TBD***	***Install Advanced Meters to Meet Metering Mandates[1]***	***$110,000,000***	***$13,000,000***	***$97,000,000***
***EN**	***TBD***	***TBD***	***TBD***	***Construct Renewably Fueled Cogeneration Systems at up to 9 Sites[1]***	***$38,636,000***	***$7,400,000***	***$31,236,000***
				Total—TBD	**$161,122,000**	**$20,400,000**	**$140,722,000**
9	Mountain Home	TN	1	Renovate Administrative Space	$1,120,062	$99,062	$1,021,000
9	Mountain Home	TN	1	Construct New Electrical Distribution System	$950,000	$—	$950,000
9	Mountain Home	TN	1	Renovate Canteen	$400,000	$36,000	$364,000
9	Mountain Home	TN	1	Renovate Pharmacy	$400,000	$36,000	$364,000
9	Mountain Home	TN	1	Replace Nurses Stations	$336,065	$23,000	$313,065
9	Mountain Home	TN	1	Replace Switch Board	$549,000	$—	$549,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
***9**	**Mountain Home**	**TN**	**1**	**Repair and Upgrade Site Lighting**	**$176,000**	**$16,000**	**$160,000**
***9**	**Mountain Home**	**TN**	**1**	**Evaluate Feasibility of a Wind Turbine[1]**	**$50,000**	**$—**	**$50,000**
9	Nashville	TN	5	Renovate Research Lab	$4,303,000	$461,000	$3,842,000
9	Nashville	TN	5	Renovate Inpatient Ward	$1,766,000	$140,000	$1,626,000
9	Nashville	TN	5	Repair and Replace Exterior	$1,000,000	$—	$1,000,000
9	Murfreesboro	TN	6	Upgrade Electrical Distribution System	$3,560,000	$—	$3,560,000
9	Murfreesboro	TN	6	Construct New Pharmacy Code Requirements	$1,826,000	$196,000	$1,630,000
9	Murfreesboro	TN	6	Modernize and Upgrade Outpatient Area	$1,000,000	$—	$1,000,000
9	Memphis	TN	9	Renovate for Cat Scanner and Ultrasound	$969,973	$—	$969,973
9	Memphis	TN	9	Repair and Upgrade Medical Gas System	$668,000	$—	$668,000
9	Memphis	TN	9	Construct Intensive Care Unit Family Waiting Rooms	$280,000	$—	$280,000
***9**	**Memphis**	**TN**	**9**	**Replace Water Cooled Condensers**	**$246,000**	**$—**	**$246,000**
				Total—Tennessee	**$19,600,100**	**$1,007,062**	**$18,593,038**

17	***Bonham***	***TX***	***4***	***Install New Heating, Ventilation and Air Conditioning System and Upgrade Electrical in Building 2***	***$2,000,000***	***$—***	***$2,000,000***
16	Houston	TX	9	Repair/Replace Elevator Controls and Motor	$850,000	$—	$850,000
16	Houston	TX	9	Site Prep/Renovation for Supply, Processing and Distribution Equipment Replacement	$500,000	$—	$500,000
16	Houston	TX	9	Renovate Existing Parking Lot	$1,600,000	$—	$1,600,000
16	***Houston***	***TX***	***9***	***Upgrade Heating, Ventilation and Air Conditioning Controls***	***$3,250,000***	***$—***	***$3,250,000***
18	Amarillo	TX	13	Replace/Upgrade Fire Alarm Panels	$560,000	$—	$560,000
18	***Amarillo***	***TX***	***13***	***4th Floor Heating, Ventilation and Air Conditioning Modifications***	***$495,500***	***$50,000***	***$445,500***
18	Amarillo	TX	13	Repair/Upgrade Water and Fire Sprinkler System	$400,000	$40,000	$360,000
18	Amarillo	TX	13	Renovate Nursing Home Care Unit	$750,000	$75,000	$675,000
18	Amarillo	TX	13	Renovate Patient Rooms for Isolation Rooms	$305,000	$30,000	$275,000
18	Amarillo	TX	13	Renovate Nursing Home	$900,000	$—	$900,000
18	Amarillo	TX	13	Repair/Upgrade Flooring in Patient Care Areas of Building 1	$638,000	$—	$64,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
18	Amarillo	TX	13	Renovate Intensive Care Unit Storage and Patient/ Family Waiting Area	$550,000	$—	$55,000
18	Amarillo	TX	13	Replace Plumbing in Intensive Care Unit	$275,000	$—	$28,000
***18**	***Amarillo***	***TX***	***13***	***Implement Selected Conservation Measures[1]***	***$1,142,857***	***$—***	***$1,142,857***
***18**	***Amarillo***	***TX***	***13***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
***18**	***El Paso***	***TX***	***16***	***Replace Domestic and Heating Water Valves***	***$825,000***	***$72,000***	***$753,000***
18	El Paso	TX	16	Renovate Primary Care Space for Behavioral Health	$280,000	$—	$280,000
***18**	***El Paso***	***TX***	***16***	***Repair/Replace Site Lighting and Ballasts—FCA Corrections***	***$27,250***	***$2,250***	***$25,000***
***18**	***El Paso***	***TX***	***16***	***Repair/Replace Damaged Heating, Ventilation and Air Conditioning Ducts***	***$239,000***	***$17,000***	***$222,000***
18	El Paso	TX	16	Convert Site to Desert Xeriscape Landscaping	$550,000	$50,000	$500,000
18	El Paso	TX	16	Renovate Patient Care Areas on 3rd Floor, Phase 1	$220,000	$20,000	$200,000

18	***El Paso***	***TX***	***16***	***Implement Selected Conservation Measures[1]***	***$1,142,857***	***$—***	***$1,142,857***
17	***Waco***	***TX***	***17***	***Replace Heating, Ventilation and Air Conditioning, Phase 1***	***$2,500,000***	***$—***	***$2,500,000***
17	Waco	TX	17	Relocate Canteen from Building 8 to Building 1	$500,000	$—	$500,000
17	Waco	TX	17	Repair/Upgrade Electrical Feeder	$760,000	$—	$760,000
17	Waco	TX	17	Renovate/Upgrade Existing Water Tower	$745,081	$—	$745,081
17	Waco	TX	17	Improve/Enhance Storm Water Drainage for Facility—FCA Correction	$800,000	$—	$800,000
17	Waco	TX	17	Repair/Replace Roads, Phase 2	$900,000	$—	$900,000
17	***Waco***	***TX***	***17***	***Replace Windows in Building 1***	***$747,000***	***$—***	***$747,000***
17	Waco	TX	17	Renovate Basement of Building 6 for Rehabilitation Service	$1,000,000	$—	$1,000,000
18	Big Spring	TX	19	Asbestos Abatement	$750,000	$74,000	$676,000
18	Big Spring	TX	19	Renovate 2nd and 3rd Floors of Building 1 patient care areas	$400,000	$40,000	$360,000
18	Big Spring	TX	19	Renovate Main Entrance to include asbestos abatement	$750,000	$—	$750,000
18	***Big Spring***	***TX***	***19***	***Repair/Upgrade Steam and Chiller Pipes***	***$694,000***	***$67,000***	***$627,000***

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

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	City	State	Congressional District				
18	Big Spring	TX	19	Ground Safety and Handicap Accessibility Improvements	$500,000	$64,000	$436,000
18	Big Spring	TX	19	Renovate Canteen in Building 1	$598,000	$58,000	$540,000
18	Big Spring	TX	19	Plumbing System Improvements, Building 1, Phase 3	$750,000	$—	$750,000
18	Big Spring	TX	19	Replace/Repair Air, Oxygen, and Vacuum System Piping	$450,000	$—	$45,000
***18**	***Big Spring***	***TX***	***19***	***Implement Selected Conservation Measures[1]***	***$1,142,857***	***$—***	***$1,142,857***
***18**	***Big Spring***	***TX***	***19***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
17	San Antonio	TX	20	Renovate Operating Room #2	$600,000	$—	$600,000
17	San Antonio	TX	20	Renovate for New Outpatient Clinic	$3,525,000	$—	$3,525,000
***17**	***Kerrville***	***TX***	***21***	***Upgrade/Repair Boiler Plant, Building 19***	***$756,173***	***$—***	***$756,173***
***17**	***Kerrville***	***TX***	***21***	***Replace/Upgrade Air Handler Units in various buildings throughout the campus***	***$1,900,050***	***$—***	***$1,900,050***

17	Kerrville	TX	21	Replace/Upgrade Roofs on Buildings 11, 18, 46 & 47	$1,184,000	$—	$1,184,000
17	Dallas	TX	30	Replace Campus Fire Alarm System	$3,753,000	$—	$3,753,000
17	Dallas	TX	30	Building 2 Ward Renovation for Patient Privacy	2,200,000$	$—	$2,200,000
				Total—Texas	**$45,425,625**	**$659,250**	**$43,045,375**
19	Salt Lake City	UT	2	Replace/Repair of Primary Electrical Panel for Building 14	$750,000	$75,000	$675,000
***19**	***Salt Lake City***	***UT***	***2***	***Replace Chilled Water Distribution Line, Phase 3***	***$750,000***	***$75,000***	***$675,000***
19	Salt Lake City	UT	2	Expand Fiber and Networking Capability, Phase 1	$750,000	$—	$750,000
19	Salt Lake City	UT	2	Upgrade Electrical Distribution Substation	$750,000	$75,000	$675,000
19	Salt Lake City	UT	2	Repair/Upgrade Domestic Water Distribution, Phase 3	$750,000	$75,000	$675,000
***19**	***Salt Lake City***	***UT***	***2***	***Johnson Control Upgrade/ Replacement Phase 1 (energy)***	***$750,000***	***$75,000***	***$675,000***
***19**	***Salt Lake City***	***UT***	***2***	***Evaluate Feasibility of Direct Geothermal[1]***	***$342,857***	***$—***	***$342,857***
***19**	***Salt Lake City***	***UT***	***2***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
***19**	***Salt Lake City***	***UT***	***2***	***Evaluate Feasibility of a Solar Photovoltaic System[1]***	***$10,000***	***$—***	***$10,000***
				Total—Utah	**$4,902,857**	**$375,000**	**$4,527,857**

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
6	Hampton	VA	3	Replace Nurse Call	$715,950	$—	$715,950
6	Hampton	VA	3	Upgrade Fire Alarm Various Buildings	$1,118,500	$—	$1,118,500
6	Hampton	VA	3	Replace/Upgrade Electrical Distribution Systems	$6,216,000	$—	$6,216,000
***6**	***Richmond***	***VA***	***3***	***Upgrade and Replace Heating, Ventilation and Air Conditioning System***	***$782,000***	***$—***	***$782,000***
6	Richmond	VA	3	Repair Exterior Facing with Caulk and Sealing	$1,170,000	$—	$1,170,000
***6**	***Richmond***	***VA***	***3***	***Renovate Restrooms***	***$650,000***	***$—***	***$650,000***
6	Salem	VA	6	Renovate for Environmental Compliance	$679,600	$—	$679,600
6	Salem	VA	6	Repair and Replace Elevators	$1,567,720	$—	$1,567,720
***6**	***Salem***	***VA***	***6***	***Replace Steam Piping, Phase 2***	***$723,243***	***$—***	***$723,243***
6	Salem	VA	6	Replace Fire Alarm System	$1,257,000	$—	$1,257,000
***6**	***Salem***	***VA***	***6***	***Replace Light Fixtures***	***$487,000***	***$—***	***$487,000***
***6**	***Salem***	***VA***	***6***	***Evaluate Feasibility of a Wind Turbine[1]***	***$50,000***	***$—***	***$50,000***
				Total—Virginia	**$15,417,013**	**$—**	**$15,417,013**

1	White River Junction	VT	At Large	Upgrade Elevators	$1,500,000	$—	$1,500,000
1	***White River Junction***	***VT***	***At Large***	***Upgrade Heating, Ventilation and Air Conditioning in Building 1, Phase 1***	***$1,921,125***	***$180,000***	***$1,741,125***
1	***White River Junction***	***VT***	***At Large***	***Construct a Renewably Fueled Cogeneration System[1]***	***$5,675,531***	***$31,531***	***$5,644,000***
				Total—Vermont	**$9,096,656**	**$211,531**	**$8,885,125**
20	***Vancouver***	***WA***	***3***	***Install New Boilers***	***$400,000***	***$—***	***$400,000***
20	Vancouver	WA	3	Repair/Install TV and Radio in Patient Rooms	$225,000	$—	$225,000
20	Spokane	WA	5	Replace/Upgrade Generators—FCA Correction	$3,300,000	$—	$3,300,000
20	Walla Walla	WA	5	Renovate Supply, Processing and Distribution in Building 68	$885,000	$—	$885,000
20	***Spokane***	***WA***	***5***	***Replace/Upgrade Heating, Ventilation and Air Conditioning in Building 32***	***$158,865***	***$—***	***$158,865***
20	Walla Walla	WA	5	Install Grease Trap for Canteen Kitchen, Building 75	$212,000	$—	$212,000
20	Walla Walla	WA	5	Replace Elevator, Repair Safety Deficiencies, Building 69—FCA Corrections	$485,103	$—	$485,103
20	Walla Walla	WA	5	FCA—Replace Elevator B68	$404,500	$29,279	$375,221
20	Spokane	WA	5	Repair/Upgrade Electrical Distribution	$75,000	$—	$75,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
20	Walla Walla	WA	5	Replace Elevator, Building 80	$404,520	$41,503	$363,017
***20**	***Spokane***	***WA***	***5***	***Repair/Replace Heating, Ventilation and Air Conditioning Systems in Building 3***	***$75,000***	***$—***	***$75,000***
***20**	***Walla Walla***	***WA***	***5***	***Correct Steam Distribution Systems—FCA Corrections***	***$221,663***	***$—***	***$221,663***
20	Spokane	WA	5	Replace/Upgrade Existing High Voltage Substation	$1,875,000	$75,000	$1,800,000
***20**	***Walla Walla***	***WA***	***5***	***Replace Boiler Deaerator Tank and Boiler Safety Devices***	***$170,000***	***$53,762***	***$116,238***
20	Spokane	WA	5	FCA—Upgrade Canteen Dining	$190,000	$15,000	$175,000
20	Walla Walla	WA	5	Enhance Outpatient Security	$204,464	$58,688	$145,776
20	Walla Walla	WA	5	Facility Asbestos Survey to ensure Compliance	$20,000	$—	$20,000
***20**	***Spokane***	***WA***	***5***	***Install new Heating, Ventilation and Air Conditioning System***	***$660,000***	***$—***	***$660,000***
20	Spokane	WA	5	Community Living Center Renovation	$26,000	$—	$26,000

20	Walla Walla	WA	5	Conduct Facility Lead Paint Survey to ensure compliance	$30,000	$—	$30,000
20	Walla Walla	WA	5	Paint water tower—FCA Correction	$300,000	$—	$300,000
***20**	***Seattle***	***WA***	***7***	***Replace Heating, Ventilation and Air Conditioning in Building 13***	***$618,000***	***$—***	***$618,000***
20	Seattle	WA	7	Renovate/Expand Prosthetics Clinic, Building 100	$327,000	$—	$327,000
20	Seattle	WA	7	Renovate for installation of MRI Replacement	$168,000	$—	$168,000
20	Seattle	WA	7	Renovate for Pulmonary Outpatient Clinic	$500,000	$—	$500,000
20	Seattle	WA	7	Renovate Basement for Lab, to include Morgue and Hematology, Phase I—FCA Corrections	$1,600,000	$—	$1,600,000
20	Seattle	WA	7	Remodel Outpatient Pharmacy for Patient Privacy and Security	$300,000	$—	$300,000
20	Seattle	WA	7	Repair/Install Grease Traps for Dietetics Kitchen	$100,000	$—	$100,000
20	Seattle	WA	7	Renovate for Installation of Access Control System	$299,000	$—	$299,000
20	Seattle	WA	7	Upgrade Traffic Circle for Security Enhancements	$495,000	$—	$495,000
20	Seattle	WA	7	Repair/Upgrade Dumbwaiter for Supply, Processing and Distribution and Surgery	$540,000	$—	$540,000
20	Seattle	WA	7	Renovate Emergency Room	$596,000	$—	$596,000

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
20	Seattle	WA	7	Renovate existing Canteen for Chapel, Building 100	$660,000	$—	$660,000
20	Seattle	WA	7	Renovate Old Emergency Room for Musculo-Skeletal Specialty Care Clinic	$2,000,000	$—	$2,000,000
20	Seattle	WA	7	Relocate Canteen Food Service to Basement Bldg. 100	$842,000	$—	$842,000
20	Seattle	WA	7	Relocate Canteen Retail Store to Basement Building 100	$426,000	$—	$426,000
20	Seattle	WA	7	Renovate Existing Fiscal Space for Education Offices	$681,000	$—	$681,000
20	American Lake	WA	9	Renovate Outpatient Pharmacy for Patient Privacy/Security	$260,000	$—	$260,000
20	American Lake	WA	9	Renovate/Expand Gold Clinic, Building 81	$100,000	$—	$100,000
20	American Lake	WA	9	Upgrade Security/Rekey Locks at American Lake	$213,000	$—	$213,000
20	American Lake	WA	9	Renovate for New Dispatch Room in Building 19	$299,000	$—	$299,000
20	American Lake	WA	9	Renovate Warehouse for Medical Records, Building 19	$1,100,000	$—	$1,100,000

20	American Lake	WA	9	Renovate Building 85 for Eye Clinic, Compensation and Pension Exam Program and Mental Health Research	$760,000	$—	$760,000
				Total—Washington	**$23,206,115**	**$273,232**	**$22,932,883**
12	Madison	WI	2	Renovate Research	$2,750,000	$—	$2,750,000
12	Madison	WI	2	Renovate and Modernize Flooring and Walls	$475,000	$—	$475,000
12	Madison	WI	2	Renovate Clinical Space	$430,000	$—	$430,000
12	Tomah	WI	3	Replace Medical Gas System	$300,000	$—	$300,000
12	Tomah	WI	3	Construct Parking Lot & Pave Gravel Lots	$550,000	$—	$550,000
12	Tomah	WI	3	Renovate and Expand Rehabilitation Service	$1,575,000	$—	$1,575,000
***12**	***Tomah***	***WI***	***3***	***Replace Windows***	***$350,000***	***$—***	***$350,000***
***12**	***Tomah***	***WI***	***3***	***Install Central Air Conditioning***	***$225,000***	***$—***	***$225,000***
12	Tomah	WI	3	Renovate Urgent Care	$1,625,000	$50,000	$1,575,000
12	Tomah	WI	3	Replace Nurse Call System	$350,000	$—	$350,000
12	Tomah	WI	3	Upgrade Electrical Distribution System	$250,000	$—	$250,000
12	Tomah	WI	3	Upgrade Electrical Distribution System	$275,000	$—	$275,000
12	Tomah	WI	3	Renovate for Mental Health Clinics	$300,000	$—	$300,000
12	Milwaukee	WI	4	Replace and Upgrade Fire Alarm System	$262,305	$—	$262,305

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
12	Milwaukee	WI	4	Replace Fire Alarm System	$389,681	$—	$389,681
12	Milwaukee	WI	4	Replace Fire Alarm System	$683,014	$—	$683,014
12	Milwaukee	WI	4	Replace Fire Alarm System	$1,516,013	$—	$1,516,013
12	Milwaukee	WI	4	Replace Fire Alarm System	$604,957	$—	$604,957
12	Milwaukee	WI	4	Replace Roof	$200,000	$—	$200,000
12	Milwaukee	WI	4	Replace Roof	$499,795	$—	$499,795
12	Milwaukee	WI	4	Replace Operating Room Roofs	$120,500	$—	$120,500
****12***	***Milwaukee***	***WI***	***4***	***Replace Heating, Ventilation and Air Conditioning Condenser***	***$211,054***	***$—***	***$211,054***
12	Milwaukee	WI	4	Replace Roof	$499,795	$—	$499,795
12	Milwaukee	WI	4	Re-insulate Roof	$111,060	$—	$111,060
12	Milwaukee	WI	4	Repair and Upgrade Exterior Modification	$25,000	$—	$25,000
12	Milwaukee	WI	4	Install Smoke Barrier Walls	$203,914	$—	$203,914
12	Milwaukee	WI	4	Install Smoke Barrier Walls	$152,936	$—	$152,936
12	Madison	WI	16	Renovate Clinical Space	$3,040,000	$—	$3,040,000
				Total—Wisconsin	**$17,975,024**	**$50,000**	**$17,925,024**

4	Clarksburg	WV	1	Renovate Emergency Room Area	$575,000	$—	$575,000
4	***Clarksburg***	***WV***	***1***	***Upgrade and Replace Boiler Plant Equipment***	***$466,440***	***$—***	***$466,440***
4	Clarksburg	WV	1	Renovate Dental Lab	$150,000	$—	$150,000
5	***Martinsburg***	***WV***	***2***	***Replace Heating, Ventilation and Air Conditioning in Building 501B***	***$2,800,000***	***$—***	***$2,800,000***
5	Martinsburg	WV	2	Replace Main Transformer	$750,000	$—	$750,000
5	***Martinsburg***	***WV***	***2***	***Replace Heating Plant Surge Tank***	***$200,000***	***$—***	***$200,000***
5	Martinsburg	WV	2	Replace Patient Wandering System	$300,000	$—	$300,000
5	Martinsburg	WV	2	Replace Nurse Call/Code Blue System	$750,000	$—	$750,000
5	Martinsburg	WV	2	Relocate the Mailroom to Mitigate Security Vulnerability	$475,000	$—	$475,000
5	Martinsburg	WV	2	Upgrade Environmental Monitoring	$2,500,000	$—	$2,500,000
5	***Martinsburg***	***WV***	***2***	***Implement Selected Conservation Measures[1]***	***$3,333,333***	***$—***	***$3,333,333***
6	***Beckley***	***WV***	***3***	***Replace Steam and Plumbing Line***	***$980,000***	***$—***	***$980,000***
6	Beckley	WV	3	Modernize Patient Areas	$665,000	$—	$665,000
9	***Huntington***	***WV***	***3***	***Replace Air Handling Units***	***$4,000,000***	***$—***	***$4,000,000***
9	***Huntington***	***WV***	***3***	***Replace Steam Distribution System***	***$1,500,000***	***$160,000***	***$1,340,000***

FY 2009 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

VISN	Location			Project Title	Estimated Budget Cost	Prior Year Obligations	ARRA Funding
	City	State	Congressional District				
9	Huntington	WV	3	Renovate Prosthetics & Rehab Medicine	$447,000	$47,000	$400,000
9	Huntington	WV	3	Renovate and Modernize Inpatient Ward Finishes	$250,000	$—	$250,000
9	Huntington	WV	3	Upgrade Outpatient Waiting	$250,000	$—	$250,000
				Total—West Virginia	**$20,391,773**	**$207,000**	**$20,184,773**
19	Cheyenne	WY	At Large	Renovate Surgery to include two additional Operating Rooms	$900,000	$—	$900,000
19	Sheridan	WY	At Large	Replace Secondary Electrical Distribution, Phase 1	$550,000	$50,000	$500,000
****19***	***Cheyenne***	***WY***	***At Large***	***Replace Heating, Ventilation and Air Conditioning Controls, Phase 2***	***$750,000***	***$70,000***	***$680,000***
19	Sheridan	WY	At Large	Replace Water Tower Interior Coating	$330,000	$30,000	$300,000
19	Cheyenne	WY	At Large	Repair/Upgrade interior finishes, Phase 3	$750,000	$70,000	$680,000
19	Sheridan	WY	At Large	Repair/Replace Sanitary Sewer System	$650,000	$150,000	$500,000
19	Cheyenne	WY	At Large	Repair/Replace Roads, Sidewalks, and Parking Lots, Phase 2	$750,000	$70,000	$680,000

19	Cheyenne	WY	At Large	Repair/Upgrade Exterior Finishes	$750,000	$70,000	$680,000
19	Sheridan	WY	At Large	Expand Parking Lots to meet patient and visitor demand	$820,000	$70,000	$750,000
***19**	***Cheyenne***	***WY***	***At Large***	***Repair/Upgrade Heating, Ventilation and Air Conditioning***	***$750,000***	***$70,000***	***$680,000***
19	Cheyenne	WY	At Large	Expand Emergency Power	$750,000	$70,000	$680,000
***19**	***Cheyenne***	***WY***	***At Large***	***Install Renewable Energy Systems, Phase 2***	***$750,000***	***$70,000***	***$680,000***
***19**	***Sheridan***	***WY***	***At Large***	***Energy Reduction Project Phase 1***	***$750,000***	***$70,000***	***$680,000***
19	Cheyenne	WY	At Large	Repair/Upgrade Interior Finishes, Phase 2	$560,000	$60,000	$500,000
				Total—Wyoming	**$9,810,000**	**$920,000**	**$8,890,000**
				Cumulative Total	**$1,136,567,218**	**$37,918,467**	**$1,085,672,652**[2]

[1] Projects are provided for with VISN wide contracts.

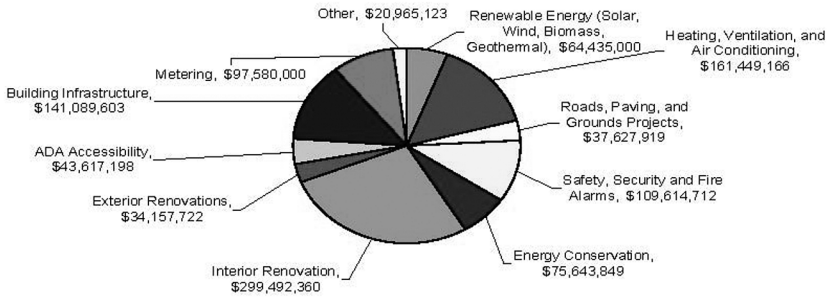
[2] The total funding for projects included in these plans is slightly more than the ARRA funds provided in order to account for the potential slippage of projects due to unforeseen technical issues.

FY 09 Veterans Health Administration Non-Recurring Maintenance (NRM)/ Energy ARRA Spending

Veterans Health Administration ARRA Spending Category

	Qty	Totals	All Energy Related Projects	Renewable Energy	Percentage of Total
Renewable Energy (Solar, Wind, Biomass, Geothermal)	62	$64,435,000	$64,435,000	$64,435,000	6%
Heating, Ventilation, and Air Conditioning	170	$161,449,166	$161,449,166	—	15%
Roads, Paving, and Grounds Projects	42	$37,627,919	—	—	3%
Safety, Security and Fire Alarms	102	$109,614,712	—	—	10%
Energy Conservation	56	$75,643,849	$75,643,849	—	7%
Interior Renovation	276	$299,492,360	—	—	28%
Exterior Renovations	47	$34,157,722	—	—	3%
ADA Accessibility	45	$43,617,198	—	—	4%
Building Infrastructure	106	$141,089,603	—	—	13%
Metering	3	$97,580,000	$97,580,000	—	9%
Other	47	$20,965,123	—	—	2%
Total[1]	**956**	**$1,085,672,652**	**$399,108,015**	**$64,435,000**	**100%**

[1] The total funding for projects included in these plans is slightly more than the ARRA funds provided in order to account for the potential slippage of projects due to unforeseen.



FY 09 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—By State

AARA Overview

State	Number of Projects	ARRA Funding
AK	4	$600,000
AL	14	$17,230,490
AR	9	$14,380,000
AZ	25	$19,868,571
CA	99	$92,701,199
CO	12	$8,035,000
CT	4	$10,119,075
DC	8	$15,393,333
DE	5	$8,066,440
FL	46	$34,996,726
GA	13	$15,193,861
HI	4	$850,000
IA	15	$7,690,201
ID	5	$6,092,857
IL	43	$63,555,749
IN	3	$4,866,000
KS	9	$9,190,000
KY	10	$11,441,000
LA	8	$8,265,000
MA	11	$24,078,000
MD	29	$19,810,333
ME	3	$13,260,493
MI	17	$24,050,224
MN	36	$16,637,000
MO	14	$24,098,400
MS	7	$12,440,000
MT	7	$4,252,857
NC	17	$21,864,000
ND	4	$3,266,230
NE	11	$7,500,000
NH	2	$1,551,500
NJ	16	$14,502,000
NM	12	$4,487,857
NV	12	$5,510,000

FY 09 Veterans Health Administration Non-Recurring Maintenance (NRM)/Energy ARRA Spend Plan—By State—Continued

AARA Overview

State	Number of Projects	ARRA Funding
NY	104	$109,562,683
OH	15	$39,643,331
OK	9	$4,554,000
OR	25	$7,125,338
PA	30	$46,432,830
PR	9	$7,878,675
RI	4	$11,550,000
SC	3	$4,454,652
SD	25	$7,503,657
TBD	5	$140,722,000
TN	18	$18,593,038
TX	48	$43,045,375
UT	9	$4,527,857
VA	12	$15,417,013
VT	3	$8,885,125
WA	43	$22,932,883
WI	28	$17,925,024
WV	18	$20,184,773
WY	14	$8,890,000
Total	**956**	**$1,085,672,652**[1]

[1] The total funding for projects included in these plans is slightly more than the ARRA funds provided in order to account for the potential slippage of projects due to unforeseen technical issues.

FY 2009 Grants for State Extended Care Facilities ARRA Spend Plan

VISN	Location			Project Title	Total Grant Cost	ARRA Funding
	City	State	Congressional District			
18	Phoenix	AZ	4	Facility Renovation, Phase 1	$364	$364
18	Tucson	AZ	7	180-Bed NHC (New) & 35 Participant ADHC	$18,671	$18,671
				Total—Arizona	**$19,035**	**$19,035**
19	Walsenburg	CO	3	General Renovations	$2,045	$2,045
				Total—Colorado	**$2,045**	**$2,045**
1	Rocky Hill	CT	1	Domiciliary Renovations—Buildings 2, 3 and 4	$5,397	$5,397
				Total—Connecticut	**$5,397**	**$5,397**
8	Daytona Beach	FL	7	General Renovation & Facility Upgrade	$3,250	$3,250
				Total—Florida	**$3,250**	**$3,250**
7	Milledgeville	GA	12	Dietary Facility Renovation	$715	$715
				Total—Georgia	**$715**	**$715**
23	Marshalltown	IA	4	Dining & Activity Room Expansion	$2,377	$2,377
23	Marshalltown	IA	4	Renovate Medical Clinic Space	$727	$727
				Total—Iowa	**$3,104**	**$3,104**
12	Manteno	IL	11	Construct Storage Building	$1,610	$1,610
12	Manteno	IL	11	Convert/Upgrade Resident Outdoor Activity Space & Staff Offices	$2,320	$2,320
12	LaSalle	IL	11	80–Bed NHC Addition	$8,308	$8,308

FY 2009 Grants for State Extended Care Facilities ARRA Spend Plan—Continued

VISN	Location			Project Title	Total Grant Cost	ARRA Funding
	City	State	Congressional District			
23	Quincy	IL	17	Bus & Ambulance Garage	$565	$565
				Total—Illinois	**$12,803**	**$12,803**
11	Lafayette	IN	4	Facility Upgrade	$869	$869
				Total—Indiana	**$869**	**$869**
1	Chelsea	MA	8	Roof Replacement—Quigley Building	$793	$793
				Total—Massachusetts	**$793**	**$793**
1	Caribou	ME	2	Multipurpose Room Addition	$354	$354
1	South Paris	ME	2	Replace Flooring	$353	$353
				Total—Maine	**$707**	**$707**
11	Grand Rapids	MI	3	Code Fire Suppression, Nurse Call Replacement	$704	$704
				Total—Michigan	**$704**	**$704**
23	Fergus Falls	MN	7	Dementia—Special Care Unit—(24 Beds—New)	$4,799	$4,799
				Total—Minnesota	**$4,799**	**$4,799**
15	St. Louis	MO	1	Emergency Generator, Etc.	$944	$944
15	Warrensburg	MO	4	Emergency Generator, Etc.	$372	$372
15	Cameron	MO	6	Emergency Generator, Etc.	$372	$372
16	Mt. Vernon	MO	7	Emergency Generator, Etc.	$372	$372

15	St. James	MO	8	Emergency Generator, Etc.	$372	$372
15	Cape Girardeau	MO	8	Fire Lane, Hydrant and Lighting	$708	$708
15	Mexico	MO	9	Emergency Generator, Etc.	$372	$372
				Total—Missouri	**$3,512**	**$3,512**
6	Pending—Eastern	NC	1 & 3	100-Bed NHC (New)	$8,147	$8,147
6	Pending—Western	NC	11	100–Bed NHC (New)	$8,147	$8,147
				Total—North Carolina	**$16,294**	**$16,294**
3	Paramus	NJ	5	Multipurpose Room Addition	$1,415	$1,415
3	Paramus	NJ	5	HVAC Replacement, Phase 2	$475	$475
				Total—New Jersey	**$1,890**	**$1,890**
3	Stony Brook	NY	1	Emergency Generator and System Upgrade	$470	$470
				Total—New York	**$470**	**$470**
10	Georgetown	OH	2	Security Upgrades, Phase 1	$330	$330
10	Georgetown	OH	2	Security Upgrades, Phase 2	$331	$331
10	Sandusky	OH	9	Kitchen Upgrade—Secrest Hall	$260	$260
10	Sandusky	OH	9	Corridor Renovation	$325	$325
				Total—Ohio	**$1,246**	**$1,246**
4	Spring City	PA	6	112–Bed DOM Replacement + 8 Additional Beds	$17,109	$17,109
				Total—Pennsylvania	**$17,109**	**$17,109**
1	Bristol	RI	1	General Renovations	$1,204	$1,204
				Total—Rhode Island	**$1,204**	**$1,204**
17	Tyler	TX	1	160–Bed NHC (New)	$8,680	$8,680

FY 2009 Grants for State Extended Care Facilities ARRA Spend Plan—Continued

VISN	Location			Project Title	Total Grant Cost	ARRA Funding
	City	State	Congressional District			
16	Houston	TX	TBD	160-Bed NHC (New)	$8,680	$8,680
	Pending	TX	TBD	160-Bed NHC (New)	$8,680	$8,680
	Pending	TX	TBD	160-Bed NHC (New)	$8,680	$8,680
				Total—Texas	**$34,720**	**$34,720**
19	Ogden	UT	1	120-Bed NHC (New)	$12,573	$12,573
19	Salt Lake City	UT	2	General Renovations	$645	$645
				Total—Utah	**$13,218**	**$13,218**
6	Roanoke	VA	6	General Renovations	$372	$372
				Total—Virginia	**$372**	**$372**
12	Union Grove	WI	1	Upgrade Main Electrical Switchgear	$263	$263
12	Union Grove	WI	1	Aboveground Building Connectors	$2,217	$2,217
12	Union Grove	WI	1	24-Bed DOM Addition (New)	$1,625	$1,625
12	King	WI	8	Replace Resident Wandering Monitoring System	$386	$386
12	King	WI	8	Ceiling Resident Lift System	$1,892	$1,892
12	King	WI	8	Remodel Laundry Facility	$283	$283
				Total—Wisconsin	**$6,666**	**$6,666**
				Cumulative Total	**$150,922**	**$150,922[1]**

[1] Grant costs exceed ARRA funding because they are estimates and may be adjusted based upon actual costs as projects are completed.

FY 2009 Grants for State Extended Care Facilities ARRA Spend Plan

ARRA Overview

State	Number of Projects	ARRA Funding
AZ	2	$19,035
CO	1	$2,045
CT	1	$5,397
FL	1	$3,250
GA	1	$715
IA	2	$3,104
IL	4	$12,803
IN	1	$869
MA	1	$793
ME	2	$707
MI	1	$704
MN	1	$4,799
MO	7	$3,512
NC	2	$16,294
NJ	2	$1,890
NY	1	$470
OH	4	$1,246
PA	1	$17,109
RI	1	$1,204
TX	4	$34,720
UT	2	$13,218
VA	1	$372
WI	6	$6,666
Total	**49**	**$150,922**[1]

[1] Grant costs exceed ARRA funding because they are estimates and may be adjusted based upon actual costs as projects are completed.

Veterans Benefits Administration—Hiring Temporary Claims Processors Expenditure Plan

VBA: $150M Recovery Act Hiring Temporary Claims Processors Operating Plan

TAFS: 0150B1

(Dollars in thousands—000s)

FY 2009	Total Cumulative FTE	Monthly Payroll ($K)	Monthly Non Payroll ($K)	Monthly Total Obligations ($K)
Apr	248	$2,009	$2,729	**$4,738**
May	539	$3,029	$4,379	**$7,408**
Jun	831	$4,296	$4,379	**$8,675**
Jul	1,133	$5,656	$4,379	**$10,034**
Aug	1,435	$6,312	$4,379	**$10,691**
Sep	1,5002	$6,824	$4,379	**$11,203**
FYTD (SEP)	**476**	**$28,125**	**$24,623**	**$52,748**
FY 2010	**Total Cumulative FTE**	**Monthly Payroll ($K)**	**Monthly Non Payroll ($K)**	**Monthly Total Obligations ($K)**
Oct	1,500	$6,953	$955	$7,908
Nov	1,500	$6,718	$956	$7,673
Dec	1,500	$7,260	$956	$8,216
Jan	1,500	$6,965	$956	$7,921
Feb	1,500	$6,708	$956	$7,664
Mar	1,500	$7,556	$956	$8,512
Apr	1,500	$7,289	$956	$8,244
May	1,500	$7,020	$956	$7,975
Jun	1,500	$7,311	$956	$8,267
Jul	1,500	$7,323	$956	$8,279
Aug	1,500	$7,335	$956	$8,291
Sep	1,500	$7,347	$956	$8,302
FYTD (SEP)	**1,500**	**$85,784**	**$11,467**	**$97,252**
Grand Total		**$113,910**	**$36,090**	**$150,000**

$150M 0150B1
U.S. Department of Veterans Affairs, Veterans Benefits Administration

Veterans Benefits Administration—Support for Economic Recovery Payments Expenditure Plan

VBA: $7.1M Recovery Act Veteran Economic Recovery Payments

TAFS: 0150R1

(Dollars in thousands—000s)

FY 2009	Total Cumulative FTE	Monthly Payroll ($K)	Monthly Non Payroll ($K)	Monthly Total Obligations ($K)
Apr	5	$198		$198
May	9	$189	$4,729	$4,918
Jun	12	$198	$1,260	$1,458
Jul	13	$156		$156
Aug	13	$81		$81
Sep	14	$85		$85
FYTD (SEP)	**14**	**$907**	**$5,989**	**$6,896**
FY 2010	**Total Cumulative FTE**	**Monthly Payroll ($K)**	**Monthly Non Payroll ($K)**	**Monthly Total Obligations ($K)**
Oct	8	$45		
Nov	7	$25		
Dec	6	$28		
Jan	5	$15		
Feb	5	$14		
Mar	5	$16		
Apr	4	$12		
May	4	$9		
Jun	4	$10		
Jul	4	$10		
Aug	3	$10		
Sep	3	$8		
FYTD (SEP)	**3**	**$203**		
Grand Total		**$1,110**	**$5,989**	**$7,100**

$7.1M 0150R1
U.S. Department of Veterans Affairs, Veterans Benefits Administration

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
5	Ft Richardson	AK	At Large	Slurry Seal Roads	$10,000	$10,000
				Total—Alaska	**$10,000**	**$10,000**
2	Mobile	AL	1	Paint Wall and Fences (Repair)	$45,000	$45,000
2	Mobile	AL	1	Maint Bldg—Paint	$5,000	$5,000
2	Ft Mitchell	AL	3	Mower	$20,000	$20,000
				Total—Alabama	**$70,000**	**$70,000**
2	Little Rock	AR	2	Admin and Maint Bldgs—Paint	$10,000	$10,000
2	Little Rock	AR	2	Minnesota Monument,1916	$10,000	$10,000
2	Fayetteville	AR	3	Bldgs—Paint	$20,000	$20,000
2	Fayetteville	AR	3	Reseal Roads	$15,000	$15,000
2	Fayetteville	AR	3	Riding Mower	$25,000	$25,000
2	Ft Smith	AR	3	Mower	$1,300	$1,300
2	Ft Smith	AR	3	Mower	$1,300	$1,300
				Total—Arkansas	**$82,600**	**$82,600**
5	Prescott	AZ	1	Slurry Seal New Road at Columbarium	$20,000	$20,000
5	NMC of Arizona	AZ	3	Repair Columbaria Floors	$165,000	$165,000
5	NMC of Arizona	AZ	3	Street Sweeper	$90,427	$90,427

5	NMC of Arizona	AZ	3	Articulated Dumper	$53,852	$53,852
5	NMC of Arizona	AZ	3	Sand Rake	$20,643	$20,643
5	NMC of Arizona	AZ	3	Utility Vehicle (trade-in)	$2,083	$2,083
				Total—Arizona	**$352,005**	**$352,005**
5	San Francisco	CA	8	Pacific Coast GAR Monument, 1897	$15,000	$15,000
5	Sacramento	CA	10	Electric Cart	$9,145	$9,145
5	Sacramento	CA	10	Electric Cart	$9,145	$9,145
5	Golden Gate	CA	12	Install Spoils Bay Cover	$18,000	$18,000
5	Golden Gate	CA	12	Replace Damaged Floor Covering In Admin	$6,000	$6,000
5	Golden Gate	CA	12	Replace Doors	$12,000	$12,000
5	Golden Gate	CA	12	Slurry Seal Roads	$50,000	$50,000
5	Golden Gate	CA	12	Shredder	$40,137	$40,137
***5**	***San Joaquin Valley**	***CA**	***18**	***Rooftop solar photovoltaic power**	***$1,448,000**	***$1,448,000**
5	San Joaquin Valley	CA	18	Utility Vehicle	$16,237	$16,237
5	San Joaquin Valley	CA	18	Utility Vehicle	$16,237	$16,237
5	Los Angeles	CA	30	Headstones/Markers and Gravesites	$4,310,068	$4,310,068
5	Los Angeles	CA	30	Utility Vehicle	$18,900	$18,900
5	Los Angeles	CA	30	National Home for Disabled Veteran Soldiers (NHDVS) Monument, ca. 1900	$75,000	$75,000
5	Riverside	CA	44	Headstones/Markers and Gravesites	$1,306,295	$1,306,295

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
5	Riverside	CA	44	Slurry Seal Roads	$200,000	$200,000
5	Riverside	CA	44	Mower	$83,271	$83,271
5	Riverside	CA	44	Turf VAC/Sweeper	$18,995	$18,995
5	Riverside	CA	44	Hydraulic Excavator	$155,666	$155,666
5	Ft Rosecrans	CA	52	Headstones/Markers and Gravesites	$2,000,000	$2,000,000
5	Ft Rosecrans	CA	52	Compact Excavator	$60,500	$60,500
5	Ft Rosecrans	CA	52	Utility Vehicle	$28,167	$28,167
5	Ft Rosecrans	CA	52	Chipper	$9,649	$9,649
5	Ft Rosecrans	CA	52	USS Bennington Monument, 1907	$250,000	$250,000
				Total—California	**$10,156,412**	**$10,156,412**
3	Ft Logan	CO	1	Renovate lakeside erosion near Public Information Center	$50,000	$50,000
3	Ft Logan	CO	1	Utility Vehicle	$26,500	$26,500
3	Ft Logan	CO	1	Electric Cart	$9,860	$9,860
3	Ft Logan	CO	1	Lowering Device	$4,000	$4,000
3	Ft Logan	CO	1	Compact Excavator	$65,000	$65,000
3	Ft Logan	CO	1	Utility Vehicle	$26,200	$26,200

3	Ft Logan	CO	1	Landscape Rake	$5,900	$5,900
3	Ft Logan	CO	1	Dumper	$34,000	$34,000
3	Ft Lyon	CO	4	Install equipment shelter	$45,000	$45,000
				Total—Colorado	**$266,460**	**$266,460**
2	Barrancas	FL	1	Maint Bldg—Paint	$5,000	$5,000
2	Barrancas	FL	1	Mower	$18,000	$18,000
2	Florida	FL	5	Admin and Maint Bldgs—Paint	$50,000	$50,000
2	Florida	FL	5	Carillon—Paint	$5,000	$5,000
2	Florida	FL	5	Reseal Roads	$50,000	$50,000
2	Florida	FL	5	Mower	$45,000	$45,000
2	Florida	FL	5	Utility vehicle	$30,000	$30,000
2	Florida	FL	5	Backhoe	$80,000	$80,000
2	Florida	FL	5	Articulated Dumper	$70,000	$70,000
2	Florida	FL	5	Articulated Dumper	$55,000	$55,000
2	St. Augustine	FL	7	Maint Bldg and Wall—Paint	$10,000	$10,000
2	St. Augustine	FL	7	Dade's Pyramids(3), 1 842	$100,000	$100,000
2	Bay Pines	FL	10	Riding Mower	$25,000	$25,000
				Total—Florida	**$543,000**	**$543,000**
2	Marietta	GA	11	Monumental Arch, c.1870	$100,000	$100,000
				Total—Georgia	**$100,000**	**$100,000**
5	NMC of the Pacific	HI	1	Slurry Seal Roads	$80,000	$80,000
5	NMC of the Pacific	HI	1	Compact Sweeper	$103,774	$103,774
5	NMC of the Pacific	HI	1	3-Way Dump Trailer	$8,800	$8,800

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
				Total—Hawaii	**$192,574**	**$192,574**
4	Keokuk	IA	2	Mower, Lawn, Riding, 60" Mulch Kit	$12,381	$12,381
4	Keokuk	IA	2	Vacuum, Leaf, Pull Behind, Trac Vac	$3,500	$3,500
				Total—Iowa	**$15,881**	**$15,881**
4	Oak Woods	IL	1	Confederate Mound Monument, 1893	$250,000	$250,000
4	Abraham Lincoln	IL	11	Replace Asphalt Roadways	$350,000	$350,000
4	Abraham Lincoln	IL	11	Truck, Utility, 4 WD, Casket Carrier	$39,000	$39,000
4	Abraham Lincoln	IL	11	Harrow, Disc., Pull Behind, 3-Point Hitch	$2,000	$2,000
4	Mound City	IL	12	Illinois State Soldiers & Sailors Monument, 1874	$150,000	$150,000
4	North Alton	IL	12	Confederate POW Dead Monument, 1910	$250,000	$250,000
4	Danville	IL	15	Headstones/Markers and Gravesites	$704,000	$704,000
4	Danville	IL	15	Replace Chain Link Fence	$75,000	$75,000
4	Danville	IL	15	Loader, Utility, Compact, Attach	$37,000	$37,000

4	Danville	IL	15	Soldiers (NHDVS) Monument, 1917	$15,000	$15,000
4	Rock Island	IL	17	Truck, Utility, 4 WD, with Lift Kit	$43,000	$43,000
4	Rock Island	IL	17	Truck, Utility, 4 WD, w/Attach.	$39,000	$39,000
4	Rock Island	IL	17	Truck, Utility, 4 WD	$28,000	$28,000
4	Camp Butler	IL	18	Headstones/Markers and Gravesites	$431,935	$431,935
4	Camp Butler	IL	18	Attachments, Dozer & Snow Blade & Bucket	$9,690	$9,690
4	Camp Butler	IL	18	Carriage, Casket, Stainless Steel	$1,995	$1,995
4	Camp Butler	IL	18	Street Sweeper	$43,000	$43,000
				Total—Illinois	**$2,468,620**	**$2,468,620**
4	Marion	IN	5	Headstones/Markers and Gravesites	$124,000	$124,000
4	Marion	IN	5	New Asphalt Road at section 11/12	$75,000	$75,000
4	Marion	IN	5	Replace Gravel Road w/ Asphalt Paving at section 2/4–3/6	$65,000	$65,000
4	Marion	IN	5	Vacuum, Leaf, Gas Powered, Pull Behind	$30,875	$30,875
4	Marion	IN	5	Truck, Utility	$9,762	$9,762
4	Marion	IN	5	Tiller, Pull Behind, 51”, Med. Grade	$2,300	$2,300
4	Marion	IN	5	Scraper, Box, Pull Behind, 48”	$490	$490
4	Marion	IN	5	Mower, Lawn, Riding	$17,091	$17,091

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
4	Marion	IN	5	Screener, Dirt, Pull Behind, Gas Powered	$22,919	$22,919
4	Marion	IN	5	Trailer, Utility, 12,000 lb, 81-1/2" Wide, 2 Axles	$4,000	$4,000
4	Marion	IN	5	Soldiers (NHDVS) Monument, 1914	$10,000	$10,000
4	New Albany	IN	9	Headstones/Markers and Gravesites	$320,000	$320,000
4	New Albany	IN	9	Generator, Electric, Portable, Gas Powered	$1,000	$1,000
4	New Albany	IN	9	Generator, Electric, Portable, Gas Powered	$1,000	$1,000
				Total—Indiana	**$683,437**	**$683,437**
3	Ft Leavenworth	KS	2	Paint maintenance shop exterior	$8,000	$8,000
3	Ft Leavenworth	KS	2	Resurface Roadways and replace curbing	$200,000	$200,000
3	Ft Leavenworth	KS	2	Lowering Device	$4,000	$4,000
3	Ft Scott	KS	2	Repair and resurface all roadways	$250,000	$250,000
3	Leavenworth	KS	2	Repair/replacement of stone lined drainage ditches	$250,000	$250,000

3	Leavenworth	KS	2	Paint Maintenance Shop exterior	$15,000	$15,000
3	***Leavenworth***	***KS***	***2***	***Replace windows in Maintenance Bldg***	***$12,000***	***$12,000***
3	Leavenworth	KS	2	Utility Vehicle	$33,000	$33,000
3	Leavenworth	KS	2	NHDVS Obelisk, 1919	$35,000	$35,000
3	Leavenworth	KS	2	NHDVS Chapel Fountain, ca. 1900	$15,000	$15,000
				Total—Kansas	**$822,000**	**$822,000**
4	Lebanon	KY	2	Roof Covered Material Bins	$70,000	$70,000
4	Lebanon	KY	2	Truck, Utility, 4WD, Diesel Engine	$22,000	$22,000
4	Lebanon	KY	2	Generator, Electric, Portable, Gas Powered	$1,000	$1,000
4	Lebanon	KY	2	Mower, Riding, Lawn, 60” Mulching Deck	$11,000	$11,000
4	Zachary Taylor	KY	3	Truck, Utility, 4 WD, w/Attach.	$39,000	$39,000
4	Zachary Taylor	KY	3	Zachary Taylor Monument (& secondary small obelisk & a memorial sundial), 1 930s	$50,000	$50,000
4	Camp Nelson	KY	6	Headstones/Markers and Gravesites	$591,540	$591,540
4	Camp Nelson	KY	6	Emergency Generator for Admin Bldg	$10,000	$10,000
4	Camp Nelson	KY	6	Loader, Backhoe	$82,000	$82,000
4	Camp Nelson	KY	6	Auger, 12” & 18” Bits, Hydraulic, Attachment	$5,500	$5,500

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
4	Camp Nelson	KY	6	Truck, Utility, 4WD, Diesel Engine	$22,000	$22,000
4	Camp Nelson	KY	6	Roller, Lawn, Self Propelled, Vibrator Enhanced	$35,000	$35,000
4	Camp Nelson	KY	6	Mower, Riding, Lawn, 34" Cross Cut	$4,127	$4,127
4	Camp Nelson	KY	6	Bucket, Loader, Attachment	$1,500	$1,500
4	Camp Nelson	KY	6	Aerator, Core, Hydraulic, Pull Behind	$1,100	$1,100
4	Camp Nelson	KY	6	Generator, Electric, Portable, Gas Powered	$1,000	$1,000
				Total—Kentucky	**$946,767**	**$946,767**
2	Alexandria	LA	5	Maint Bldg—Paint	$4,000	$4,000
2	Baton Rouge	LA	6	Massachusetts Monument, 1909	$15,000	$15,000
2	Port Hudson	LA	6	Articulated Dumper	$55,000	$55,000
				Total—Louisiana	**$74,000**	**$74,000**
1	***Massachusetts***	***MA***	***10***	***Wind turbine***	***$1,610,000***	***$1,610,000***
1	Massachusetts	MA	10	Soil Screener	$76,500	$76,500
1	Massachusetts	MA	10	Dump Truck	$87,522	$87,522
1	Massachusetts	MA	10	Tractor w/front loader	$35,780	$35,780

				Total—Massachusetts	**$1,809,802**	**$1,809,802**
1	Point Lookout	MD	5	Soldiers & Sailors Monument, 1911	$250,000	$250,000
1	Baltimore	MD	7	Remove Stone Sidewalks—Repl w/ Stamped Concrete	$70,000	$70,000
1	Baltimore	MD	7	4x4 Stake Body truck w/towing, plow & lift gate	$47,635	$47,635
1	Baltimore	MD	7	Tractor	$20,350	$20,350
1	Loudon Park	MD	7	Maryland Sons Monument, 1884	$60,000	$60,000
1	Loudon Park	MD	7	Unknown Dead Monument, 1895	$50,000	$50,000
1	Loudon Park	MD	7	GAR Monument, 1898	$10,000	$10,000
1	Loudon Park	MD	7	Maryland Naval Monument, 1896	$10,000	$10,000
				Total—Maryland	**$517,985**	**$517,985**
1	Togus	ME	1	Headstones/Markers and Gravesites	$732,000	$732,000
1	Togus	ME	1	Soldiers & Sailors Monument (1 of 2), 1889	$60,000	$60,000
1	Togus	ME	1	Soldiers & Sailors Monument (2 of 2), 1916	$50,000	$50,000
				Total—Maine	**$842,000**	**$842,000**
4	Ft Custer	MI	6	Truck, Pickup, 2 WD, Stake	$49,944	$49,944
4	Ft Custer	MI	6	Exchanger, Coolant, Recycle, Radiator Fluid	$2,390	$2,390
4	Ft Custer	MI	6	Box, Tool, Mechanic's Set	$4,901	$4,901
4	Ft Custer	MI	6	Vacuum, Leaf, Pull Behind	$36,000	$36,000

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
4	Ft Custer	MI	6	Trailer, Utility, Pull Behind, 8.5' X 24'	$8,550	$8,550
4	Ft Custer	MI	6	Saw, Table, Portable, Electric	$550	$550
4	Great Lakes	MI	8	Lowering Device, Vault, Hydraulic	$12,369	$12,369
4	Great Lakes	MI	8	Truck, Utility, 4 WD, Casket Carrier	$39,000	$39,000
4	Great Lakes	MI	8	Cultivator, Soil, Attachment	$4,948	$4,948
4	Great Lakes	MI	8	Breaker, Hydraulic, Attachment	$5,762	$5,762
4	Great Lakes	MI	8	Saw, Chain, Gas Powered, 20"	$407	$407
4	Great Lakes	MI	8	Saw, Pole, Pruning, 1 Each	$520	$520
				Total—Michigan	**$165,341**	**$165,341**
4	Ft Snelling	MN	5	Replace Asphalt Paving at Various Areas	$300,000	$300,000
4	Ft Snelling	MN	5	Truck, Dump, 4 WD, Diesel Eng.	$96,000	$96,000
4	Ft Snelling	MN	5	Loader, Backhoe	$82,000	$82,000
4	Ft Snelling	MN	5	Sweeper, Street, Gas Powered	$96,000	$96,000
4	Ft Snelling	MN	5	Tractor, Utility, 4 WD	$58,000	$58,000
4	Ft Snelling	MN	5	Truck, Utility, 4 WD	$30,000	$30,000

4	Ft Snelling	MN	5	Truck, Utility, 4 WD	$30,000	$30,000
				Total—Minnesota	**$692,000**	**$692,000**
4	Jefferson Barracks	MO	3	Replace Chapel Siding	$150,000	$150,000
4	Jefferson Barracks	MO	3	Enclosed Pole Barn w/concrete slab	$75,000	$75,000
4	Jefferson Barracks	MO	3	Replace Asphalt Roads Various Locations	$1,000,000	$1,000,000
4	Jefferson Barracks	MO	3	Sweeper, Street, Gas Powered, Broom Bear	$126,109	$126,109
4	Jefferson Barracks	MO	3	Tampers, 2 Cycle Engine	$15,748	$15,748
4	Jefferson Barracks	MO	3	Winch, Electric Power, 12 Volt	$1,548	$1,548
4	Jefferson Barracks	MO	3	Box, Tool, Mechanic's Set, Upper/Lower	$996	$996
4	Jefferson Barracks	MO	3	Truck, Pickup, 4 WD, W/Box Bed	$81,000	$81,000
4	Jefferson Barracks	MO	3	Screener, Dirt, Pull Behind	$89,000	$89,000
4	Jefferson Barracks	MO	3	Tractor, Utility, 4 WD	$26,000	$26,000
4	Jefferson Barracks	MO	3	Truck, Utility, 4 WD	$28,000	$28,000
4	Jefferson Barracks	MO	3	Truck, Utility, 4 WD, Casket Carrier	$39,000	$39,000
4	Jefferson Barracks	MO	3	Truck, Utility, 4 WD, Casket Carrier	$39,000	$39,000
4	Jefferson Barracks	MO	3	35th Division Water Fountain Memorial, 1952	$10,000	$10,000
4	Jefferson City	MO	4	39th MO Infantry Regiment Monument, 1873	$10,000	$10,000
4	Springfield	MO	7	Replace Chain Link Fence	$40,000	$40,000

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
				Total—Missouri	**$1,731,401**	**$1,731,401**
2	Natchez	MS	3	Utility Vehicle	$25,000	$25,000
2	Biloxi	MS	4	Tamper	$3,400	$3,400
2	Biloxi	MS	4	Mini Truck	$10,000	$10,000
2	Biloxi	MS	4	National Cemetery Memorial, 1941	$100,000	$100,000
				Total—Mississippi	**$138,400**	**$138,400**
2	New Bern	NC	1	Reseal Roads	$5,000	$5,000
2	New Bern	NC	1	Rhode Island Monument, 1909	$30,000	$30,000
2	New Bern	NC	1	Massachusetts Monument, 1908	$30,000	$30,000
2	Raleigh	NC	2	Maint Bldg—Paint	$2,000	$2,000
2	Wilmington	NC	7	Replace Fence	$10,000	$10,000
2	Salisbury	NC	12	Reseal Roads	$50,000	$50,000
2	Salisbury	NC	12	Riding Mower	$30,000	$30,000
2	Salisbury	NC	12	Maine Monument, 1908	$40,000	$40,000
2	Salisbury	NC	12	Unknown Dead Monument, 1875	$40,000	$40,000
2	Salisbury	NC	12	Pennsylvania Monument, 1909	$75,000	$75,000
				Total—North Carolina	**$312,000**	**$312,000**

3	Ft McPherson	NE	3	Headstones/Markers and Gravesites	$687,112	$687,112
3	Ft McPherson	NE	3	Concrete pad under fill pile	$50,000	$50,000
3	Ft McPherson	NE	3	Install new floral and activities signage	$4,000	$4,000
***3**	***Ft McPherson***	***NE***	***3***	***Modify Public Information Center lighting***	***$10,000***	***$10,000***
3	Ft McPherson	NE	3	Repair sidewalk at Committal Shelter	$5,000	$5,000
***3**	***Ft McPherson***	***NE***	***3***	***Replace windows in Maintenance Building***	***$20,000***	***$20,000***
3	Ft McPherson	NE	3	Challenger Lifts	$2,600	$2,600
3	Ft McPherson	NE	3	Utility Vehicle w/Casket Carrier	$32,500	$32,500
3	Ft McPherson	NE	3	Tire Changer	$1,500	$1,500
3	Ft McPherson	3	NE	Mower	$22,600	$22,600
				Total—Nebraska	**$835,312**	**$835,312**
1	Finn's Point	NJ	2	Union Monument, 1879	$40,000	$40,000
1	Finn's Point	NJ	2	Confederate POW Dead Monument, 1910	$250,000	$250,000
				Total—New Jersey	**$290,000**	**$290,000**
3	Ft Bayard	NM	2	Top Dresser	$9,539	$9,539
3	Ft Bayard	NM	2	Tamper	$3,200	$3,200
3	Ft Bayard	NM	2	Lowering Device	$4,000	$4,000
3	Santa Fe	NM	3	Install mezzanine in Maintenance Bldg	$15,000	$15,000

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
3	Santa Fe	NM	3	Renovate spoils area (remove excess materials)	$25,000	$25,000
3	Santa Fe	NM	3	Repair cracking in columbaria structure	$75,000	$75,000
3	Santa Fe	NM	3	Resurface Roadways and replace curbing	$350,000	$350,000
3	Santa Fe	NM	3	Snow blower	$3,500	$3,500
3	Santa Fe	NM	3	Backhoe	$58,355	$58,355
3	Santa Fe	NM	3	Utility Vehicle	$22,500	$22,500
3	Santa Fe	NM	3	Aerator	$22,300	$22,300
				Total—New Mexico	**$588,394**	**$588,394**
1	Calverton	NY	1	Headstones/Markers and Gravesites	$2,000,000	$2,000,000
****1***	***Calverton***	***NY***	***1***	***Rooftop solar photovoltaic power***	***$582,000***	***$582,000***
1	Calverton	NY	1	Replace Façade on Admin and Committal Bldgs	$211,500	$211,500
1	Calverton	1	NY	Replace Admin Oil USD with Convault AST	$40,920	$40,920
1	Calverton	NY	1	Mini excavator & trailer	$49,350	$49,350

1	Calverton	NY	1	Two burners to thaw frozen ground	$10,800	$10,800
1	Calverton	NY	1	Two 4x4 dump trucks	$79,600	$79,600
1	Calverton	NY	1	Air compressor w/jackhammer	$12,000	$12,000
1	Long Island	NY	2	5 Utility Vehicles	$80,000	$80,000
1	Long Island	NY	2	Interment vehicle	$22,726	$22,726
1	Cypress Hills	NY	12	Remove/Repl All Roads at Cypress Hills & Union Plot	$85,800	$85,800
1	Cypress Hills	NY	12	Remove/Repl All Roads at Cypress Hills & Union Plot	$1,009,000	$1,009,000
1	Cypress Hills	NY	12	Eagle Monument, 1934	$10,000	$10,000
1	Cypress Hills	NY	12	French Monument, ca. 1920	$10,000	$10,000
1	Saratoga	NY	20	Utility vehicle	$25,700	$25,700
1	Saratoga	NY	20	Mower	$16,029	$16,029
1	Bath	NY	29	Mower	$18,000	$18,000
1	Bath	NY	29	Dump Truck	$47,000	$47,000
1	Woodlawn	NY	29	Utility Tractor	$38,163	$38,163
1	Woodlawn	NY	29	Snow blower attachment for Utility Tractor	$3,700	$3,700
				Total—New York	**$4,352,288**	**$4,35$2,288**
4	Dayton	OH	3	Lowering Device, Casket, Pull Behind	$7,900	$7,900
4	Dayton	OH	3	Tamper, Pneumatic, Portable, Gas Powered	$3,640	$3,640
4	Dayton	OH	3	Truck, Utility, 4 WD	$36,788	$36,788

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
4	Dayton	OH	3	National Soldiers (NHDVS) Monument, 1877	$510,000	$510,000
4	Camp Chase	OH	15	Memorial Boulder & Arch, 1880 & 1902	$25,000	$25,000
4	Ohio Western Reserve	OH	16	Truck, Utility, 4 WD, Casket Carrier	$39,000	$39,000
4	Ohio Western Reserve	OH	16	Dump, Articulating, 4 WD	$39,600	$39,600
4	Ohio Western Reserve	OH	16	Truck, Utility, 4 WD, w/Attach.	$39,000	$39,000
4	Ohio Western Reserve	OH	16	Broom, Angle, 84”	$4,400	$4,400
4	Ohio Western Reserve	OH	16	Aerator, Core, 6’ Wide, Pull Behind, Heavy Duty	$3,000	$3,000
4	Ohio Western Reserve	OH	16	Truck, Utility, 4 WD	$28,000	$28,000
				Total—Ohio	**$736,328**	**$736,328**
3	Ft Gibson	OK	2	Front entrance sign and planting bed	$10,000	$10,000
3	Ft Gibson	OK	2	Repair/Replace concrete sidewalk to flag pole	$8,000	$8,000
3	Ft Gibson	OK	2	Renovate existing flag pole and lighting	$35,000	$35,000
3	Ft Gibson	OK	2	Tamper	$3,700	$3,700
3	Ft Gibson	OK	2	Utility Loader	$2,400	$2,400

3	Ft Gibson	OK	2	Utility Loader	$40,000	$40,000
3	Ft Gibson	OK	2	Backhoe Loader	$50,900	$50,900
***3**	***Ft Sill***	***OK***	***4***	***Repair defective gaskets in glazing at Public Information Center***	***$4,000***	***$4,000***
3	Ft Sill	OK	4	Dumper	$55,000	$55,000
3	Ft Sill	OK	4	Compact Roller	$4,950	$4,950
				Total—Oklahoma	**$213,950**	**$213,950**
***5**	***Eagle Point***	***OR***	***2***	***Replace Windows In Committal Shelter***	***$35,000***	***$35,000***
5	Eagle Point	OR	2	Slurry Seal Roads	$30,000	$30,000
5	Eagle Point	OR	2	Utility Vehicle	$26,978	$26,978
5	Eagle Point	OR	2	Utility Vehicle	$26,978	$26,978
***5**	***Willamette***	***OR***	***3***	***Upgrade Admin Bldg Lighting***	***$13,000***	***$13,000***
5	Willamette	OR	3	Install Electric Gate/Side Two	$6,000	$6,000
5	Willamette	OR	3	Install Maintenance Shop Oil and Grease Dispensers	$27,000	$27,000
5	Willamette	OR	3	Slurry Seal Roads, Ph I & II	$150,000	$150,000
5	Willamette	OR	3	Articulated Dumper	$53,852	$53,852
5	Willamette	OR	3	Fertilizer Spreader	$6,834	$6,834
5	Willamette	OR	3	Fertilizer Spreader	$6,834	$6,834
5	Willamette	OR	3	Diesel Utility Vehicle	$15,680	$15,680
5	Willamette	OR	3	Over seeder	$8,437	$8,437
				Total—Oregon	**$406,593**	**$406,593**

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
*1	Indiantown Gap	PA	17	Repair Admin HVAC System	$60,720	$60,720
*1	Indiantown Gap	PA	17	Replace Glass Windows & Doors, B–1 (Admin Bldg)	$80,000	$80,000
1	Indiantown Gap	PA	17	Turf vac	$16,490	$16,490
1	Indiantown Gap	PA	17	Lawn Tractor	$8,956	$8,956
1	NC of the Alleghenies	PA	18	Utility Vehicle w/casket carrier	$40,896	$40,896
1	NC of the Alleghenies	PA	18	Utility Loader w/ swivel auger power head and bit	$19,274	$19,274
1	Prospect Hill	PA	19	Soldiers Monument, 1874	$100,000	$100,000
				Total—Pennsylvania	**$326,336**	**$326,336**
2	Puerto Rico	PR	At Large	Lowering device	$2,700	$2,700
2	Puerto Rico	PR	At Large	Utility Vehicle w/hydraulic lift	$30,000	$30,000
2	Puerto Rico	PR	At Large	Utility vehicle w/2 ft extension	$15,000	$15,000
2	Puerto Rico	PR	At Large	Rotary Brush for Tractor	$6,550	$6,550
2	Puerto Rico	PR	At Large	Street sweeper	$88,000	$88,000
2	Puerto Rico	PR	At Large	Articulated Dumper	$55,000	$55,000
				Total—Puerto Rico	**$197,250**	**$197,250**
2	Beaufort	SC	2	Admin Bldg—Repair Electrical System	$20,000	$20,000

2	Beaufort	SC	2	Electric Maint Truck	$7,500	$7,500
2	Beaufort	SC	2	Turbine Blower	$7,000	$7,000
2	Beaufort	SC	2	Parts Cleaner	$1,000	$1,000
2	Beaufort	SC	2	Pressure Washer	$1,000	$1,000
2	Beaufort	SC	2	MIG Welder Kit	$500	$500
2	Beaufort	SC	2	Mower	$15,000	$15,000
2	Beaufort	SC	2	Casket Truck	$1,500	$1,500
2	Beaufort	SC	2	Union Dead Box Tomb, 1870	$10,000	$10,000
2	Florence	SC	6	Backhoe	$70,000	$70,000
2	Florence	SC	6	Articulated Dumper	$55,000	$55,000
2	Florence	SC	6	Street sweeper	$28,000	$28,000
2	Florence	SC	6	Mower	$20,000	$20,000
2	Florence	SC	6	Mower	$20,000	$20,000
				Total—South Carolina	**$256,500**	**$256,500**
3	Black Hills	SD	At Large	Provide protection for IT equipment in Admin basement	$10,000	$10,000
3	Black Hills	SD	At Large	Repair/Replace domestic water line	$35,000	$35,000
3	Black Hills	SD	At Large	Re-paint wood trim and surfaces on Admin and Maint Bldgs	$5,000	$5,000
3	Black Hills	SD	At Large	Establish section P for in-ground cremain sites	$15,000	$15,000
3	Black Hills	SD	At Large	Replace irrigation control valve solenoids	$5,000	$5,000
3	Black Hills	SD	At Large	Road repair/ renovation	$897,000	$897,000

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
3	Black Hills	SD	At Large	Hydraulic Breaker	$3,700	$3,700
3	Black Hills	SD	At Large	4X4 Dump Truck	$46,900	$46,900
3	Black Hills	SD	At Large	Vehicle, Casket Carrier	$28,500	$28,500
3	Black Hills	SD	At Large	Mower	$20,000	$20,000
3	Black Hills	SD	At Large	Snow blower	$3,900	$3,900
3	Hot Springs	SD	At Large	Headstones/Markers and Gravesites	$70,000	$70,000
3	Hot Springs	SD	At Large	Replace old wire fence	$15,000	$15,000
3	Hot Springs	SD	At Large	Battle Mountain Sanitarium Monument, 1914	$35,000	$35,000
				Total—South Dakota	**$1,190,000**	**$1,190,000**
2	Mountain Home	TN	1	Admin & Maint Bldgs—Paint	$10,000	$10,000
2	Mountain Home	TN	1	Mower	$30,000	$30,000
2	Knoxville	TN	2	Union Soldiers Monument, 1906	$250,000	$250,000
2	Chattanooga	TN	3	Admin Bldg and Maint Bldg—Paint interior and exterior	$20,000	$20,000
2	Chattanooga	TN	3	Admin Bldg—Repair Bldg and Renovate Cabinets	$15,000	$15,000
2	Chattanooga	TN	3	Utility vehicle	$25,000	$25,000

2	Chattanooga	TN	3	Monumental Arch, c.1870	$100,000	$100,000
2	Chattanooga	TN	3	Andrew's Raiders Monument, 1890	$10,000	$10,000
2	Nashville	TN	5	Admin and Maint Bldgs—Paint	$10,000	$10,000
2	Nashville	TN	5	Monumental Arch, c. 1870	$250,000	$250,000
2	Nashville	TN	5	Minnesota Monument, 1920	$10,000	$10,000
2	Memphis	TN	9	Admin and Maint Bldgs—Paint	$10,000	$10,000
2	Memphis	TN	9	Utility Vehicle	$27,000	$27,000
2	Memphis	TN	9	State of Illinois Memorial, 1928	$40,000	$40,000
2	Memphis	TN	9	Minnesota Monument, 1916	$25,000	$25,000
				Total—Tennessee	**$832,000**	**$832,000**
3	Ft Bliss	TX	16	Reroof and Renovate Pump House	$8,000	$8,000
3	Ft Bliss	TX	16	Repair/Replace storm drainage throughout cemetery	$250,000	$250,000
3	Ft Bliss	TX	16	Update signage to reflect Xeroscaping	$5,000	$5,000
3	Ft Bliss	TX	16	Replace existing fencing around storage area.	$10,000	$10,000
3	Ft Bliss	TX	16	Resurface Roadways and replace curbing	$400,000	$400,000
3	Ft Bliss	TX	16	Electric Cart	$8,503	$8,503
3	Ft Bliss	TX	16	Utility Vehicle	$22,500	$22,500
3	Ft Bliss	TX	16	Utility Vehicle	$22,500	$22,500
3	Ft Bliss	TX	16	Sand rake	$17,800	$17,800

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
3	Houston	TX	18	Headstones/Markers and Gravesites	$3,183,980	$3,183,980
3	Houston	TX	18	Remove, repair, and resurface Hemicycle assembly areas	$100,000	$100,000
3	Houston	TX	18	Repair & repaint 3 committal shelter metal roofs	$15,000	$15,000
3	Houston	TX	18	Road Maintenance	$450,000	$450,000
3	Houston	TX	18	Utility Cart	$5,500	$5,500
3	Houston	TX	18	Utility Cart	$5,500	$5,500
3	Houston	TX	18	Tractor	$16,700	$16,700
3	Houston	TX	18	Utility Cart	$6,300	$6,300
3	Houston	TX	18	Utility Cart	$6,300	$6,300
3	Houston	TX	18	Excavator	$52,700	$52,700
3	Ft Sam Houston	TX	21	Headstones/Markers and Gravesites	$4,916,846	$4,916,846
3	Ft Sam Houston	TX	21	Repair/Recondition/Repaint casket biers at 5 committal shelters	$8,000	$8,000
3	Ft Sam Houston	TX	21	Resurface Roadways and replace curbing	$650,000	$650,000
3	Ft Sam Houston	TX	21	Utility Vehicle	$29,000	$29,000

3	Ft Sam Houston	TX	21	1 Ton Dump Truck	$40,000	$40,000
3	Ft Sam Houston	TX	21	1 Ton Truck	$40,000	$40,000
3	Ft Sam Houston	TX	21	2 Each Water Tank 300 Gallon	$10,000	$10,000
3	Ft Sam Houston	TX	21	Utility Vehicle	$29,000	$29,000
3	Ft Sam Houston	TX	21	Hoist Lift Frame	$5,000	$5,000
3	Ft Sam Houston	TX	21	Utility Vehicle w/Casket Carrier	$32,500	$32,500
3	Ft Sam Houston	TX	21	Sweeper	$11,900	$11,900
3	Kerrville	TX	23	Headstones/Markers and Gravesites	$280,000	$280,000
3	Kerrville	TX	23	Install irrigation system	$50,000	$50,000
3	Dallas	TX	24	Utility Vehicle w/Casket Carrier	$29,900	$29,900
3	Dallas	TX	24	Mower	$29,900	$29,900
3	Dallas	TX	24	Utility Vehicle	$22,500	$22,500
3	Dallas-Ft Worth	TX	24	Install additional irrigation at section 27	$5,000	$5,000
3	Dallas-Ft Worth	TX	24	Establish sections 16 thru 19 for in-ground cremain sites	$25,000	$25,000
3	San Antonio	TX	28	Headstones/Markers and Gravesites	$350,000	$350,000
3	San Antonio	TX	28	Renovate and expand existing irrigation system	$150,000	$150,000
				Total—Texas	**$11,300,828**	**$11,300,828**
1	Quantico	VA	1	Headstones/Markers and Gravesites	$898,091	$898,091
1	Quantico	VA	1	Replace Gutters Committals A, B, C, Admin, & Public Restroom	$24,362	$24,362

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
1	Quantico	VA	1	Replace All Brick Paver Walkways w/Concrete	$60,720	$60,720
1	Quantico	VA	1	Street Sweeper	$146,500	$146,500
1	Quantico	VA	1	Turf vac with dethatching wheel	$31,000	$31,000
1	Hampton	VA	3	Replace Maintenance Bldg Roofs (2)	$84,000	$84,000
1	Hampton	VA	3	Union Soldiers (NHDVS) Monument, 1868	$250,000	$250,000
1	Culpeper	VA	7	Pennsylvania Monument, 1909	$40,000	$40,000
1	Culpeper	VA	7	Restore Brick Walls	$228,690	$228,690
1	Culpeper	VA	7	Utility tractor	$26,000	$26,000
1	Culpeper	VA	7	Utility vehicle	$17,000	$17,000
1	Winchester	VA	10	Headstones/Markers and Gravesites	$642,520	$642,520
				Total—Virginia	**$2,448,883**	**$2,448,883**
5	Tahoma	WA	8	Road Repairs	$30,000	$30,000
5	Tahoma	WA	8	Street Sweeper/Vacuum	$75,619	$75,619
5	Tahoma	WA	8	Compact Dual Drum Roller	$18,000	$18,000
5	Tahoma	WA	8	Electric Cart	$11,600	$11,600

				Total—Washington	**$135,219**	**$135,219**
4	Wood	WI	4	Replace Water System throughout Cemetery	$250,000	$250,000
4	Wood	WI	4	Replace Chain Link Fence	$90,000	$90,000
4	Wood	WI	4	Replace Asphalt Roads @ Sections A–C	$220,000	$220,000
4	Wood	WI	4	Loader, Backhoe, Compact	$51,869	$51,869
4	Wood	WI	4	Articulated Dumper, Turf Track	$35,000	$35,000
4	Wood	WI	4	Sprayer, Water, 200 Gallon, Skid Mount	$2,250	$2,250
4	Wood	WI	4	Bucket, Front, Loader, 68”, Skid Steer	$794	$794
4	Wood	WI	4	Headstones/Markers and Gravesites	$81,000	$81,000
4	Wood	WI	4	Civil War Soldiers & Sailors Monument, 1903	$250,000	$250,000
				Total—Wisconsin	**$980,913**	**$980,913**
1	West Virginia	WV	1	Provide-Install Irrigation Booster Pump	$20,460	$20,460
1	West Virginia	WV	1	Repair Roadway	$16,500	$16,500
1	West Virginia	WV	1	4x4 dump truck w/snow plow	$34,562	$34,562
				Total—West Virginia	**$71,522**	**$71,522**
*	***NCA wide***	***TBD***		***Implement selected energy and water conservation measures***	***$345,000***	***$345,000***

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan—Continued

*Projects in ***BOLD ITALICS*** incorporate energy efficiency and renewable energy.

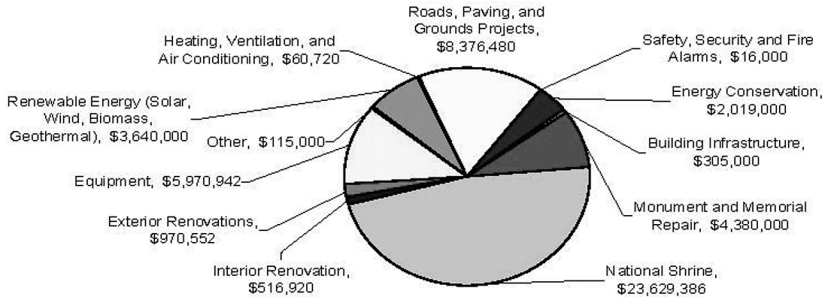
MSN	Location			Project Title	Estimated Budget Cost	ARRA Funding
	Cemetery	State	Congressional District			
*	***NCA wide***	***TBD***		***150 Facilities—Environmental management systems***	***$1,500,000***	***$1,500,000***
				Total—NCA wide	**$1,845,000**	**$1,845,000**
				Cumulative Total	**$50,000,000**	**$50,000,000[1]**

[1] The following NCA activities are included under the general heading of "Monument and Memorial Repairs and Energy Projects": (1) national shrine projects to raise, realign, and clean headstones/markers and repair sunken graves at various locations across the country; (2) repairs to historic monuments and memorials at national cemeteries; (3) projects for repairing roads, buildings, and other cemetery infrastructure at locations nationwide; (4) equipment purchases for cemetery operations; and (5) projects that conserve energy and water through the use of wind turbines, solar power and other measures.

FY 09 National Cemetery Administration (NCA)/Energy ARRA Spend Plan

National Cemetery Administration ARRA Spending by Category

	Qty	Totals	All Energy Related Projects	Renewable Energy	Percentage of Total
Renewable Energy (Solar, Wind, Biomass, Geothermal)	3	$3,640,000	$3,640,000	$3,640,000	7%
Heating, Ventilation, and Air Conditioning	1	$60,720	$60,720	—	0%
Roads, Paving, and Grounds Projects	52	$8,376,480	—	—	17%
Safety, Security and Fire Alarms	2	$16,000	—	—	0%
Energy Conservation	9	$2,019,000	$2,019,000	—	4%
Building Infrastructure	3	$305,000	—	—	1%
Monument and Memorial Repair	49	$4,380,000	—	—	9%
National Shrine	19	$23,629,386	—	—	47%
Interior Renovation	12	$516,920	—	—	1%
Exterior Renovations	25	$970,552	—	—	2%
Equipment	216	$5,970,942	—	—	12%
Other	4	$115,000	—	—	0%
Total	**395**	**$50,000,000**	**$5,719,720**	**$3,640,000**	**100%**



FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan[1]

ARRA Overview

State	Number of Projects	ARRA Funding
AK	1	$10,000
AL	3	$70,000
AR	7	$82,600
AZ	6	$352,005
CA	24	$10,156,412
CO	9	$266,460
CT	0	—
DC	0	—
DE	0	—
FL	13	$543,000
GA	1	$100,000
HI	3	$192,574
IA	2	$15,881
ID	0	—
IL	17	$2,468,620
IN	14	$683,437
KS	10	$822,000
KY	16	$946,767
LA	3	$74,000
MA	4	$1,809,802
MD	8	$517,985
ME	3	$842,000
MI	12	$165,341
MN	7	$692,000
MO	16	$1,731,401
MS	4	$138,400
MT	0	—
NC	10	$312,000
ND	0	—
NE	10	$835,312
NH	0	—
NJ	2	$290,000
NM	11	$588,394
NV	0	—
NY	20	$4,352,288

FY 2009 National Cemetery Administration (NCA)/Energy ARRA Spend Plan[1]—Continued

ARRA Overview

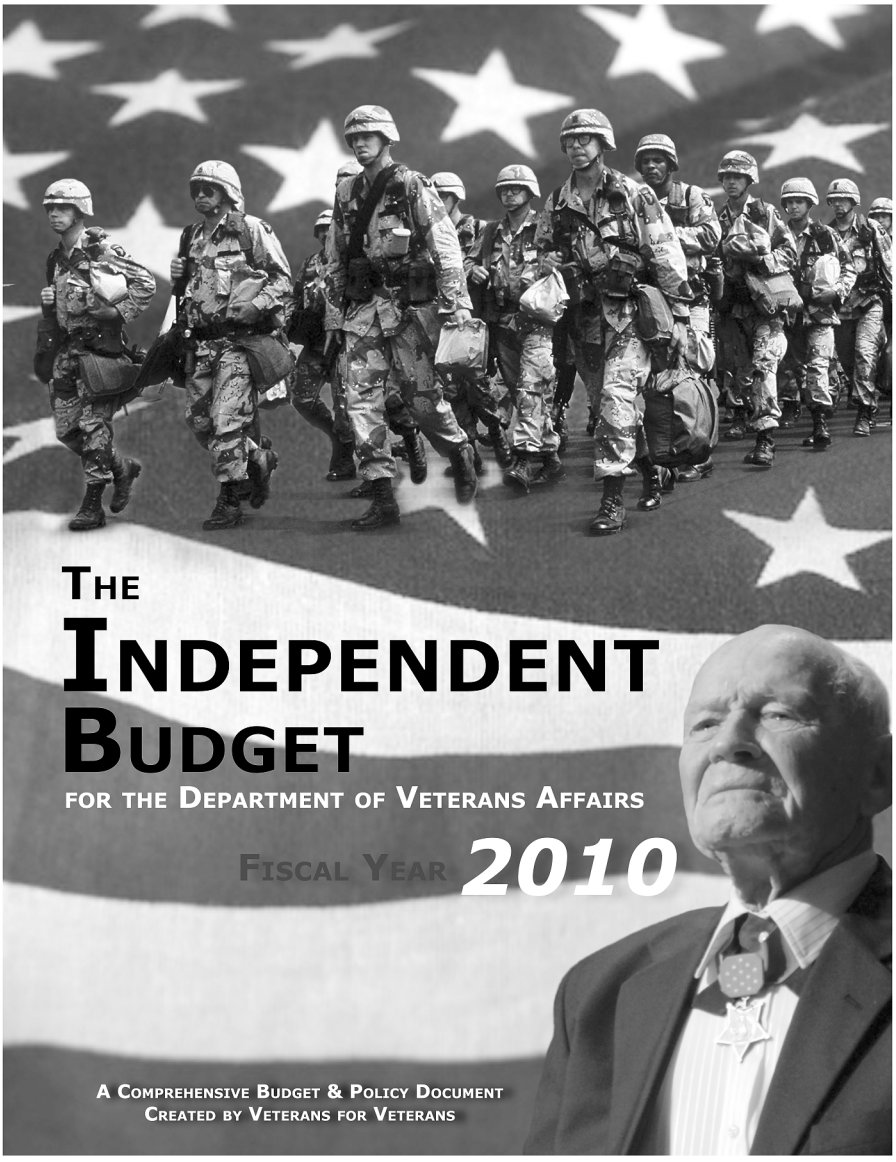
State	Number of Projects	ARRA Funding
OH	11	$736,328
OK	10	$213,950
OR	13	$406,593
PA	7	$326,336
PR	6	$197,250
RI	0	—
SC	14	$256,500
SD	14	$1,190,000
TBD	2	$1,845,000
TN	15	$832,000
TX	39	$11,300,828
UT	0	—
VA	12	$2,448,883
VT	0	—
WA	4	$135,219
WI	9	$980,913
WV	3	$71,522
WY	0	—
Total	395	$50,000,000

[1] The following NCA activities are included under the general heading of "Monument and Memorial Repairs and Energy Projects": (1) national shrine projects to raise, realign, and clean headstones/markers and repair sunken graves at various locations across the country; (2) repairs to historic monuments and memorials at national cemeteries; (3) projects for repairing roads, buildings, and other cemetery infrastructure at locations nationwide; (4) equipment purchases for cemetery operations; and (5) projects that conserve energy and water through the use of wind turbines, solar power and other measures.

Information Technology Recovery Expenditure Plan

U.S. Department of Veterans Affairs

Chapter 33—Post-9/11 GI Bill		
Funding Requirement	**Cost**	**Description**
Project infrastructure, configuration management, application development, testing, and training	$46,925,000	SPAWAR to provide the necessary resources and support infrastructure to manage the strategic, tactical, business and technical components of the program execution; to design, procure, install, and configure the necessary hardware, operating systems, and network infrastructure; to design, develop, implement, and maintain the necessary data integration infrastructure; and to develop and execute all testing efforts to support the end-to-end development, deployment, and maintenance of the system.
Operations	$1,075,000	Provide on-going life cycle solution management and maintenance support for the solution.
New Hires for VA	$500,000	Additional IT staff will be hired to support field station and program management personnel in planning and administering the execution of the Chapter 33 program.
Chapter 33 Subtotal	**$48,500,000**	
Paperless Processing of Veterans Benefits		
Funding Requirement	**Cost**	**Description**
Network upgrades for VBA infrastructure	$1,500,000	Partial funding for the required network upgrades to stabilize the VBA network. Redesign continues with the upgrade of DS3 circuits to all regional offices and selected outbased sites.
Paperless Subtotal	**$1,500,000**	
VETSNET—Economic Recovery Payment Capabilities		
Funding Requirement	**Cost**	**Description**
Modifications to existing Compensation and Pension payment application	$100,000	Modifications to the existing application in the Veterans Service Network (VETSNET), VA's primary Compensation and Pension payment system.
VETSNET Subtotal	**$100,000**	
Grand Total	**$50,100,000**	


THE
INDEPENDENT
BUDGET
FOR THE DEPARTMENT OF VETERANS AFFAIRS
FISCAL YEAR 2010
A COMPREHENSIVE BUDGET & POLICY DOCUMENT
CREATED BY VETERANS FOR VETERANS

Prologue

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

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

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

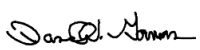
With this reality ever present in our minds, we must do everything we can to ensure that VA has *all* the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve in the darkest corners of the world, keeping the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

(Continued)

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

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

James B. King
National Executive Director
AMVETS



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Supporters

Administrators of Internal Medicine
African American Post Traumatic Stress Disorder Association
African American War Veterans, USA
Alliance for Academic Internal Medicine
American Coalition for Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees
American Foundation for the Blind
American Military Retirees Association
American Military Society
American Psychological Association
American Veterans Alliance
Armed Forces Top Enlisted Association
Association for Service Disabled Veterans
Association of American Medical Colleges
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Specialty Professors
Blinded Veterans Association
Brain Injury Association of America
Catholic War Veterans, USA, Inc.
Clerkship Directors in Internal Medicine
Combined Korea and US Veterans Associations
Enlisted Association of the National Guard of the United States
Fleet Reserve Association
Forty and Eight
Gold Star Wives of America
Iraq and Afghanistan Veterans of America
Japanese American Veterans Association

Jewish War Veterans of the USA
Kansas Commission on Veterans' Affairs
Lung Cancer Alliance
Mental Health America
Military Officers Association of America
Military Order of the Purple Heart of the USA, Inc.
National Alliance on Mental Illness
National Association for Uniformed Services
National Association of American Veterans, Inc.
National Association of Disability Representatives
National Association of State Head Injury Administrators
National Association of State Veterans Homes
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
National Disability Rights Network
National Gulf War Resource Center
National Society of Military Widows
Naval Reserve Association
New Jersey Veterans Memorial Home at Paramus
Non Commissioned Officers Association of the USA
Nurses Organization of Veterans Affairs
Oklahoma Department of Veterans Affairs
Society of Cuban American Veterans
Society of Hispanic Veterans
Title II Community AIDS National Network
United Spinal Association
United States Coast Guard CPOA/CGEA
United States Federation of Korea Veterans Organization
US-Korea Allies Council
Veterans Affairs Physician Assistant Association
Vietnam Veterans of America
Washington State, Office of the Governor
Wisconsin Department of Veterans Affairs

Guiding Principles

- Veterans must not have to wait for benefits to which they are entitled.
- Veterans must be ensured access to high-quality medical care.
- Veterans must be guaranteed timely access to the full continuum of health-care services, including long-term care.
- Veterans must be assured burial in state or national cemeteries in every state.
- Specialized care must remain the focus of the Department of Veterans Affairs (VA).
- VA's mission to support the military medical system in time of war or national emergency is essential to the nation's security.
- VA's mission to conduct medical and prosthetic research in areas of veterans' special needs is critical to the integrity of the veterans' health-care system and to the advancement of American medicine.
- VA's mission to support health professional education is vital to the health of all Americans.

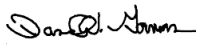
Dedication

The veterans service organizations that collectively author *The Independent Budget* wish to acknowledge and express our deep appreciation to Mr. Richard Fuller for his guidance and many contributions to this document over the years. Richard, who worked for Paralyzed Veterans of America for almost 20 years, died in February 2008 after a prolonged illness.

A tireless advocate for veterans, Richard dedicated himself to ensuring that all men and women who have served in the uniform of this nation have access to the highest quality health care and receive the benefits to which they are entitled. For many years as the lead author of the Medical Care section of *The Independent Budget*, Richard worked to ensure the document reflected the highest degree of professionalism, technical expertise, and compassion.

Richard embodied the true meaning of "citizen soldier." A graduate of Duke University; a veteran of the United States Air Force with service in Vietnam, Thailand, and Okinawa as a Vietnamese linguist; and as an advocate for his fellow service members his entire professional life, he set a standard for excellence and dedication that will remain at the heart of *The Independent Budget*.

James B. King
National Executive Director
AMVETS



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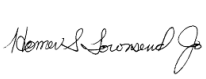

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Table of Contents

Introduction

Once again, the four veterans service organizations who coauthor *The Independent Budget (IB)*—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—offer budget and program recommendations for the Department of Veterans Affairs (VA) based upon our unique expertise and experience concerning the resources that will be necessary to meet the needs of America's veterans in fiscal year (FY) 2010. In fact, this FY 2010 issue of the *IB* represents the 23rd consecutive year that this partnership of veterans service organizations has joined together to produce a comprehensive budget document that highlights the needs of elderly veterans and those of the younger men and women who join their ranks each year as they return from the conflicts in Afghanistan and Iraq and other hostile areas around the world.

Thousands of men and women who have sacrificed themselves in the global war on terrorism are returning home. These brave men and women are relying on VA health-care and benefits systems to help rebuild their lives and become productive members of society. Currently, according to information released by the VA on October 29, 2008, America's current veteran population is projected to be 23,442,000, which includes 1,802,000 females. Of the 23,442,000, 7.8 million veterans are enrolled in the VA health-care system. According to VA data, 5.5 million veterans are identified as unique individual patients who actually received care in VA facilities in 2007. Also, 2.95 million veterans receive disability compensation for injuries they received while on active duty. In addition, 333,196 spouses of deceased veterans rely on VA's dependency and indemnity compensation for the costs of everyday life.

The Veterans Health Administration, similar to private sector health-care providers and other federal health-care programs, including Medicare, Medicaid, and TRICARE, is facing growing demand for services, as the country ages and medical treatment and administrative costs spiral upward. In addition to increasing medical operational costs, almost 40 percent of America's veterans are 65 years of age or older. This group of elderly veterans has an increased demand for VA health and long-term-care services. Additionally, the influx of new, and often severely disabled, veterans entering the VA system brings new demands for care. These age-related, economic, and new patient factors make accurate resource forecasting difficult but more important each year.

Year after year, the coauthors of *The Independent Budget* review VA workload information and medical and administrative cost data and then call upon Congress to provide funding necessary to meet the health-care needs of veterans and to do so in a timely manner. Unfortunately, Congress historically has been unable to complete the VA appropriation process prior to the beginning of the new fiscal year. The *IB* offers reasonable solutions to this serious budget-timing problem—through either a mandatory or an advance appropriation process. The *IB*'s goal is to secure sufficient, timely, and predictable funding that allows VA to conduct effective planning and provide quality services.

With regard to veterans' benefits, the *IB* recommends that VA fast-track real steps that will help ameliorate nagging barriers to claims processing. Continuing studies to find solutions must be replaced by real action plans that produce positive results. These action steps must be implemented before VA's claims system becomes further mired in its own red tape and ultimately collapses under its own weight. Veterans and their families deserve prompt decisions regarding the benefits for which they have shed their blood. These benefits are part of a covenant between our nation and the men and women who have defended it. Veterans have fulfilled their part of the covenant; now VA must avoid further delay and move forward to meet its obligations in a timely manner.

The Independent Budget for Fiscal Year 2010 provides recommendations for consideration by our nation's decision makers that are based on rigorous and rational methodology designed to support the Congressionally authorized VA programs that serve our nation's veterans. *The Independent Budget* veterans service organizations are proud that more than 60 veteran, military, medical service, and disability organizations have signed on in support of this *IB*. Our primary purpose is to inform and encourage the United States government to provide the necessary resources to care for the men and women who have answered the call of our country and taken up arms to protect and defend our way of life.

VA Accounts FY 2010 (Dollars in Thousands)

	FY 2009 Appropriation	FY 2010 IB
Veterans Health Administration		
Medical Services	30,969,903	36,572,421
Medical Support and Compliance	4,450,000	4,584,964
Medical Facilities	5,029,000	5,402,015
Subtotal Medical Care, Discretionary	**40,448,903**	**46,559,400**
Medical Care Collections	2,544,000	
Total, Medical Care Budget Authority *(including Medical Collections)*	**42,992,903**	**46,559,400**
Medical and Prosthetic Research	510,000	575,000
Total, Veterans Health Administration	**40,958,903**	**47,134,400**
General Operating Expenses		
Veterans Benefits Administration	1,466,095	1,629,230
General Administration	335,772	353,552
Total, General Operating Expenses	**1,801,867**	**1,982,782**
Departmental Admin and Misc. Programs		
Information Technology	2,489,391	2,713,058
National Cemetery Administration	230,000	291,500
Office of Inspector General	87,818	90,719
Total, Dept. Admin. and Misc. Programs	**2,807,209**	**3,095,277**
Construction Programs		
Construction, Major	923,382	1,123,000
Construction, Minor	741,534	827,000
Grants for State Extended-Care Facilities	175,000	250,000
Grants for Construction of State Veterans Cemeteries	42,000	52,000
Total, Construction Programs	**1,881,916**	**2,252,000**
Other Discretionary	158,926	163,217
Total, Discretionary Budget Authority *(Including Medical Collections)*	**50,152,821**	**54,627,676**
Cost for Priority Group 8 Veterans Denied Enrollment	**375,000***	**544,200****

*The FY 2009 Appropriations Bill provided $375 million to expand enrollment for Priority Group 8 veterans by 10 percent.

**Cost for Priority Group 8 veterans based on known total cumulative number denied enrollment since 2003 (approximately 565,000 veterans) and a utilization rate of approximately 25 percent.

Benefit Programs

Through the Department of Veterans Affairs (VA), our nation's veterans are provided a comprehensive range of benefits. Included are disability compensation, dependency and indemnity compensation (DIC), pensions, vocational rehabilitation and employment, education benefits, housing loans, ancillary benefits for service-connected disabled veterans, life insurance, and burial benefits.

Disability compensation payments fulfill our primary obligation to attempt to make up for the economic and other losses veterans suffer as a result of the effects of service-connected diseases and injuries. When service members are killed on active duty or veterans' lives are cut short by service-connected injuries or following a substantial period of total service-connected disability, eligible family members receive DIC. Veterans' pensions provide a measure of financial relief for needy veterans of wartime service who are totally disabled as a result nonservice-connected causes or who have reached 65 years of age. Death pensions are paid to needy eligible survivors of wartime veterans. Burial benefits assist families in meeting a portion of the costs of veterans' funerals and burials and provide for burial flags and grave markers. Miscellaneous assistance includes other special allowances for smaller select groups of veterans and dependents and attorney fee awards under the Equal Access to Justice Act. Congress has also authorized special programs to provide a monthly financial allowance, health care, and vocational rehabilitation for the children of some Vietnam and Korean war veterans who suffer from spina bifida and other birth defects.

In recognition of the disadvantages that result from a life of military service, Congress has authorized various benefits to assist veterans in their readjustment to civilian life. These readjustment benefits provide veterans financial assistance for education or vocational rehabilitation programs and provide seriously disabled veterans financial assistance for specially adapted housing and automobiles. Education benefits are also available for children and spouses of those who die on active duty, of those are permanently and totally disabled, or of those who die as a result of service-connected disability. Qualifying students pursuing VA education or rehabilitation programs may receive work-study allowances. For temporary financial assistance to veterans undergoing vocational rehabilitation, loans are available from the vocational rehabilitation revolving fund.

Under its home loan program, VA guarantees commercial home loans for veterans, certain surviving spouses of veterans, certain service members, and eligible reservists and National Guard members. VA also makes direct loans to supplement specially adapted housing grants and direct housing loans to Native Americans living on trust lands.

Under several different plans, VA offers life insurance to eligible veterans, disabled veterans, and members of the Retired Reserve. A group plan also covers service members and members of the Ready Reserve and their family members. Mortgage life insurance protects veterans who have received VA specially adapted housing grants.

COMPENSATION AND PENSIONS

Compensation

ANNUAL COST-OF-LIVING ADJUSTMENT:

Congress should provide a cost-of-living adjustment (COLA) for compensation and dependency and indemnity compensation (DIC) benefits.

On average, veterans with service-connected disabilities earn less than those who were not disabled in service to America. Compensation is intended to replace lost earning capacity. However, each year increasing consumer prices erode the value of compensation and increase the hardship on those who have already sacrificed much for our nation. Further, the families of those who died in service or from service-connected disabilities depend on the small monthly stipend granted them by a grateful nation.

Compensation and DIC rates are modest—inflation erodes this fixed income and has a detrimental impact on its recipients. These benefits must therefore be regularly adjusted to keep pace with increases in the cost of living. Observant of this need, Congress has traditionally adjusted compensation and DIC rates to be equal to the annual adjustment for Social Security benefits. However, timely action by Congress is not guaranteed.

Recommendation:

Congress should enact legislation that automatically adjusts compensation and dependency and indemnity compensation by a percentage equal to the increase received by Social Security recipients in order to offset the rise in the cost of living.

FULL COST-OF-LIVING ADJUSTMENT FOR COMPENSATION:

Congress must provide cost-of-living adjustments (COLAs) equal to the annual increase in the cost of living without rounding down such increases to the next whole dollar.

Congress increases disability compensation and dependency and indemnity compensation (DIC) rates each year in an attempt to keep pace with the cost of living. However, as a temporary measure to reduce the budget deficit, Congress enacted legislation in 1978 to round monthly payments down to the nearest whole dollar after adjustment for increases in the cost of living. Finding this a convenient way to meet budget reconciliation targets and fund spending for other purposes, Congress refuses to break its recurring habit of extending this provision, even in the face of prior budget surpluses. Inexplicably, VA has recommended that Congress make round-down monthly payment increases a permanent part of the law.

The cumulative effect of this practice over 30 years has eroded and will continue to substantially erode the value of compensation and DIC. This continued practice is entirely unjustified. It robs monies from the benefits of some of our most deserving veterans and their dependents and survivors who have no choice but to rely on modest VA compensation for life's necessities.

Recommendations:

Congress should reject any recommendations to permanently extend provisions for rounding down compensation cost-of-living adjustments and allow the temporary round-down provisions to expire on their statutory sunset date.

In the alternative, Congress should enact a one-time adjustment to ensure that veterans and the survivors of those who gave the ultimate sacrifice in service to our nation again receive the full value of benefits intended by a grateful nation.

STANDARD FOR SERVICE CONNECTION:

Standards for determining "service connection" should remain grounded in current law.

A member of the armed forces on active duty is at the disposal of military authority and, in effect, serves on duty 24 hours a day, 7 days a week.

Under many circumstances, a service member may be directly engaged in performing various duties for far more extended periods than a typical eight-hour workday and may be on call or standing by for duty the remainder of the day. Other circumstances require service members to live with their unit 24 hours a day, such as when on duty on naval vessels or at remote military outposts. There is no distinction between "on duty" and "off duty" for purposes of legal status in America's military service, nor is there any clear demarcation between the two. In the overall military environment, there are rigors, physical and mental stresses, known and unknown risks, and hazards unlike and far beyond those seen in civilian occupations.

Compensation for "service-connected" disabilities or death is the core of veterans' benefits. When disability or death results from injury or disease incurred or aggravated in the "line of duty," the disability or death is service connected for purposes of entitlement to these benefits. "Line of duty" means "an injury or disease incurred or aggravated during a period of active military, naval, or air service unless such injury or disease was the result of the veteran's own willful misconduct or, for claims filed after October 31, 1990, was a result of his or her abuse of alcohol or drugs."[1] Accordingly, *any* such occurrence during service that meets the current requirements of law satisfies the criteria for service connection.

These principles are expressly set forth in law. The term "service connected" means, with respect to disability or death, "that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in the line of duty in the active military, naval, or air service." The term "active military, naval, or air service" contemplates, principally, "active duty," although duty for training qualifies when a disability is incurred during such period. The term "active duty" means "full-time" duty in the armed forces of the United States.

For these reasons, current law requires only that an injury or disease be incurred or aggravated coincident with military service. There is no requirement that the veteran prove a causal connection between military service and a disability for which service-connected status is sought.

In spite of these long-standing principles, some Congressional members have proposed the abolishment of these rules by replacing the "line of duty" standard with a strict "performance of duty" standard, under which service connection would not generally be granted unless a veteran could offer proof that a disability was caused by the actual performance of military duty.

Congress created the Veterans' Disability Benefits Commission (VDBC) to carry out a study of "the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service, and to produce a report on the study." After more than 30 months of meetings, study, analysis, and debate, the VDBC, in October 2007, unanimously endorsed the current standard for determining service connection.
The Independent Budget veterans service organizations believe that current standards governing service connection for veterans' disabilities and deaths are equitable, practical, sound, and time-tested. We urge Congress to reject any revision of this long-standing policy.

Recommendation:

Congress should reject all suggestions from any source to change the terms for service connection of veterans' disabilities and deaths.

[1] 38 C.F.R. § 3.1(m).

STANDARD FOR DETERMINING COMBAT-VETERAN STATUS:

Veterans should be presumed to have engaged in combat while serving in an active combat zone.

Current law provides a relaxed evidentiary standard for those veterans who incurred disability or experienced an event that causes a disability, while in combat with the enemy. This standard helps both veterans and the Department of Veterans Affairs. It helps veterans because it is often impossible to prove through documentary evidence that a disease or injury occurred while in combat. The law requires VA to accept as true a veteran's statement that a particular injury or event occurred in combat. (This only relieves the burden of showing service incurrence. Medical evidence must still demonstrate that a disability currently exists and that it is related to service.) It helps VA because it relieves it from spending months or even years researching military records trying to prove that a disease, injury, or event occurred.

Although VA states that evidence of combat is not limited to certain documents, in practice, VA claims processors accept only evidence showing receipt of a certain military decoration[2] or military unit records. Unfortunately, many veterans who were in combat never received a medal on VA's list. Further, unit records, if existent, are notoriously incomplete, vague, or both. These two factors (no combat medal or no accurate unit records) make it impossible for many combat veterans to obtain service connection for disabilities incurred in or caused by combat.

If VA applied 38 U.S.C.A. section 1154 properly, these problems, and others, would be resolved. Section 1154(a) reads in part: "[I]n each case where a veteran is seeking service-connection for any disability due consideration shall be given to the places, types, and circumstances of such veteran's service...."[3] Likewise, section 1154(b) states:

> In the case of any veteran who *engaged in combat with the enemy* in active service...the Secretary shall accept as sufficient proof of service-connection of *any* disease or injury alleged to have been incurred in or aggravated by such service satisfactory lay or other evidence of service incurrence or aggravation of such injury or disease, if consistent with the circumstances, conditions, or hardships of such service, *notwithstanding the fact that there is no official record of such incurrence or aggravation in such service,* and, to that end, shall resolve every reasonable doubt in favor of the veteran.[4]

Specific to post-traumatic stress disorder (PTSD) resulting from combat, VA has determined that service connection requires (1) medical evidence of the condition; (2) credible supporting evidence that a claimed in-service stressor occurred; and (3) a link, established by medical evidence, between the diagnosis and the in-service stressor.[5] Section 3.304(f) appears on its face to be consistent with the statute by stating:

> If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.[6]

It is evident that the provisions of the foregoing statute and regulation do not require validation by official military records of an in-service combat stressor. The law merely requires, absent "clear and convincing evidence to the contrary," " 'credible,' satisfactory lay or other evidence" of an in-service stressor "consistent with the circumstances, conditions, or hardships of the veteran's service." Congress made clear its intent of not requiring such proof to be in the form of official military records when it stated, "notwithstanding the fact that there is no official record of such *incurrence* or aggravation in such service." In cases of combat-related PTSD, the *incurrence* of the disability is the actual exposure to the event; therefore, requiring proof through official records of the *incurrence* violates the law.

Notwithstanding the plain language of the foregoing statute and regulation, VA has circumvented the law by conducting improper rulemaking through its general counsel and its adjudication procedures manual, M21-1MR. Specifically, veterans are required to prove they engaged in combat as shown through official military records, thus contradicting the intent of the statute. VA Office of General Counsel Opinion 12-99 reads in part:

> In order to determine whether VA is required to accept a particular veteran's "satisfactory lay or

> other evidence" as sufficient proof of service connection, an initial determination must be made as to whether the veteran "engaged in combat with the enemy." That determination is not governed by the specific evidentiary standards and procedures in section 1154(b), which only apply once combat service has been established.[7]

This general counsel opinion requires veterans to establish by official military records or decorations that they "personally participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality." Further, VA has promulgated internal instructions that arguably go beyond the general counsel's opinion by instructing rating authorities as follows:

> Credible supporting evidence that an in-service stressor actually occurred includes not only evidence that specifically documents the veteran's personal participation in the event, but evidence that indicates the veteran served in the immediate area and at the particular time in which the stressful event is alleged to have occurred, and supports the description of the event.[8]

The M21-1 manual gives the following two "examples" to VA adjudicators considering whether a veteran has submitted sufficient evidence of an in-service combat stressor:

- When considered as a whole, evidence consisting of a morning report, radio log, and nomination for a Bronze Star may be sufficient to corroborate a veteran's account of an event, even if it does not specifically include mention of the veteran's name.
- Unit records documenting the veteran's presence with a specific unit at the time mortar attacks occurred may be sufficient to corroborate a veteran's statement that she/he experienced such attacks personally.

These examples exceed statutory and regulatory requirements. By requiring official records to prove the "incurrence" of a disease or injury—the in-service stressor serving as the incurrence, or injury, in the case of PTSD—VA has effectively read "satisfactory lay or other evidence" out of the law, thereby exceeding its authority.

For decades VA has required such proof before recognizing a claimant as a "combat veteran." As a result, those who suffer a disease or injury resulting from combat are forced to provide evidence that may not exist or must wait a year or more while VA conducts research to determine whether a veteran's unit engaged in combat. Many claims that satisfy the requirements of the statute are improperly denied.

Congress should amend title 38, United States Code, section 1154(b) to clarify when a veteran is considered to have engaged in combat for purposes of determining combat-veteran status. In the alternative, Congress could amend title 38, section 1101, and define who is considered to have engaged in combat with the enemy. It is hoped that such clarification would allow for utilization of nonofficial evidence—such as a veteran's statement alone if the statement is "credible" and "consistent with the circumstances, conditions, or hardships" of the veteran's service and is otherwise not contradicted by clear and convincing evidence—as proof of an in-service occurrence of a combat-related disease or injury, to include PTSD.

This type of legislation would remove a barrier to the fair adjudication of claims for disabilities incurred or aggravated by military service in a combat zone. This legislation would follow the original intent of the law by requiring VA to accept as sufficient proof lay or other evidence that a veteran engaged in combat with the enemy as well as suffered a disease or injury as a result of that combat, if consistent with that veteran's service.

Many veterans disabled by their service in Iraq and Afghanistan, and those who served in earlier conflicts, are unable to benefit from liberalizing evidentiary requirements found in the current version of the applicable statute, section 1154; and regulation, section 3.304(f). This results because of difficulty, even impossibility, in proving by official military documents personal participation in combat.

Congressional staff conducting oversight visits in VA regional offices found claims that had been denied under this policy because those who served in combat zones had not been able to produce official military documentation of personal participation in combat via engagement with the enemy. The only possible resolution to this problem, without amending section 1154 or otherwise defining who is considered to have engaged in combat, is for the military to record the names and personal actions of every single soldier, sailor, airman, marine, or coastguardsman involved in every single event—large or small—that constitutes combat

and/or engagement with the enemy on every battlefield. Such recordkeeping is impossible.

In numerous cases, extensive delays in claims processing occur while VA adjudicators attempt to obtain official military documents showing participation in combat—documents that may never be located. Without codifying whom VA considers to have engaged in combat, the VA will continue to apply criteria that unlawfully exceed regulatory and statutory authority.

Congress and VA must understand that the change requested herein would not open the proverbial floodgates by forcing VA to accept every unsupported claim made by any veteran who served in a combat zone. With specific regard to occurrences of combat injuries and/or combat stressors, the law would still require a claimant to satisfy some evidentiary burden. Albeit, that evidentiary burden *may,* in some circumstances, solely be a lay statement. For example, if a military truck driver who served in Iraq stated, with clarity and detail, that his convoy came under attack, absent evidence to the contrary, such a statement may be accepted without additional proof because the conditions and circumstances of the veteran's service would have placed him or her directly in the line of fire for that type of attack. However, a unit mailroom clerk's statement of the same would require additional proof of the event because the nature of that veteran's service *normally* may not include such circumstances.

The legislative amendment requested herein would overturn VA's internal requirement—a requirement inconsistent with the original intent of Congress in liberalizing the requirements for proof of service connection in cases involving veterans who served in combat areas. The Senate noted in 1941, in the report on the original bill providing special consideration for combat veterans: "The absence of an official record of care or treatment in many of such cases is readily explained by the conditions surrounding the service of combat veterans."

It was emphasized in the hearings that the establishment of records of care or treatment of veterans in other than combat areas, and particularly in the states, was a comparatively simple matter when compared to that of veterans who served in combat. Either the veterans attempted to carry on despite their disability to avoid having a record made lest they be separated from their organization, or, as in many cases, the records themselves were lost. Likewise, many records are simply never generated. Nowhere in the *law* has Congress ever required proof of combat exposure through official military records.

Recommendation:

Congress should clarify its intent by amending title 38, United States Code, section 1154(b), with respect to defining a veteran who engaged in combat for all purposes under title 38.

In the alternative, Congress should enact legislation that extends 38 U.S.C. section 1154(b) to anyone who served in a war zone. This action would ease the evidentiary burden on veterans and time-consuming development by VA while leaving in place the need for the veteran to prove the existence of a disability and medical evidence connecting the disability to service.

[2]Air Force Achievement Medal with "V" Device; Air Force Combat Action Medal; Air Force Commendation Medal with "V" Device; Air Force Cross; Air Medal with "V" Device; Army Commendation Medal with "V" Device; Bronze Star Medal with "V" Device; Combat Action Badge; Combat Action Ribbon (before February 1969, the Navy Achievement Medal with "V" Device was awarded.); Combat Aircrew Insignia; Combat Infantry/Infantryman Badge; Combat Medical Badge; Distinguished Flying Cross; Distinguished Service Cross; Joint Service Commendation Medal with "V" Device; Medal of Honor; Navy Commendation Medal with "V" Device; Navy Cross; Purple Heart; Silver Star. VA Manual M21-1MR, Part IV, Subpart ii.1.D.13.d.
[3]38 U.S.C. § 1154(a) (West 2002).
[4]Ibid., § 1154(b) (emphasis added).
[5]38 C.F.R. § 3.304(f) (2007).
[6]Ibid., § 3.304(f)(1).
[7]VA Gen. Coun. Prec. 12-99, October 18, 1999.
[8]VA Manual M21-1MR, Part IV, Subpart ii, 1.D.13.

CONCURRENT RECEIPT OF COMPENSATION AND MILITARY RETIRED PAY:

All military retirees should be permitted to receive military retired pay and VA disability compensation concurrently.

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

Entitlement to 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. Their earning potential is reduced commensurate with the degree of service-connected disability.

To put retirees disabled from service on equal footing with nondisabled retirees, VA should provide full military retired pay and compensation to account for reduction of their earning capacity. To the extent that military retired pay and VA disability compensation now offset each other, the disabled retiree is treated less fairly than a nondisabled military retiree. 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 compensation and full civilian retired pay—including retirement from any federal civil service. A veteran who performed 20 or more years of military service should have that same right.

A disabled veteran should not suffer a financial penalty for choosing military service as a career rather than a civilian career, especially where in all likelihood a civilian career would have involved fewer sacrifices and greater rewards. Disability compensation to a disabled veteran should not be offset against military longevity retired pay. While Congress has made progress in recent years in correcting this injustice, *The Independent Budget* veterans service organizations believe the time has come to finally remove this prohibition completely.

Recommendation:

Congress should enact legislation to totally repeal the inequitable requirement that veterans' military retired pay be offset by an amount equal to their rightfully earned VA disability compensation. To do otherwise results in the government compensating disabled retirees with *nothing* for their service-connected disabilities. *The Independent Budget* veterans service organizations urge Congress to correct this continuing inequity.

CONTINUATION OF MONTHLY PAYMENTS FOR ALL COMPENSABLE SERVICE-CONNECTED DISABILITIES:

Lump-sum settlements of disability compensation should be fully rejected.

The government pays disability compensation monthly to eligible veterans on account of, and at a rate commensurate with, diminished earning capacity resulting from the effects of service-connected diseases and injuries. By design, compensation provides relief from service-connected disability for the life of the condition's disabling effects. The severity of disability determines the rate of compensation, which usually warrants reevaluation when changes in severity occur.

Lump-sum payments have been suggested as a way for the government to avoid the administrative costs of reevaluating service-connected disabilities and as a way to avoid future liabilities to qualified veterans when their disabilities worsen or cause secondary disabilities. Under such a scheme, the Department of Veterans Affairs would use the immediate availability of a lump-sum settlement to entice veterans to bargain away future benefits. Lump-sum payments are not in the best interests of disabled veterans.

In its final report, the Veterans' Disability Benefits Commission rejected the concept of paying a lump sum in lieu of recurring compensation because the "complexity of lump sum payments would likely be excessive and difficult for veterans to understand and accept...[b]e difficult and costly to administer...would have significant short-term impact on the budget of the United States[,] and the break-even point when the up-front costs would be offset by future savings would be many years in the future.... "[9] *The Independent Budget* veterans service organizations strongly oppose any change in law to provide for lump-sum payments of compensation.

Recommendation:

Congress should reject any recommendation to permit VA to discharge its future obligation to compensate service-connected disabilities through payment of lump-sum settlements to veterans.

[9]*Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century,* Veterans' Disability Benefits Commission, October 2007, p. 278.

MENTAL HEALTH RATING CRITERIA:

The Department of Veterans Affairs should compensate mental health disabilities on parity with physical disabilities.

Two recent studies, the first by the Center for Naval Analysis, Inc. (commissioned by the Veterans' Disability Benefits Commission)[10] and second by the Econ-Systems (commissioned by the Department of Veterans Affairs),[11] found that veterans who suffer from service-connected psychiatric disabilities suffer greater lost earnings at all levels than do veterans with nonpsychiatric disabilities. VA should update its mental health rating criteria to ensure that those veterans with service-connected psychiatric disabilities are equitably and appropriately evaluated.

Recommendation:

VA should propose a rule change in the *Federal Register* that would update the mental health rating criteria to more accurately reflect the severe impact that psychiatric disabilities have on veterans' average earning capacity.

[10]Ibid., pp. 233, 473.
[11]*A Study of Compensation Payments for Service-Connected Disabilities,* vol. 1. Economic Systems, Inc., September 2008, p. 31.

MORE EQUITABLE RULES FOR SERVICE CONNECTION OF HEARING LOSS AND TINNITUS:

For combat veterans and those with military occupations that typically involved acoustic trauma, service connection for hearing loss or tinnitus should be presumed.

Many veterans exposed to acoustic trauma during service, who are now suffering from hearing loss or tinnitus, are unable to prove service connection because of inadequate testing procedures, lax examination practices, or poor recordkeeping. The presumption requested herein would resolve this long-standing injustice.

The Institute of Medicine (IOM) issued a report in September 2005 titled "Noise and Military Service: Implications for Hearing Loss and Tinnitus." The IOM found that patterns of hearing loss consistent with noise exposure can be seen in cross-sectional studies of military personnel. Because large numbers of people have served in the military since World War II, the total number who experienced noise-induced hearing loss by the time their military service ended may be substantial.

Hearing loss and tinnitus are common among combat veterans. The reason is simple: Combat veterans are typically exposed to prolonged, frequent, and exceptionally loud noises from such sources as gunfire, tanks and artillery, explosive devices, and aircraft. Exposure to acoustic trauma is a well-known cause of hearing loss and tinnitus. Yet many combat veterans are not able to document their in-service acoustic trauma nor can they prove their hearing loss or tinnitus is due to military service. World War II veterans are particularly at a disadvantage because testing by spoken voice and whispered voice was universally insufficient to detect all but the most severe hearing loss.

Audiometric testing in service was insufficient, and testing records are lacking for a variety of reasons. Congress has made special provisions for other deserving groups of veterans whose claims are unusually difficult to establish because of circumstances beyond their control. Congress should do the same for veterans exposed to acoustic trauma, including combat veterans. Congress should instruct VA to develop a list of military occupations that are known to expose service members to noise. VA should be required to presume noise exposure for anyone who worked in one of those military occupations and grant service connection for those who now experience documented hearing loss or tinnitus. Further, this presumption should be expanded to anyone who is shown to have been in combat.

Recommendation:

Congress should enact a presumption of service-connected disability for combat veterans and veterans whose military duties exposed them to high levels of noise and who subsequently suffer from tinnitus or hearing loss.

COMPENSABLE DISABILITY RATING FOR HEARING LOSS NECESSITATING A HEARING AID:

The VA disability-rating schedule should provide a minimum 10 percent disability rating for hearing loss that requires use of a hearing aid.

The VA *Schedule for Rating Disabilities* does not provide a compensable rating for hearing loss at certain levels severe enough to require hearing aids. The minimum disability rating for any hearing loss warranting use of a hearing aid should be 10 percent, and the schedule should be amended accordingly.

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment and the disadvantages of artificial hearing restoration, hearing aids negatively affect the wearer's physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of

VA disability compensation that ratings are not offset by the function artificially restored by a prosthetic device. For example, a veteran receives full compensation for amputation of a lower extremity although he or she may be able to ambulate with a prosthetic limb.

Providing a compensable rating for this condition would be consistent with minimum ratings provided elsewhere when a disability does not meet the rating formula requirements but requires continuous medication. Such a change would be equitable and fair.

Recommendation:

VA should amend its *Schedule for Rating Disabilities* to provide a minimum 10 percent disability rating for any hearing loss medically requiring a hearing aid.

Temporary Total Compensation Awards:

Congress should exempt temporary awards of total disability compensation from delayed payment dates.

An inequity exists in current law controlling the beginning date for payment of increased compensation based on periods of incapacity due to hospitalization or convalescence. Hospitalization exceeding 21 days for a service-connected disability entitles the veteran to a temporary total disability rating of 100 percent. This rating is effective the first day of hospitalization and continues to the last day of the month of discharge from hospital. Similarly, where surgery for a service-connected disability necessitates at least one month's convalescence or causes complications or where immobilization of a major joint by cast is necessary, a temporary 100 percent disability rating is awarded effective on the date of hospital admission or outpatient visit.

The effective date of temporary total disability ratings corresponds to the beginning date of hospitalization or treatment. However, title 38, United States Code, section 5111 delays the effective date for payment purposes until the first day of the month following the effective date of the increased rating.

This provision deprives veterans of an increase in compensation to offset the total disability during the first month in which temporary total disability occurs. This deprivation and consequent delay in the payment of increased compensation often jeopardizes disabled veterans' financial security and unfairly causes them hardship.

The Independent Budget veterans service organizations urge Congress to enact legislation exempting these temporary total disability ratings, administered under title 38, Code of Federal Regulations, sections 4.29 and 4.30, from the provisions of title 38, United States Code, section 5111.

Recommendation:

Congress should amend the law to authorize increased compensation based on a temporary total rating for hospitalization or convalescence to be effective, for payment purposes, on the date of admission to the hospital or the date of treatment, surgery, or other circumstances necessitating convalescence.

Pensions

PENSION FOR NONSERVICE-CONNECTED DISABILITY:

Congress should extend basic eligibility for nonservice-connected pension benefits to veterans who serve in combat environments, despite no declaration of war.

Veterans totally disabled from nonservice-connected conditions (or are at least 65 years old) with low income and wartime service are eligible to receive a modest pension. The amount of pension awarded is reduced for every dollar of income received from any other source. It is designed to ensure that wartime veterans do not become charges on the public welfare.

Under the Constitution, Congress is charged with declaring war. However, in the past century large numbers of service members have been sent into many hostile areas around the world to conduct operations in support of American foreign policy and to protect American interests. Typically, these military actions are not conducted under the umbrella of a declaration of war and not all are considered to be a "war" under VA regulations.[12] As a consequence, not all veterans who have been engaged in combat are eligible for a VA pension. Another factor to consider is that some expeditionary medals and combat badges are awarded to members of the armed forces who have served in hostile regions, in situations and circumstances other than those officially designated combat operations, or during a wartime era as declared by Congress.

Recommendation:

Congress should amend eligibility requirements in title 38, United States Code, chapter 15 to authorize nonservice-connected disability pension benefits to veterans who have been awarded the Armed Forces Expeditionary Medal, Navy/Marine Corps Expeditionary Medal, Purple Heart, Combat Infantryman's Badge, Combat Medical Badge, or Combat Action Ribbon for participation in military operations not falling within an officially designated or declared period of war.

[12] 38 C.F.R. § 3.2.

Dependency and Indemnity Compensation

INCREASE OF DEPENDENCY AND INDEMNITY COMPENSATION FOR SURVIVING SPOUSES OF SERVICE MEMBERS:

Congress should increase rates of dependency and indemnity compensation (DIC) to survivors of active duty military personnel who die while on active duty.

Current law authorizes the Department of Veterans Affairs to pay an enhanced amount of DIC, in addition to the basic rate, to surviving spouses of veterans who die from service-connected disabilities after at least an eight-year period of the veteran's total disability rating prior to death. However, surviving spouses of military service members who die on active duty receive only the basic rate of DIC. This is inequitable because surviving spouses of deceased active duty service members face the same financial hardship as survivors of deceased service-connected veterans who were totally disabled for eight years prior to their deaths.

Recommendation:

Congress should authorize disability and indemnity eligibility at increased rates to survivors of deceased military personnel on the same basis as that for the survivors of totally disabled service-connected veterans.

Repeal of Offset against Survivor Benefit Plan:

The current requirement that the amount of an annuity under the Survivor Benefit Plan (SBP) be reduced on account of and by an amount equal to dependency and indemnity compensation (DIC) 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 VA. This benefit indemnifies survivors, in part, for the losses associated with the veteran's death from service-connected causes or after a period of time when the veteran was unable, because of total disability, to accumulate an estate for inheritance by survivors.

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

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

Recommendation:

Congress should repeal the offset between dependency and indemnity compensation and the Survivor Benefit Plan.

Retention of Remarried Survivors' Benefits at Age 55:

Congress should lower the age required for survivors of veterans who die from service-connected disabilities who remarry to be eligible for restoration of dependency and indemnity compensation (DIC) to conform with the requirements of other federal programs.

Current law permits the Department of Veterans Affairs to reinstate DIC benefits to remarried survivors of veterans if the remarriage occurs at age 57 or older or, if survivors have already remarried, they apply for reinstatement of DIC at age 57. While *The Independent Budget* veterans service organizations appreciate the action Congress took to allow this restoration of rightful benefits, the current age threshold of 57 years is arbitrary. Remarried survivors of retirees in other federal programs obtain a similar benefit at age 55. We believe the survivors of veterans who died from service-connected disabilities should not be further penalized for remarriage and that equity with beneficiaries of other federal programs should govern Congressional action for this deserving group.

Recommendation:

Congress should lower the existing eligibility age for reinstatement of disability and indemnity compensation to remarried survivors of service-connected veterans from 57 years of age to 55 years of age.

READJUSTMENT BENEFITS

Housing Grants

GRANT FOR ADAPTATION OF SECOND HOME:

Grants should be available for special adaptations to homes that veterans purchase or build to replace initial specially adapted homes.

Like those of other families today, veterans' housing needs tend to change with time and new circumstances. An initial home may become too small when the family grows or become too large when children leave home. Changes in the nature of a veteran's disability may necessitate a home configured differently and/or changes to the special adaptations. These evolving requirements merit a second grant to cover the costs of adaptations to a new home.

Recommendation:

Congress should establish a grant to cover the costs of home adaptations for veterans who replace their specially adapted homes with new housing.

GRANTS FOR ADAPTATION OF HOMES FOR VETERANS LIVING IN FAMILY-OWNED TEMPORARY RESIDENCES:

Grants should be increased for special adaptations to homes in which veterans temporarily reside that are owned by a family member.

The Department of Veterans Affairs may provide specially adapted housing grants for veterans who have service-connected disabilities for certain combinations of loss or loss of use of extremities and blindness or other organic diseases or injuries when those veterans reside in but do not intend to permanently reside in a residence owned by a family member. Specifically, the assistance for the first group may not exceed $14,000 for veterans who have a permanent and total service-connected disability as a result of the loss or loss of the use of both lower extremities, such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair. For the second group, the assistance may not exceed $2,000 for veterans who have a permanent and total service-connected disability rating due to blindness in both eyes with 5/200 visual acuity or less and the disability includes the anatomical loss or loss of use of both hands. Unless the amounts of these grants are periodically adjusted, inflation erodes these benefits that are payable to a select few, albeit among the most seriously disabled service-connected veterans.

Recommendation:

Congress should increase the allowance from $14,000 to $28,000 for those veterans meeting the criteria of the first group and increase the allowance from $2,000 to $5,000 for veterans meeting the criteria of the second group. Then it should provide for automatic annual adjustments in the future to keep pace with inflation.

Automobile Grants and Adaptive Equipment

INCREASE IN AMOUNT OF AUTOMOBILE GRANT AND AUTOMATIC ANNUAL ADJUSTMENTS FOR INCREASED COSTS:

The automobile and adaptive equipment grants need to be increased and automatically adjusted annually to cover increases in costs.

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

Congress initially fixed the amount of the automobile grant to cover the full cost of the automobile. However, because adjustments have not kept pace with increased costs, over the past 52 years the value of the automobile allowance has been substantially eroded. In 1946 the $1,600 allowance represented 85 percent of the average retail cost and was sufficient to pay the full cost of automobiles in the "low-price field." Comparing the Department of Energy's average price of a new vehicle to the automobile allowance that was in effect for that year, Table 1 demonstrates the dramatic decline in this benefit.

The National Automobile Dealers Association has confirmed that the $28,500 average price of a new car in 2007 is the same for 2008. The table below shows that an $11,000 automobile allowance represents only about 39 percent of the average cost of a new automobile. To restore equity between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be $22,800.

Veterans eligible for the automobile allowance under title 38, United States Code, section 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the nature of their disabilities requires the larger and more expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current $11,000 allowance is only a fraction of the cost of even the most modest and smaller models, which are often not suited to these veterans' special needs. Accordingly, if this benefit is to accomplish its purpose, it must be adjusted to reflect the current cost of automobiles.

Recommendation:

Congress should increase the automobile allowance to 80 percent of the average cost of a new automobile in 2008 and then provide for automatic annual adjustments based on the rise in the cost of living.

Price of New Vehicle vs. Auto Allowance

Year	Auto Allowance	Avg. Cost of New Car	Cost as a % of Allowance
1946	$1,600	$1,875	85%
1971	$2,800	$3,919	72%
1975	$3,300	$5,084	65%
1978	$3,800	$6,478	58%
1981	$4,400	$8,912	49%
1985	$5,000	$11,589	43%
1988	$5,500	$13,418	41%
1998	$8,000	$18,479	43%
2001	$9,000	$19,654	46%
2007	$11,000	$28,500	39%

INSURANCE

Government Life Insurance

VALUE OF POLICIES EXCLUDED FROM CONSIDERATION AS INCOME OR ASSETS:

For purposes of other government programs, the cash value of veterans' life insurance policies should not be considered assets, and dividends and proceeds should not be considered income.

For nursing home care under Medicaid, the government forces veterans to surrender their government life insurance policies and apply the amount received from the surrender for cash value toward nursing home care as a condition for Medicaid coverage of the related expenses of needy veterans. It is unconscionable to require veterans to surrender their life insurance to receive nursing home care. Similarly, dividends and proceeds from veterans' life insurance should be exempt from countable income for purposes of other government programs.

Recommendation:

Congress should enact legislation to exempt the cash value of, and dividends and proceeds from, VA life insurance policies from consideration in determining entitlement under other federal programs.

LOWER PREMIUM SCHEDULE FOR SERVICE-DISABLED VETERANS' INSURANCE:

The Department of Veterans Affairs should be authorized to charge lower premiums for Service-Disabled Veterans' Insurance (SDVI) policies based on improved life expectancy under current mortality tables.

Because of service-connected disabilities, disabled veterans have difficulty getting or are charged higher premiums for life insurance on the commercial market. Congress therefore created the SDVI program to furnish disabled veterans life insurance at standard rates.

When this program began in 1951, its rates, based on mortality tables then in use, were competitive with commercial insurance. Commercial rates have since been lowered to reflect improved life expectancy shown by current mortality tables. However, VA continues to base its rates on mortality tables from 1941. Consequently, SDVI premiums are no longer competitive with commercial insurance and therefore no longer provide the intended benefit for eligible veterans.

Recommendation:

Congress should enact legislation to authorize VA to revise its premium schedule for Service Disabled Veterans' Insurance to reflect current mortality tables.

INCREASE IN MAXIMUM SERVICE-DISABLED VETERANS' INSURANCE COVERAGE:

The current $10,000 maximum for life insurance under Service-Disabled Veterans' Insurance (SDVI) does not provide adequately for the needs of survivors.

When life insurance for veterans was first made available to members of the armed forces in October of 1917, coverage was limited to $10,000. At that time, the law authorized an annual salary of $5,000 for the director of the Bureau of War Risk Insurance. Obviously, the average annual wages of service members in 1917 was considerably less than $5,000. Then, a $10,000 life insurance policy provided sufficiently for the loss of income from the death of an insured in 1917.

Today, more than 90 years later, maximum coverage under the base SDVI policy remains at $10,000. Given that the annual cost of living is many times what it was in 1917, the same maximum coverage now nearly a century later clearly does not provide meaningful income replacement for the survivors of service-disabled veterans.

A May 2001 report from an SDVI program evaluation conducted for VA recommended that basic SDVI coverage be increased to $50,000 maximum. *The Independent Budget* veterans service organizations therefore recommend that the maximum protection available under SDVI be increased to $50,000.

Recommendation:

Congress should enact legislation to increase the maximum protection under base Service Disabled Veterans' Insurance policies to $50,000.

Veterans' Mortgage Life Insurance

INCREASE IN MAXIMUM VETERANS' MORTGAGE LIFE INSURANCE COVERAGE:

The maximum amount of mortgage protection under Veterans' Mortgage Life Insurance (VMLI) needs to be increased.

The maximum VMLI coverage was last increased in 1992. Since then, housing costs have risen substantially. Because of the great geographic differentials in the costs associated with accessible housing, many veterans have mortgages that exceed the maximum face value of VMLI. Thus, the current maximum coverage amount does not cover many catastrophically disabled veterans' outstanding mortgages. Moreover, severely disabled veterans may not have the option of purchasing extra life insurance coverage from commercial insurers at affordable premiums.

Recommendation:

Congress should increase the maximum coverage under Veterans' Mortgage Life Insurance from $90,000 to $150,000.

General Operating Expenses

From its central office in Washington, D.C., and through a nationwide system of field offices, the Department of Veterans Affairs administers its veterans' benefits programs. Responsibility for the various benefit programs is divided among five services within the Veterans Benefits Administration: Compensation and Pension, Vocational Rehabilitation and Employment, Education, Loan Guaranty, and Insurance. Under the direction and control of the Under Secretary for Benefits and various deputies, the program directors set policy and oversee their programs from the VA Central Office. The field offices receive benefit applications, determine entitlement, and authorize benefit payments and awards.

The Office of the Secretary of Veterans Affairs and the assistant secretaries provide departmental management and administrative support. These offices, along with the Office of General Counsel and the Board of Veterans' Appeals, are the major activities under the General Administration portion of the General Operating Expenses (GOE) appropriation. The GOE appropriation funds the benefits delivery system-VBA and its constituent line, staff, and support functions—and the functions under General Administration.

The best-designed benefit programs achieve their intended purposes only if the benefits are delivered to entitled beneficiaries in a timely manner and in the correct amounts. *The Independent Budget* veterans service organizations make the following recommendations to maintain VA's benefits delivery infrastructure and to improve VA performance and service to veterans.

VETERANS BENEFITS ADMINISTRATION

VBA Management

MORE AUTHORITY OVER FIELD OFFICES:

VA program directors should have more accountability for benefits administration in the field offices.

The Veterans Benefits Administration (VBA) has introduced several new initiatives to improve its claims processes. Besides fundamental reorganization of claims-processing methods to achieve increased efficiencies, the initiatives include several measures to improve quality in claims decisions. Among these measures are better quality assurance and accountability for technically correct decisions. The VBA's current management structure presents a serious obstacle to enforcement of accountability because program directors lack direct authority over those who make claims decisions in the field. Of VBA management, program directors have the most hands-on experience with and intimate knowledge of their benefit lines, and they have the most direct involvement in day-to-day monitoring of field office compliance. Program directors are therefore in the best position to advise the Under Secretary on enforcing quality standards and program policies within their respective benefit programs.

While higher-level VBA managers are properly positioned to direct operational aspects of field offices, they are indirectly involved in the substantive elements of the benefit programs. To enforce accountability for technical accuracy and to ensure uniformity in claims decisions, program directors logically should have more accountability for the field decision-making process and should be enabled to advise the Under Secretary to order remedial measures when variances are identified.

In its August 1997 report to Congress, the National Academy of Public Administration (NAPA) attributed many of the VBA's problems to unclear lines of accountability. NAPA found that a sense of powerlessness to take action permeates the VBA. In turn, field personnel perceived VBA's central office staff as incapable of taking firm action. NAPA said that a number of executives interviewed by its study team indicated that VBA executives have difficulty giving each other bad news or disciplining one another. NAPA concluded that until the VBA is willing to deal with this conflict and modify its decentralized management style, it will not be able to effectively analyze the variations in performance and operations existing among its regional offices. Neither will it be able to achieve a more uniform level of performance. Regarding the Compensation and Pension (C&P) Service especially, NAPA concluded that the C&P director's lack of influence or authority over its field office employees would greatly hamper any efforts to implement reforms and real accountability.

NAPA recommended that the Under Secretary for Benefits strengthen C&P influence over field operations and close the gaps in accountability. *The Independent Budget* veterans service organizations (IBVSOs) continue to agree with that assessment and urge the Under Secretary to empower the C&P director to become more involved in direct field operations. In its March 2004 "Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veteran," the VA Vocational Rehabilitation and Employment (VR&E) Task Force recommended that the director of the VR&E Service be given "some line-of-sight authority for the field administration of the program." The IBVSOs agree with this assessment as well.

Recommendation:

To improve the management structure of the Veterans Benefits Administration for purposes of enforcing program standards and raising quality, the VA Under Secretary for Benefits should give VBA program directors more accountability for the performance of VA regional office directors.

Compensation and Pension Service

IMPROVEMENTS IN CLAIMS PROCESSING:

Congress should restore fairness to the claims process by providing solid structure and enforceable rights to claims development where too much personal discretion otherwise exists.

The Department of Veterans Affairs administers a complex set of laws and regulations designed to compensate veterans for the average impairment of earnings capacity due to disabilities (the residuals of disease or injury) incurred coincident with or as a result of military service.

The compensation program is not workers compensation, nor is it akin to Social Security Disability Insurance (SSDI). The first is intended to protect workers from lost wages as the result of disabilities related to employment. This benefit is usually limited in both amount and duration of payment. It provides basic income for a finite period to injured employees. It also protects employers by providing a limit on payments. Social Security Disability Insurance is, at its heart, an insurance program. Both employees and employers pay premiums to the federal government which, in turn, pays a monthly benefit based on a number of factors.

Both workers compensation and SSDI decisions are relatively simple. With workers compensation, the decision maker gathers information on the origins and severity of a job-related injury. Workers compensation is paid if the injury is work related and at least temporarily disabling. SSDI is simpler still. Once basic eligibility is determined, the Social Security Administration need merely decide if the disability keeps the individual from working. If it does, the benefit is paid.

The payment of veterans' disability compensation, on the other hand, requires a decision that each claimed disability be related to service; a medical examination for each service-connected disability to assess the severity or impairment of the condition; and the assignment of a numerical evaluation for each condition. Finally, the decision maker must select an effective date of service connection for each condition and the level of severity for each disability, and if the disability worsened during the pendency of the claim, determine whether higher evaluations should be assigned at different points of time during that period.

The adjudication of compensation claims is complex and time consuming. Failure to develop evidence correctly requires serial redevelopment, which delays claims resolution and increases opportunities for mistakes.

Further, inadequately trained employees fail to recognize claims that have been adequately prepared for rating purposes. As a consequence, VA routinely continues to develop many claims rather than making timely decisions.

Inadequately trained and overworked employees are not limited to the Veterans Benefits Administration (VBA). Such actions usually result in appeals, followed by needless remands by the Board of Veterans' Appeals (BVA) and/or the Court of Appeals for Veterans Claims (CAVC/the Court). In many of these cases, the evidence of record supports a favorable decision on the appellant's behalf, yet the appeal is remanded nonetheless. These unjustified remands usually do nothing but perpetuate the hamster-wheel reputation of veterans law.

In far too many cases, VA continues to develop cases, and the BVA remands appeals, solely to obtain a VA medical opinion even when the claimant's submission of a private medical opinion is adequate for rating purposes. VA's conduct in these cases violates the very purpose of its pro-claimant, nonadversarial claims process.

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

These changes should begin by providing solid, nondiscretionary structure to VA's "duty to notify." Congress

meant well when it enacted VA's current statutory "notice" language. It has nonetheless led to unintended consequences that have proven detrimental to the claims process. Many Court decisions have expanded upon VA's statutory duty to notify, in terms of both content and timing. However, with the recent passage of P.L. 110-389, the "Veterans Benefits Improvement Act of 2008," Congress, with the Administration's support, took an important step to correct this problem. However, *The Independent Budget* veterans service organizations (IBVSOs) believe VA can do more.

There is ample room to improve the law concerning medical opinions in a manner that would bring noticeable efficiency to VA's claims process, such as when VA issues a Veterans Claims Assistance Act (VCAA) notice letter. Under current notice requirements and in applicable cases, VA's letter to a claimant normally informs the claimant that he or she may submit a private medical opinion. The letter also states that VA may obtain a medical opinion if VA decides to do so. However, these notice letters do not inform the claimant of what elements make private medical opinions adequate for VA rating purposes.

To correct this deficiency, the IBVSOs recommend that when VA issues proposed regulations to implement the recent amendment of section 5103 its proposed regulations contain a provision that will require it to inform a claimant, in a VCAA notice letter, of the basic elements that make medical opinions adequate for rating purposes. The VA's notice requirements should be amended to include specific information concerning the basic elements that make a medical opinion adequate for rating purposes, such as a medical statement indicating what records (for example, service medical records, copy of VA claims file, treatment records, etc.) were reviewed in reaching the opinion, a medical rationale for the opinion, and a conclusion to the opinion stated in terms of "as likely as not," "more likely than not," or "less likely than not" rather than "maybe," "possibly," or "could be."

The IBVSOs believe if a claimant's physician is made aware of the elements that make a medical opinion adequate for VA rating purposes, and provides VA with such an opinion, VA no longer needs to delay making a decision on a claim by obtaining its own medical opinion. This would reduce the number of appeals that result from conflicting medical opinions—appeals that—more often than not—are ultimately decided in an appellant's favor.

If the Administration refuses to promulgate regulations that incorporate the foregoing suggestion, Congress should amend VA's notice requirements in section 5103 to require that VA provide such notice regarding the adequacy of medical opinions. As a matter of fairness, VA does relay this exact information to its own doctors when it seeks a medical opinion.

Congress should consider amending title 38, United States Code, section 5103A(d)(1) to provide that when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request such evidence from a Department provider. These suggested changes to VA's "duty to notify" and its "duty to assist" would ensure uniformity between the two procedures.

Congress has previously attempted, to a lesser degree, to fix this problem. Congress enacted title 38, United States Code, section 5125 for the express purpose of eliminating the former 38 Code of Federal Regulations, section 3.157(b)(2) requirement that a private physician's medical examination report be verified by an official VA examination report prior to an award of VA benefits. Section 5125 states:

> For purposes of establishing any claim for benefits under chapter 11 or 15 of this title, a report of a medical examination administered by a private physician that is provided by a claimant in support of a claim for benefits under that chapter *may* be accepted without a requirement for confirmation by an examination by a physician employed by the Veterans Health Administration if the report is sufficiently complete to be adequate for the purpose of adjudicating such claim.[13]

Section 5125 was therefore codified to eliminate unnecessary delays in the adjudication of claims and to avoid the costs associated with unnecessary medical examinations. In addition to unnecessary costs, this type of overdevelopment significantly adds to VA's increasing claims and appeals backlog.

In spite of the elimination of 38 Code of Federal Regulations, section 3.157, and the enactment of title 38, United States Code, section 5125, VA consistently refuses to make decisions in claims wherein the claimant secures a private medical opinion until a VA medical opinion is obtained. Such actions are an abuse of discretion, delay decisions, and prompt needless appeals. When claimants

submit private medical evidence that is competent, credible, probative, and otherwise adequate for rating purposes, Congress should mandate that VA *must* decide the case based on such evidence rather than delaying the claim by arbitrarily requesting it provide additional medical opinion. Therefore, section 5125 should also be amended to ensure harmonious law with enforceable rights that is to a lesser degree than current law open to such wide discretionary interpretations by VA employees.

Some may view these suggestions as an attempt to tie VA's hands with respect to its consideration of private medical opinions. However, they do not. The language in these recommended changes would not require VA to accept private medical evidence if, for example, VA finds that the evidence is not credible and therefore not adequate for VA rating purposes.

Recommendations:

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

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

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

[13]38 U.S.C. § 5125 (West 2002) (emphasis added).

IMPROVEMENTS IN VBA TRAINING

Although the Department of Veterans Affairs has improved its training programs to some extent, more needs to be done to ensure decision makers and adjudicators are held accountable to training standards.

The Veterans Benefits Administration (VBA) has a standard training curriculum for new claims processors and an 80-hour annual training requirement for all claims processors. The training program in VBA is basically a three-stage system. First, VBA policy requires new staff to complete some orientation training, which is provided in their home offices. Second, they are required to attend a two- to three-week centralized training course that provides a basic introduction to job responsibilities. Third, new staff are required to spend several more months in training at their home offices, which includes on-the-job training and/or instructor-led training that follows a required curriculum via use of an online learning tool called the Training and Performance Support System (TPSS). VBA policy states that all claims processors are required to complete a minimum of 80 hours of training annually. VA regional offices (ROs) have some discretion over what training they provide to meet this requirement.

The first phase of training for new rating veteran service representatives (RVSRs) is prerequisite training; this begins at their home regional offices. This training is designed to lay the foundation for future training by introducing new employees to topics, such as the software applications used to process and track claims, medical terminology, the system for maintaining and filing a case folder, and the process for requesting medical records. The VBA specifies the topics that must be covered during prerequisite training; however, ROs can choose the format for the training and the time frame. New veteran service representatives (VSRs) and RVSRs

typically spend two to three weeks completing prerequisite training in their home office before they begin the second program phase.

The second phase of training is known as centralized training, wherein new VSRs and RVSRs spend approximately three weeks in classroom training. Participants from multiple ROs are typically brought together in centralized training sessions, which provide an overview of the technical aspects of the VSR and RVSR positions.

To practice processing different types of claims, VSRs work on either real or hypothetical claims specifically designed for training. Centralized training for new RVSRs focuses on such topics as systems of the human body, how to review medical records, and how to interpret medical exams. To provide instructors for centralized training, the VBA relies on senior RO staff who are trained as instructors. Centralized training instructors may be VSRs, RVSRs, supervisors, or other staff identified by RO managers as having the capability to be effective instructors.

The VBA has increased the number of training sessions because of the influx of new staff. In fiscal year 2007 the VBA increased the frequency of centralized training and its student capacity at the Veterans Benefits Academy. During FY 2007, the VBA held 67 centralized training sessions for 1,458 new VSRs and RVSRs. Centralized training sessions were conducted at 26 different ROs during FY 2007, in addition to the Veterans Benefits Academy. By comparison, during FY 2006, the VBA held 27 centralized training sessions for 678 new claims processors. Nonetheless, the VBA has not run its benefits academy near to full capacity in 2008, the reasons for which are unclear.

When new VSRs and RVSRs return to their home office after centralized training, they are required to begin their third phase of training, which is supposed to include on-the-job, classroom, and computer-based training modules that are part of the VBA's TPSS, all conducted by and at the RO. New VSRs and RVSRs typically take about 6 to 12 months after they return from centralized training to complete all the training requirements for new staff.

In addition to the foregoing three-phase training program, the VBA also requires 80 hours of annual training for all VSRs and RVSRs. The training is divided into two parts. At least 60 hours must come from a list of core technical training topics identified by the Compensation and Pension Service. The VBA specifies more core topics than are necessary to meet the 60-hour requirement, so regional offices can choose those topics most relevant to their needs. They can also choose the training method used to address each topic, such as classroom or TPSS training. The RO managers decide the specificities of the remaining 20 hours.

Despite the foregoing, training has not been a high priority in the VBA. One of the most essential resources is experienced and knowledgeable personnel devoted to training. More management devotion to training and quality requires a break from the status quo of production goals above all else. In a 2005 report from the VA Office of Inspector General, VBA employees were quoted as stating: "Although management wants to meet quality goals, they are much more concerned with quantity. An RVSR is much more likely to be disciplined for failure to meet production standards than for failing to meet quality standards," and "there is a lot of pressure to make your production standard. In fact, your performance standard centers around production and a lot of awards are based on it. Those who don't produce could miss out on individual bonuses, etc."[14] Little if anything has changed since the Inspector General issued this report.[15]

The VBA's problems caused by a lack of accountability do not begin in the claims development and rating process—they begin in the training program. There is little measurable accountability in the VBA's training program.

For example, some VA employees anonymously informed *The Independent Budget* veterans service organizations that many candidates begin centralized training without having had the opportunity to participate in and/or complete phase-one training. Additionally, candidates are not held responsible by formal testing on subjects taught during phase-one training. While oversight may exist for this portion of training, we could find none.

Without resorting to a critique of the substance of the VBA's subject matter taught during phase-two training, or any other phase for that matter, we limit our analysis again to accountability. As in phase one, the VBA refuses to test participants of phase-two training. The obvious goal is to ensure employees attend the required course—ensuring that employees achieve the VBA's learning objectives appears to have no priority.

By now, a new employee has had approximately one month of training and is supposedly prepared for phase-three training. Keep in mind that during phase three, new employees will work on real-world cases in which the outcomes affect the lives and livelihoods of disabled veterans and their families. Real cases notwithstanding, again there is no accountability, no testing, and no oversight outside that provided locally; again, that oversight is not measured nationally.

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

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

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

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

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

It is quite evident that a culture of quality neither exists, nor is much desired, in the Veterans Benefits Administration.

Recommendation:

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

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

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

STRONGER ACCOUNTABILITY

The Veterans Benefits Administration (VBA) must overhaul its outdated and ineffective accountability mechanisms.

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

The quality assurance tool used by the Department of Veterans Affairs for compensation and pension claims is the Systematic Technical Accuracy Review (STAR) program. Under the STAR program, VA reviews a sampling of decisions from regional offices and bases its national accuracy measures on the percentage with errors that affect entitlement, benefit amount, and effective date.

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

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

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

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

The Veterans' Benefits Improvement Act of 2008 (section 226) required VA to conduct a study on the effectiveness of the current employee work-credit system and work-management system. In carrying out the study, VA is required to consider, among other things: (1) measures to improve the accountability, quality, and accuracy for processing claims for compensation and pension benefits; (2) accountability for claims adjudication outcomes; and (3) the quality of claims adjudicated. The legislation requires VA to submit the report to Congress, which must include the components required to implement the updated system for evaluating VBA employees, no later than October 31, 2009.

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

Recommendation:

The VA Secretary's upcoming report must focus on how the Department will establish a quality assurance and accountability program that will detect, track, and hold responsible those VA employees who commit errors while simultaneously providing employee motivation for the achievement of excellence. VA should generate the report in consultation with veterans service organizations most experienced in the claims process.

Investments in VBA Initiatives

VBA INFORMATION TECHNOLOGY AND STAFF TRAINING INITIATIVES:

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

To meet ever-increasing demands while maintaining efficiency, the VBA must continually modernize the tools it uses to process and resolve claims. Given the current challenging environment in claims processing and benefits administration, and the ever-growing backlog, the VBA must continue to upgrade IT infrastructure and revise its training to stay abreast of program changes and modern business practices. However, as noted in the "Centralized Information Technology Impact on VA Health Care" section of this *Independent Budget*, the centralization of all IT to one chief information officer has brought many crucial VBA IT initiatives to a halt—or at best a slow crawl—to the detriment of reforms essential to improving the claims-processing system. Also, in spite of undeniable needs, Congress has steadily reduced funding for VBA initiatives over the past several years. In FY 2001, Congress provided $82 million for VBA-identified IT initiatives. In FY 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and in 2006, $23 million.

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

The Independent Budget veterans service organizations (IBVSOs) urge the Department of Veterans Affairs to use new funds for the purposes enumerated in this section and to ensure that new VBA personnel are properly supported with necessary IT resources. With restored investments in these initiatives, the VBA could complement staffing adjustments for increased workloads with a supportive infrastructure to improve operational effectiveness. The VBA could resume an adequate pace in its development and deployment of IT solutions, as well as to upgrade and enhance training systems for staff to improve operations and service delivery to veterans. Whereas all IT initiatives are now being funded in VA's IT appropriation and tightly controlled by the chief information officer, needed and ongoing VBA initiatives include expansion of web-based technology and deliverables, such as a web portal and Training and Performance Support System (TPSS); "Virtual VA" paperless processing; enhanced veteran self-service and access to benefit application, status, and delivery; data integration across business lines; use of the corporate database; in-

formation exchange; quality assurance programs and controls; and employee skills certification and training.

The IBVSOs believe these initiatives should receive priority funding in FY 2010:

- Complete the replacement of the antiquated and inadequate Benefits Delivery Network (BDN) with the Veterans Service Network (VETSNET) for the Compensation and Pension Service. VETSNET is a suite of applications, which include Share/Search and Participant Profile, Modern Award Processing-Development, and Rating Board Automation, that integrates several subsystems into one nationwide information system for claims development, adjudication, and payment administration;
- Enhance the Education Expert System (TEES) for the Education Service (this program will be crucial to support the new GI Bill recently enacted by Congress in Public Law 110-181). TEES provides for electronic transmission of applications and enrollment documentation along with automated expert processing; and
- Update the corporate WINRS (CWINRS) to support programs of the Vocational Rehabilitation and Employment (VR&E) Service. CWINRS is a case management and information system allowing for more efficient award processing and sharing of information nationwide.

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

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

Upgrade and Enhance Training Systems

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

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

Accelerate Implementation of Virtual Information Centers

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

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

Congress has taken notice of the chronic disconnect between VBA IT and lagging improvements in claims processing. Section 227 of Public Law 110-389 places new requirements on VA to closely examine all uses of current IT and comparable outside IT systems with respect to VBA claims processing for both compensation and pension. Following that examination, VA is required to develop a new plan to use these and other relevant technologies to reduce subjectivity, avoid remands, and reduce variances in VA regional office ratings for similar specific disabilities in veteran claimants. The act requires the VA Secretary to report the results of that examination to Congress in great detail and includes a requirement that the Secretary ensure that the plan will result, within three years of implementation, in reduc-

tion in processing time for compensation and pension claims processed by the VBA. The requirements of this section will cause heavy scrutiny on IT systems that VBA has been attempting to implement, improve, and expand for years. We believe the examination will reveal that progress has been significantly stymied as a result of a lack of directed funding to underwrite IT development and completion and lack of accountability to ensure these programs work as intended.

Recommendations:

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

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

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

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

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

SUFFICIENT STAFFING LEVELS

Recent staffing increases in the Veterans Benefits Administration (VBA) may now be sufficient to reduce the backlog of pending claims once new hires complete training. However, any move by Congress to reduce VBA staffing in the foreseeable future will guarantee a return to unacceptably high backlogs.

The Department of Veterans Affairs began making some progress in reducing pending rating claims in FY 2008. While pending rating claims remain at an unacceptably high level, with more than 386,000 pending at the end of the fiscal year, that number represents a nearly 4 percent reduction from FY 2007. Total compensation and pension (C&P) issues, both rating and nonrating, also decreased during this period by 3.2 percent. While both reductions are encouraging, an increase of 18,282 appeals (11.3 percent) to a record high of nearly 180,000 for this same period clearly indicates that VA has merely shifted resources from processing appeals to processing ratings.[16]

During FY 2008, VA hired nearly 2,000 staff authorized by Congress. This is in addition to those hired in the previous year. In the near term, this increase in claims processors is a net drain on VBA resources as experienced personnel are taken out of production to conduct extensive training and mentoring of the new hires. Historically, it takes at least two years for new nonrating claims processors to acquire sufficient knowledge and experience to be able to work independently with both speed and quality. Those selected to make rating decisions require a separate period of at least two years of training before they have the skills to accurately complete most rating claims.

The VBA has modified its training regimen in recent years in an attempt to obtain increased production from new personnel at an earlier stage in their training. While it is impossible to isolate the underlying reasons for the modest reductions in pending rating and total C&P claims, it is reasonable to assume that a part of the decrease in the backlog is due to this VBA strategy. *The Independent Budget* veterans service organizations (IBVSOs) believe that rushing trainees into production encourages managers to skimp on training and ensures

that completed work is of lower quality than it would be if it were done by fully trained personnel.

In recent years, Congress has come to recognize that staffing reductions in the VBA in the previous decades laid the foundation for the backlogs of the present. Congress' actions to dramatically increase staffing has provided VBA a major tool in stopping chronic increases in the pending claims and begin the process of regaining control of the backlog. It is vital, however, that Congress recognize that the backlog will not go away overnight: it developed through years of increasing complexity of the claims development process with an overlay of judicial review. Neither of these causes is inherently bad; in fact, both development safeguards and judicial oversight were deemed necessary to help ensure that veterans and other claimants receive every benefit to which they are entitled under the law. However, the impact of these factors was, in the view of the IBVSOs, never fully appreciated—that is, until now. Congress should recognize that it will be several years before the full impact of recent hiring initiatives is felt.

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

Recommendations:

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

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

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

[16]Monday Morning Workload Report, October 6, 2008, showing October 4, 2008, data (www.vba.va.gov/REPORTS/mmwr/index.asp).

Vocational Rehabilitation and Employment

ADEQUATE STAFFING LEVELS:

To meet its ongoing workload demands and to implement new initiatives recommended by the Secretary's Vocational Rehabilitation and Employment (VR&E) Task Force, VR&E needs to increase its staffing.

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

severely disable veterans participating in this program. VR&E needs approximately 200 additional full-time employees (FTEs) to offer these services nationally.

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

In FY 2009, VR&E was authorized 1,073 FTEs. *The Independent Budget* veterans service organizations have been informed that this number has been "frozen" due to the unknown impact the implementation of chapter 33 benefits will have on the VR&E program. Last year, we recommended that total staffing be increased to manage the current and anticipated workload as stated in the Secretary's VR&E Task Force. This recommendation is still valid and VR&E staffing should be increased by 302 FTEs to total 1,375 FTEs.

Recommendation:

Congress should authorize 1,375 total full-time employees for the Vocational Rehabilitation and Employment Service for FY 2010.

VOCATIONAL REHABILITATION AND EMPLOYMENT AND CHAPTER 33 OFFSETS:

Disabled veterans who are eligible or become eligible for Vocational Rehabilitation and Employment (VR&E) and who are already entitled to chapter 33 benefits should receive the same financial assistance provided under chapter 33 in lieu of the VR&E subsistence allowance.

With the passage of the Post 9/11 Veterans Education Assistance Act of 2008 (chapter 33), veterans eligible for VR&E who are also eligible for chapter 33 face a financial disincentive to participate in VR&E because the VR&E subsistence allowance is significantly lower than the monthly housing allowances provided under chapter 33. Consequently, disabled veterans who choose to receive the higher amount under chapter 33 will be deprived of the other significant advantages provided by VR&E, including counseling, employment services, independent living services, etc.

The Independent Budget veterans service organizations do not believe that Congress intended chapter 33 benefits to replace those of VR&E. It is imperative that veterans with employment handicaps or serious employment handicaps have access to the wide array of services provided through VR&E. In fact, that is the very purpose of its existence.

Given the unique services required to enable disabled veterans to return to the workforce, we believe that veterans eligible for both programs should receive the full benefit of VR&E with the same level of housing allowance as the chapter 33 housing allowance.

Recommendation:

Congress should amend title 38, United States Code, section 3108 (f)(1)(A) to include recipients of chapter 33 benefits.

Education Service

ADEQUATE STAFFING LEVELS:

To meet its increasing workload demands, the Education Service must increase direct program full-time employees.

As it has with its other benefit programs, the Department of Veterans Affairs has been striving to provide more timely and efficient service to its claimants for education benefits. Given the fact that Congress has authorized the Post 9/11 Veterans Education Assistance Act (chapter 33) with benefits beginning in August of 2009, *The Independent Budget* veterans service organizations are concerned that VA's Education Service will find itself severely understaffed. Chapter 33 benefits are extremely complex to administer, and VA has reported that it is unlikely that the software technology will be developed by the August 2009 deadline, so processing will have to be done manually. While we do not know at this time what this will mean in terms of the manpower necessary to manage this workload, we believe that it is obvious that VA will need a significant increase in resources to begin benefit processing in a timely manner and at a productivity level sufficient to prevent an instant backlog of claims.

Recommendation:

Congress should support VA requests for additional full-time employees at a level sufficient to minimize current claims backlogs and to fully manage the new workload they will incur with the addition of chapter 33 claims.

Judicial Review

In 1988, Congress recognized the need to change the situation that existed throughout the modern history of veterans' programs, in which claims decisions of the Department of Veterans Affairs were immune to judicial review. Congress enacted legislation to authorize judicial review and created what is now the United States Court of Appeals for Veterans Claims (CAVC) to hear appeals from VA's Board of Veterans' Appeals (BVA). Until Congress acted, the BVA enjoyed, and took advantage of, its decision making—what the Supreme Court once referred to as "splendid isolation" from the law.

Now the VA's administrative decisions on claims are subject to judicial review in much the same way as a trial court's decisions are subject to review on appeal. This provides a course for an individual to seek a remedy for an erroneous decision and a means by which to settle questions of law for application in other similar cases. When Congress established the CAVC, it added another beneficial element to appellate review: It created oversight of VA decision making by an independent, impartial tribunal from a different branch of government. Veterans are no longer without a remedy for erroneous BVA decisions.

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

THE COURT OF APPEALS FOR VETERANS CLAIMS

Scope of Review: Enforce Fairness in the Appeals Process

ENFORCE THE BENEFIT-OF-THE-DOUBT RULE:

To achieve the law's intent that the Court of Appeals for Veterans Claims (CAVC/Court) enforce the benefit-of-the-doubt rule on appellate review, Congress must enact more precise and effective amendments to the statute setting forth the Court's scope of review.

The conclusion regarding this recommendation is explained by the story of James Halvatgis. Mr. Halvatgis served approximately 25 years of honorable service. He was diagnosed with a right lumbar strain following a lifting injury during service in February 1963. Mr. Halvatgis also hurt his back when he fell approximately 20 feet while rappelling and then again in a jeep accident when he was thrown from the vehicle while swerving to avoid a landmine in Vietnam. He reported low back pain during service in July 1966, December 1968, September through November 1973, September through October 1974, and again in 1976. Many of these symptoms spanned months at a time and were accompanied by neurological symptoms indicating nerve involvement. X-rays of the veteran's low back taken *prior* to military discharge clearly revealed early signs of spinal deterioration.

Numerous private treatment records following discharge continued to document a definite back disability. A board-certified orthopedic surgeon, who was also an associate professor of orthopedic surgery, diagnosed degenerative joint disease of the lumbar spine with spinal stenosis. VA subsequently received a medical opinion from this same orthopedic surgeon wherein he stated that he felt that the veteran had had symptoms since the 1960s with respect to his low back and opined that in all likelihood, the Vietnam War injuries contributed to his early onset of arthritis and spinal stenosis.

Mr. Halvatgis filed a claim of service connection for his low back condition in January 2002. Further, he submitted a statement to VA that all doctors who provided statements regarding his claims were afforded one complete copy of his service medical records. In April 2002, VA received another opinion from a second board-certified orthopedic surgeon, who, again, was an associate professor of orthopedic surgery. This was the veteran's treating physician, who stated that he had reviewed the veteran's service medical records and then opined that the veteran's "condition is a continuation of the difficulties he developed in the service."

The veteran submitted a second medical opinion (totaling three) from one of the surgeons that stated the low back pain complained of while in the military "gradually progressed to the point where he now has post-traumatic arthritis of the lumbar spine." A second opinion from the other surgeon (totaling four) was submitted that stated, "[h]e had problems dating back to 1974 when...he was noted to have collapse, narrowing, and degeneration at the L5-S1 level. I have reviewed his medical service record which indicates this difficulty to that point in time."

In developing the claim, VA examined Mr. Halvatgis and asked for another medical opinion. The opinion was rendered by a noncertified physician assistant. Without referring to all of the treatment records in service, and without acknowledging the evidence that included four opinions presented by the two orthopedic surgeons, the physician assistant opined that Mr. Halvatgis's condition was congenital *and* otherwise age related, and therefore not related to his service. Based on the physician assistant's opinion, VA denied the claim.

Mr. Halvatgis appealed to the Board of Veterans' Appeals (BVA/Board). The Board found that there was "no competent evidence linking the veteran's low back disorder with his service...." The Board arbitrarily provided that the physician assistant's opinion was of more probative value despite that fact that all opinions were based on the same information.

Mr. Halvatgis appealed to the Court. *See Halvatgis v. Mansfield*, No. 06-0149, 2007 WL 4981384 (U.S. Vet.App., November 02, 2007). Because of the Board's nearly unreviewable authority to assign probative value (a factual finding) as arbitrarily as it sees fit, regardless of how abusive, and because of the Court's refusal to

reverse such ludicrous decisions if they contain the slightest scintilla of plausibility, the Court denied Mr. Halvatgis's claim.

Unfortunately, because the Board has such authority, cases such as this are not at all uncommon. The Board is fully aware that its power to assign such value to evidence is practically untouchable; therefore, rather than using that power to ensure fairness and objectivity when reviewing evidence, it consistently yields it as a proverbial double-edged sword to marginalize and minimize evidence to fit its own subjective view. A combination of reasons explains the inherent unfairness displayed in Mr. Halvatgis's case. Part of the problem is that a claimant's statutory right to the benefit of the doubt in cases like this has been interpreted as a "finding of fact" and subsequently converted by the Court's jurisprudence to nothing more than meaningless window dressing.

The CAVC upholds VA findings of "material fact" unless they are clearly erroneous and has repeatedly held that when there is a "plausible basis" for the Board's factual finding, it is not clearly erroneous.

Title 38, United States Code, section 5107(b) grants VA claimants a statutory right to the benefit of the doubt with respect to any benefit under laws administered by the Secretary of Veterans Affairs when there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter. Yet, the CAVC has been affirming many BVA findings of fact when the record contains only minimal evidence necessary to show a "plausible basis" for such finding. This renders a claimant's statutory right to the benefit of the doubt meaningless because claims can be denied and the denial upheld when supported by far less than a preponderance of evidence. These actions render Congressional intent under section 5107(b) meaningless.

To correct this situation, Congress amended the law with the enactment of the Veterans Benefits Improvement Act of 2002[17] to expressly require the CAVC to consider whether a finding of fact is consistent with the benefit-of-the doubt rule. The intended effect of section 401[18] of the Veterans Benefits Act of 2002 has not been upheld by the court.

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

As a result of Veterans Benefits Act section 401 amendments to section 7261(a)(4), the CAVC is now directed to "hold unlawful and set aside or reverse" any "finding of material fact adverse to the claimant...if the finding is clearly erroneous."[19] Furthermore, Congress added entirely new language to section 7261(b)(1) that mandates the CAVC to review the record of proceedings before the Secretary and the BVA pursuant to section 7252(b) of title 38 and "take due account of the Secretary's application of section 5107(b) of this title...."[20]

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

> (b) BENEFIT OF THE DOUBT - The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.[21]

Prior to enactment of Veterans Benefits Act section 401, the CAVC characterized the benefit-of-the-doubt rule as mandating that "when...the evidence is in relative equipoise, the law dictates that [the] veteran prevails" and that, conversely, a VA claimant loses only when "a fair preponderance of the evidence is against the claim."[22] Nonetheless, such characterizations have historically proven to be nothing more than lip service.

Reading amended sections 7261(a)(4) and 7261(b)(1) together, which must be done in order to determine the effect of the Veterans Benefits Act section 401 amendments, reveals that the CAVC is now directed, as part of its scope-of-review responsibility under section 7261(a)(4), to undertake three actions in deciding whether BVA fact-finding that is adverse to a claimant is clearly erroneous and, if so, what the court should hold as to that fact-finding.

Specifically, the three actions to be taken as noted in the plain meaning of the amended subsections (a)(4) and (b)(1) require the Court: (1) to review all evidence

before the Secretary and the BVA; (2) to consider the Secretary's application of the benefit-of-the-doubt rule in view of that evidence; and (3) if the Court, after carrying out actions (1) and (2), concludes that an adverse BVA finding of fact is clearly erroneous and therefore unlawful, the Court must set it aside or reverse it.

Therefore, as the foregoing discussion illustrates, Congress intended the Veterans Benefits Act section 401 amendments to section 7261(a)(4) and (b) to fundamentally alter the Court's review of BVA fact-finding. This is evident by both the plain meaning of the amended language of these subsections as well as the unequivocal legislative history of the amendments.

Further, the legislative history bolsters the plain meaning of the statute by making clear that Congress intended for the Court to take a more proactive and less deferential role in its BVA fact-finding review. For example, amendments to section 7261, dealing with the same elements as did Veterans Benefits Act section 401, were included in S. 2079, introduced by Senator Rockefeller on April 9, 2002.[23] Senator Rockefeller stated in full regarding section 401:

> Section 401 of the Compromise Agreement would maintain the current "clearly erroneous" standard of review, but modify the requirements of the review the court must perform when making determinations under section 7261(a) of title 38. CAVC would be specifically required to examine the record of proceedings—that is, the record on appeal-before the Secretary and BVA. Section 401 would also provide special emphasis during the judicial process to the "benefit of the doubt" provisions of section 5107(b) as CAVC makes findings of fact in reviewing BVA decisions. The combination of these changes is intended to provide for more searching appellate review of BVA decisions, and thus give full force to the "benefit of doubt" provision. The addition of the words "or reverse" after "and set aside" in section 7261(a)(4) is intended to emphasize that CAVC should reverse clearly erroneous findings when appropriate, rather than remand the case. This new language in section 7261 would overrule the U.S. Court of Appeals for the Federal Circuit decision of *Hensley v. West,* 212 F.3d 1255 (Fed. Cir. 2000), which emphasized that CAVC should perform only limited, deferential review of BVA decisions, and stated that BVA fact-finding "is entitled on review to substantial deference." However, nothing in this new language is inconsistent with the existing section 7261(c), which precludes the court from conducting trial de novo when reviewing BVA decisions, that is, receiving evidence that is not part of the record before BVA.[24]

Perhaps the most dramatic of the three CAVC actions directed by section 401 was the mandate that the court "take due account of the Secretary's application of section 5107(b)," the "benefit-of-the-doubt rule." It is against this more relaxed standard of review that, through Veterans Benefits Act section 401, Congress has now required the Court to review the entire record on appeal and to examine the Secretary's determination as to whether the evidence presented was in equipoise on a particular material fact. The foregoing notwithstanding, the Court's equipoise review is no better after Veterans Benefits Act section 401 than it was before section 401. Congress's intent has been ignored.

In light of this background, the post–Veterans Benefits Act section 401 mandate supercedes the previous CAVC practice of upholding a BVA finding of fact unless the only permissible view of the evidence of record is contrary to that found by the Board and that a Board finding of fact must be affirmed where there is a plausible basis in the record for the determination. Yet the nearly impenetrable "plausible basis" standard continues to prevail as if Congress never amended section 7261.

The legislative history supports the plain meaning of these provisions discussed herein by strongly evidencing the intent of Congress to bring about decisive change in the scope of the Court's review of Board fact-finding. The House and Senate Committees on Veterans' Affairs described the new provisions enacted by section 401 as follows in an explanatory statement they prepared regarding their compromise agreement: [25]

Senate bill
Section 501 of S. 2237 would amend section 7261(a)(4)...to change the [Court's] standard of review as it applies to BVA findings of fact from "clearly erroneous" to "unsupported by substantial evidence." Section 502 would also cross-reference section 5107(b) in order to emphasize that the Secretary's application of the "benefit of the doubt" to an appellant's claim would be considered by CAVC on appeal.

House bill
The House bill contains no comparable provision.

Compromise agreement
Section 401 of the Compromise Agreement followed the Senate language with the following amendments:

> The Compromise Agreement would modify the standard of review in the Senate bill in subsection (a) by deleting the change to a "substantial evidence" standard. It would modify the requirements of the review the Court must perform when it is making determinations under section 7261(a) ...since the Secretary is precluded from seeking judicial review of decisions of the Board, the addition of the words "adverse to the claimant" in subsection (a) is intended to clarify that findings of fact favorable to the claimant may not be reviewed by the Court. Further, the addition of the words "or reverse" after "and set aside" is intended to emphasize that the Committees expect the Court to reverse clearly erroneous findings when appropriate, rather than remand the case. [The Committees' expectations are being ignored by the Court.] The new subsection (b) [of section 7261] would maintain language from the Senate bill that would require the Court to examine the record of proceedings before the Secretary and BVA and the special emphasis during the judicial process on the benefit-of-doubt provisions of section 5107(b) as it makes findings of fact in reviewing BVA decisions. This would not alter the formula of the standard of review on the Court, with the uncertainty of interpretation of its application that would accompany such a change. The combination of these changes is intended to provide for more searching appellate review of BVA decisions, and thus give full force to the "benefit-of-doubt" provision.[26]

At the time of the Senate's final action on S. 2237, VBA section 401 was quite extensively explained by Senator Rockefeller, who was the chairman of the Senate Committee, the floor manager of the bill in the Senate, and the principal author of VBA section 401. In explaining section 401, he emphasized, as did the two committees in their explanatory statement,[27] that the combination of the new requirements that the CAVC "examine the...record on appeal," consider the benefit-of-the doubt rule, and "make...findings of fact in reviewing BVA decisions" is "intended to provide for more searching appellate review of BVA decisions and thus give full force to the 'benefit of the doubt' provision."[28] Chairman Rockefeller concluded that the court should "reverse clearly erroneous findings when appropriate, rather than remand the case."[29] His statement is particularly significant (1) because only the Senate had passed provisions to amend the Court's section 7261 scope-of-review provisions (in S. 2237), and the Committees on Veterans' Affairs explained that section 401 generally "follows the Senate language," and (2) because there is no legislative history that is inconsistent with his statement.[30] Representative Evans, the ranking minority member of the House Committee, spoke in strong support of S. 2237 and explained that "the bill...clarifies the authority of the Court of Appeals for Veterans Claims to reverse decisions of the [BVA] in appropriate cases and requires the decisions be based upon the record as a whole, taking into account the pro-veteran rule known as the 'benefit of the doubt.' "[31]

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

The CAVC has essentially construed these amendments—intended to require a more searching appellate review of BVA fact-finding and to enforce the benefit of-the-doubt rule—as making no substantive change. The Court's precedent decisions now make it clear that it will continue to defer to and uphold BVA fact-finding without regard to whether it is consistent with the statutory benefit-of-the-doubt rule. Congress should not allow any federal court to scoff at its legislative power, particularly one charged with the protection of rights afforded to our nation's disabled veterans and their families.

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

The Department of Veterans Affairs is a unique, non-adversarial forum for the adjudication of veterans' benefits claims. Proper and consistent application of the

benefit-of-the-doubt rule is critical to maintaining the unique characteristics of the Department. The above discussion proves that such application is absent more often than not; in fact, Court decisions are usually void of any meaningful discussion of the benefit-of-the-doubt rule. Whereas, when applying the companion to subsection 7261(b)(1), which is 38 U.S.C. section 7261(b)(2), requiring the Court to take due account of the rule of prejudicial error, the Court expressly states its determinations of such rule. Therefore, Congress should require the Court to consider and expressly state its determinations with respect to the application of the benefit-of-the-doubt doctrine under 38 U.S.C. section 7261(b)(1), when applicable.

Recommendations:

Congress should enact a joint resolution concerning changes made to title 38, United States Code, section 7261, by the Veterans Benefits Act of 2002, indicating that it was and still is the intent of Congress that the Court of Appeals for Veterans Claims provide a more searching review of the Board of Veterans' Appeals findings of fact, and that in doing so, ensure that it enforce a VA claimant's statutory right to the benefit of the doubt.

Congress should amend 38 U.S.C. section 7261(a) by adding a new section, (a)(5), that states: "(5) In conducting review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision."

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

[17]P.L. 107-330, § 401, 116 stat. 2820, 2832.
[18]Section 401 of the *Veterans Benefits Act*, effective December 6, 2002; 38 U.S.C. §§ 7261(a)(4) and (b)(1).
[19]38 U.S.C. § 7261(a)(4). See also 38 U.S.C. § 7261(b)(1).
[20]38 U.S.C. § 7261(b)(1).
[21]38 U.S.C. § 5107(b).
[22]*Gilbert v. Derwinski* 1 Vet. App. 49, 54–55 (1990).
[23]See S. 2079, 107th Cong., 2d sess. § 2.
[24]148 *Congressional Record* S11334 (remarks of Sen. Rockefeller).
[25]148 *Congressional Record* S11337, H9007.
[26]148 *Congressional Record* S11337, H9003 (daily ed. November 18, 2002) (emphasis added). (Explanatory statement printed in *Congressional Record* as part of debate in each body immediately prior to final passage of compromise agreement.)
[27]148 *Congressional Record* S11337, H9007.
[28]148 *Congressional Record* S11334.
[29]Ibid.
[30]147 *Congressional Record* S11337, H9003.
[31]148 *Congressional Record* H9003.

THE COURT'S BACKLOG:

Congress should require the Court to amend its Rules of Practice and Procedure so as to preserve its limited resources.

Congress is aware that the number of cases appealed to the U.S. Court of Appeals for Veterans Claims (CAVC/Court) has increased significantly over the past several years. Nearly half of those cases are consistently remanded back to the Board of Veterans' Appeals (BVA/Board).

The Court has attempted to increase its efficiency and preserve judicial resources through a mediation process, under Rule 33 of the Court's Rules of Practice and Procedure, to encourage parties to resolve issues before briefing is required. Despite this change to the Court's rules, VA general counsel routinely fails to admit error or agree to remand at this early stage, yet later seeks a remand, thus utilizing more of the Court's resources and defeating the purpose of the program.

In this practice, the Department of Veterans Affairs usually commits to defend the Board's decision at the early stage in the process. Subsequently, when VA general counsel reviews the appellant's brief, VA then changes its position, admits to error, and agrees to or requests a remand. Likewise, VA agrees to settle many cases in which the Court requests oral argument, suggesting acknowledgment of an indefensible VA error through the Court proceedings. VA's failure to admit error, to agree to remand, or to settle cases at an earlier stage of the Court's proceedings do not assist the Court or the vet-

eran; it merely adds to the Court's backlog. Therefore, Congress should enact a Judicial Resources Preservation Act. Such an act could be codified in a note to section 7264. For example, the new section could state:

(1) Under 38 U.S.C. section 7264(a), the Court shall prescribe amendments to Rule 33 of the Court's Rules of Practice and Procedure. These amendments shall require the following:

(a) If no agreement to remand has been reached before or during the Rule 33 conference, the Department, within seven days after the Rule 33 conference, shall file a pleading with the Court and the appellant describing the bases upon which the Department remains opposed to remand opposed.

(b) If the Department of Veterans Affairs later determines a remand is necessary, it may only seek remand by joint agreement with the appellant.
(c) No time shall be counted against the appellant where stays or extensions are necessary when the Department seeks a remand after the end of seven days after the Rule 33 conference.

(d) Where the Department seeks a remand after the end of seven days after the Rule 33 conference, the Department waives any objection to and may not oppose any subsequent filing by appellant for Equal Access to Justice Act fees and costs under 28 U.S.C. section 2412.

(2) The Court may impose appropriate sanctions, including monetary sanctions, against the Department for failure to comply with these rules.

Recommendation:

Congress should enact a Judicial Resources Preservation Act as described herein to preserve the Court's limited resources and reduce the Court's backlog.

APPOINTMENT OF JUDGES

Congress should ensure that any new judges appointed to the Court of Appeals for Veterans Claims are themselves a veteran's advocate and skilled in the practice of veterans law.

The United States Court of Appeals for Veterans Claims received well over 4,000 cases during FY 2008. According to the Court's annual report, the average number of days it took to dispose of cases was nearly 450. This period has steadily increased each year over the past four years, despite the Court having recalled retired judges numerous times over the past two years specifically because of the backlog.

Veterans law is an extremely specialized area of the law that currently has fewer than 500 attorneys nationwide whose practices are primarily in veterans law. Significant knowledge and experience in this practice area would reduce the amount of time necessary to acclimate a new judge to the Court's practice, procedures, and body of law. A reduction in the time to acclimate would allow a new judge to begin a full caseload in a shorter period, thereby benefiting the veteran population. Congress should therefore consider appointing new judges to the Court from the selection pool of current veterans law practitioners.

Recommendation:

Congress should enact a joint resolution indicating that it is the sense of Congress that any new judges appointed to the Court of Appeals for Veterans Claims be selected from the knowledgeable pool of current veterans law practitioners.

Court Facilities

COURTHOUSE AND ADJUNCT OFFICES:

The Court of Appeals for Veterans Claims (CAVC) should be housed in its own dedicated building, designed and constructed to its specific needs and befitting its authority, status, and function as an appellate court of the United States.

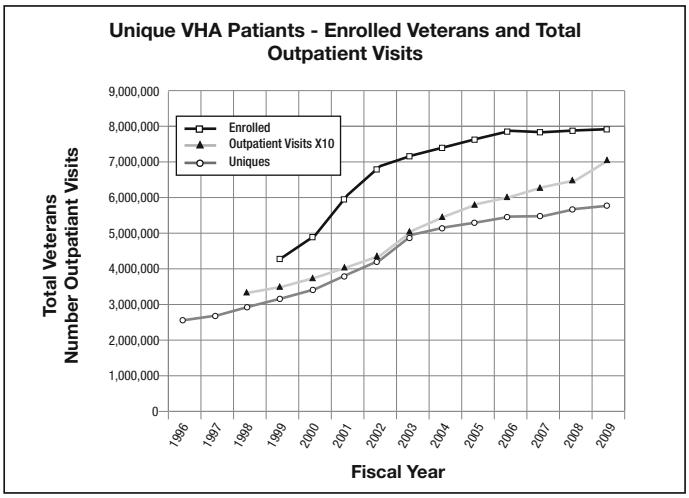
During the nearly 16 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse. The "Veterans Court" should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Rather than being a tenant in a commercial office building, the court should have its own dedicated building that meets its specific functional and security needs, projects the proper image, and concurrently allows the consolidation of VA general counsel staff, court practicing attorneys, and veterans service organization representatives to the court in one place. The CAVC should have its own home, located in a dignified setting with distinctive architecture that communicates its judicial authority and stature as a judicial institution of the United States. Construction of a courthouse and justice center requires an appropriate site, authorizing legislation, and funding.

Recommendation:

Congress should enact legislation and provide the funding necessary to construct a courthouse and justice center for the Court of Appeals for Veterans Claims.

Medical Care

The Veterans Health Administration (VHA) is the largest direct provider of health-care services in the nation. The VHA provides the most extensive training environment for health professionals and is the nation's most clinically focused setting for medical and prosthetics research. Additionally, the VHA is the nation's primary backup to the Department of Defense (DOD) in time of war or domestic emergency. Of the nearly 8 million veterans that the Department of Veterans Affairs anticipates enrolling in the health-care system in fiscal year 2010, the VHA will provide health care to nearly 75 percent of them—approximately 6 million unique patients. It is a well-established fact that the quality of VHA care is at least equivalent to, and in most cases better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any other system in the United States or worldwide. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors.



Unique VHA Patients and Enrolled Veterans—This chart shows the trend toward the increasing number of patients treated in VHA facilities and the increase of veterans enrolled for care.

Although the VHA makes no profit, buys no advertising, pays no insurance premiums, and compensates its physicians and clinical staff significantly less than private-sector health-care systems, it is the most efficient and cost-effective health-care system in the nation. The VHA sets the standards for quality and efficiency, and it does so at or below Medicare rates, while serving a population of veterans that is older, sicker, and has a higher prevalence of mental and related health problems.

Whereas, historically, VA has faced inadequate appropriations, Congress and the Administration have shown some desire to correct this trend in the past couple of years. But more work remains to be done. More often than not, appropriations are delayed beyond the start of the fiscal year on October 1, placing the VHA at a competitive disadvantage for health-care professionals. In fact, in 19 of the past 21 years VA did not receive its appropriations prior to the start of the new fiscal year. This creates a domino effect wherein the VA is unable to hire enough quality professionals, which leads to longer waits for health-care appointments. It also creates significant access problems for veterans. As a result of these occurrences, *The Independent Budget* continues to advocate for a method to ensure that VA receives adequate funding in a timely manner in order to continue providing timely, quality health care to all veterans.

With this in mind, the coauthors of *The Independent Budget,* in conjunction with the Partnership for Veterans' Health Care Budget Reform, will advocate for Congress to reform VA's medical care appropriation to give it an advance appropriation status, to provide funding for veterans' health care one year or more in advance of the operating year. This would ensure funding becomes timely and predictable, without converting it to mandatory status or requiring it to meet Congressional PAYGO (pay-as-you-go) rules for mandatory accounts. Moreover, we believe Congress should require VA's internal budget model to be shared publicly to provide accurate estimates for VA health-care funding, with the information audited by the Government Accountability Office.

We also recognize that VA must continue to meet the demands of the newest generation of veterans as they turn to VHA for their care. The difficulties in this crossover between VA and the DOD have elevated seamless transition to the top of concerns for both departments. As such, it is critically important for VA and DOD to implement the systems needed to make this transition, particularly from one health-care system to the other, as smooth as possible.

Ultimately, the policy proposals we present and the funding recommendations we make serve to enhance and strengthen the VA health-care system. It is our responsibility, along with Congress and the Administration, to vigorously defend a system that has set itself above all other major health-care systems in this country. For all of the criticism that the VA health-care system receives, it continues to outperform, both in quality of care and patient satisfaction, every other health-care system in America.

FINANCE ISSUES

SUFFICIENT, TIMELY, AND PREDICTABLE FUNDING FOR VA HEALTH CARE:

The Department of Veterans Affairs must receive sufficient funding for veterans' health care and Congress must reform the funding process to ensure sufficient, predictable, and timely funding.

As in years past, the FY 2008 appropriations process was neither seamless nor efficient. *The Independent Budget* veterans service organizations (IBVSOs) were very disappointed when, for the 13th time in the past 15 years, VA did not receive its appropriation at the start of the new fiscal year, October 1. Although the appropriations bill was eventually enacted, it included budgetary gimmicks the IBVSOs have long opposed. The maximum appropriation available to VA matched or exceeded the *IB's* recommendations; however, the vast majority of this increase was contingent upon the Administration making an emergency funding request for the additional money Congress approved. Fortunately, the Administration recognized the importance of this critical funding and triggered its release to VA. This emergency request provided VA with $3.7 billion more than the Administration had sought for VA in FY 2008.

The process leading up to FY 2009 was equally challenging. For the second year in a row, VA received historic funding levels that matched, and in some cases exceeded, the recommendations of the *IB*. Moreover, for only the third time in the past 20 years, VA received its budget prior to the start of the new fiscal year. However, this funding was provided through a combination continuing resolution/omnibus appropriations act. The underlying Military Construction and Veterans Affairs appropriations bill for FY 2009 was not actually completed by Congress in the regular order. While the House passed the bill in the summer, the Senate never brought its bill up for a floor vote. This fact serves as a continuing reminder that, despite excellent funding levels provided over the past two years, the larger appropriations process is completely broken.

Although significant strides have been made to increase the level of VA health-care funding during the past several years, the inability of Congress and the Administration to agree upon and enact veterans' health-care appropriations legislation on time continues to hamper and threaten VA health care. When VA does not receive its funding in a timely manner, it is forced to ration health care. Much-needed medical staff cannot be hired, medical equipment cannot be procured, waiting times for veterans increase, and the quality of care suffers.

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

On February 4, 2008, the President's budget submission for the Department of Veterans Affairs for FY 2009 was released, which included a total funding request of $41.2 billion for VA medical care, an increase of $2.1 billion over the FY 2008 funding level. This request included $38.7 billion in discretionary funding and $2.5 billion in medical care collections. *The Independent Budget for Fiscal Year 2009* recommended approximately $42.8 billion in total funding for medical care—an increase of $3.7 billion over the FY 2008 approved funding level and approximately $1.6 billion over the Administration's request. In the end, Congress provided approximately $43 billion for total medical spending in VA. This included $40.5 billion in discretionary budget authority and an additional $2.5 billion in medical care collections.

Although the IBVSOs have long opposed the use of collections in establishing the VA operating budget, we recognize that a significant amount of funding is available to the Department each year from these collections. However, we urge Congress to review the actual collection rates VA achieves each year if it continues to use collections to increase its operating budget. Our own analysis suggests that VA has only collected about 79 percent of its estimated collection rates dating back to FY 2004. This would suggest that VA will likely only collect approximately $2 billion for FY 2009, even though the Office of Management and Budget and the appropriators will credit VA's estimate of $2.5 billion to offset budgetary needs.

For FY 2010, *The Independent Budget* recommends approximately $46.6 billion for total medical care, an in-

crease of $3.6 billion over the FY 2009 operating budget level established by P. L. 110-329, the "Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009." Our recommendation reinforces the long-held policy that medical care collections should be a supplement to, not a substitute for, operating funds. Therefore, until Congress and the Administration fairly address the inaccurate estimates for medical care collections, the VA operating budget should not include inflated estimates as a component.

The Medical Care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2010, *The Independent Budget* recommends approximately $36.6 billion for Medical Services, as outlined in the table below.

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

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

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

For Medical Support and Compliance, the *IB* recommends approximately $4.6 billion. This new account was established by the FY 2009 appropriations bill, replacing the Medical Administration account. Finally, for Medical Facilities, the *IB* recommends approximately $5.4 billion. This amount includes an additional $150 million for nonrecurring maintenance for VA to begin addressing its massive backlog of infrastructure needs.

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

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

For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations, has advocated reform in the VA health-care budget process. The Partnership

has worked with both House and Senate veterans' leaders to craft legislation that would change VA's health-care funding process from a discretionary to a mandatory system. If enacted, such a change would be intended to guarantee that VA health-care funding would be sufficient, timely, and predictable. This technique would guarantee funding is made available on time every year, with automatic adjustments to account for medical inflation and enrollment changes. However, despite the fact that legislation has been introduced in recent years to shift VA health-care funding to mandatory status, to date, Congress has not shown interest in moving this legislation forward. As a result, the Partnership worked with Committees on Veterans' Affairs to develop an alternative proposal (S. 3527/H. R. 6939) that would change VA's medical care appropriation to an "advance appropriation," guaranteeing funding for the health-care system up to one year in advance of the operating year. This alternative proposal would ensure that the VA received its funding in a timely and predictable manner. Furthermore, it would provide an option the IBVSOs believe to be politically more viable than mandatory funding and unquestionably better than the current process. Moreover, to ensure sufficiency, our advance appropriations proposal would require that VA's internal budget actuarial model be shared publicly with Congress to reflect the accuracy of its estimates for VA health-care funding, as determined by a Government Accountability Office audit, before political considerations take over the process. This feature would add transparency and integrity to the VA health-care budget process.

Recommendations:

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

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

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

Advance Appropriations for VA Health Care:

Congress should enact and implement legislation reforming the VA budget and appropriations process to fund veterans' medical care through a one-year advance appropriation, and require the Government Accountability Office (GAO) to audit and publicly report on VA's budget methodology and estimates.

On September 30, 2008, legislation providing appropriations for the Department of Veterans Affairs was enacted into law one day before the start of the new fiscal year, the first time the VA budget had been approved on time in more than a decade, and just the third time in the 22-year history of *The Independent Budget*. Despite the commitment of the current Congress to provide sufficient and timely funding for veterans' health care, there is a consistent record of late and insufficient funding for veterans' health care over the past two decades, which has occurred under the Congressional and Presidential leadership of both political parties. Even with the large increases of the past few years, veterans continue to wait to receive medical services and VA is still unable to enroll all veterans seeking care, including more than 600,000 priority group 8 veterans who have been turned away by VA over the past five years.

VA is the largest integrated health-care system in the United States, employing more than 200,000 personnel who provide medical care to more than 5.5 million veterans at more than 1,400 access points across the country. As a direct provider of services, VA is especially vulnerable to the inherently unpredictable nature of the annual discretionary appropriations process. Effectively managing such a large enterprise requires sufficient, timely, and predictable funding. Without reform of the budget process, the veterans' health-care system will face greater challenges and pressures that could threaten the long-term quality of care provided to veterans.

To ensure the long- term viability and quality of the VA health-care system, Congress should approve legislation enabling one-year advance appropriations for veterans' medical care programs and subsequently approve both the regular FY 2010 VA appropriations bill and an advance appropriations bill for FY 2011 veterans' medical care accounts during the FY 2010 budget cycle. To enhance Congress's ability to provide accurate and sufficient appropriations levels for VA medical care, the GAO should audit, assess, and publicly report to Congress an assessment of the accuracy and sufficiency of VA's budget forecasting methodology, as well as the budget projections derived from it.

On September 18, 2008, the chairmen of Committees on Veterans' Affairs introduced legislation (S. 3527/H.R. 6939) to reform the VA budget process by providing advance appropriations for veterans' health care. The legislation was developed in consultation with the Partnership for Veterans Health Care Budget Reform (Partnership), which includes the four *Independent Budget* veterans service organizations (IBVSOs). The Military Coalition, composed of 35 military and veterans organizations, has also endorsed this proposal as a top legislative priority. S. 3527 and H.R. 6939 have been supported by a bipartisan group of Senate and House cosponsors, including then-Senator Barack Obama and Sen. John McCain. In a recent letter to the American Federation of Government Employees, then-candidate Obama stated clearly that he would "...recommend passage of advance appropriation legislation for the FY 2010 appropriations cycle...." The IBVSOs call on Congress to work with the President to fulfill this promise.

For more than a decade the Partnership has worked to achieve a sensible and lasting reform of the funding process for veterans' health care. With today's economic crisis further exacerbating the federal government's budget outlook, such a change may be even more difficult to achieve. Over the past two years, the Partnership has explored several other budget reform options that would achieve the same goals for which mandatory funding was proposed—sufficient, timely, and predictable funding—while taking into account the political and economic changes that have occurred since the Partnership was first formed.

Despite the significant, and in some cases historic, funding increases for veterans programs that occurred over the past couple of years, the long-term funding outlook for veterans' health care remains uncertain. There is an unfortunate historical trend that when wars wind down, so, too, does the public's interest, and by extension Congress's attention to providing sufficient funding. With the potential for a long recession or worse on the horizon, veterans can be expected to rely more heavily on VA to meet their health-care needs. In addition, the scale and complexity of the wounds and disabilities suffered by our newest veterans, and the costly cutting-edge treatments available to help them recover, are likely to require increasing levels of funding far into the future, even if the veterans' population continues to contract over the next decade.

Unlike government grant or transfer payment programs, VA is a direct provider of services, and, as such, suffers more when funding is late and unpredictable. Testimony submitted to a Senate Veterans' Affairs Committee hearing on VA health-care funding quoted three former VA medical center (VAMC) directors. One stated, "For the past 13 years, I served as the Director of the Spokane VA Medical Center...(and)...in all but one year of my tenure as Director, we began the budget cycle in a continuing resolution." Another longtime VAMC director stated that because of "...the uncertainty of sufficient resources to meet the needs of the veteran population...[d]ecisions were made based on the availability of funds daily." Another person, who served both as a VAMC director and as VHA's chief business officer, summed it up best when he said, "...VA funding and the appropriations process is a process that no effective business could tolerate."[32]

For the past two decades, VA has been forced to operate without knowing when or what amount of funding would be available for its health-care programs. This unpredictability is a hindrance for VA directors as they seek to recruit and hire new doctors, nurses, and other health-care professionals, a process that already takes months in the best of circumstances. And even if their budget is approved a few days or weeks before the start of the new

fiscal year, VA directors are not able to hire the medical personnel necessary to provide expanded care to new veterans or begin new specialized care programs for several months into the new fiscal year. Negotiating equipment purchases or facility leases also takes time to ensure fiscally responsible contracts, further delaying the provision of expanded health care, for which funding increases are intended. Until VA can have some assurance that its funding will arrive in a timely and predictable manner, these types of inefficiencies will continue to hinder VA's provision of health care.

The Veterans Health Care Budget Reform Act (S. 3527/H.R. 6939) would address these problems by authorizing advance appropriations for VA medical care. Advance appropriations are different from biennial budgeting, in which Congress approves a full two-year appropriations bill every two years, providing funding that can be spent throughout the entire two-year period. It is also different from forward funding and advance funding, which provide the flexibility to spend some appropriated funds in the preceding or next fiscal year. With advance appropriations, funding would be appropriated for each fiscal year to be spent only during that fiscal year; it is only the law that is done in advance. The benefit of advance appropriations is that when the law is approved a year in advance, VA has the statutory authority to plan how best to spend the approved funding on the first day of the fiscal year, regardless of what happens with the rest of the federal budget process.

Unlike mandatory funding proposals, advance appropriations is a discretionary funding process, and therefore Congress and the Administration maintain their role in setting funding levels for each fiscal year. Advance appropriations do not have to comply with Congressional PAYGO budget rules because there is no mandatory scoring to be offset by matching spending cuts or tax increases. Nor is there any reasonable argument to be made that Congressional oversight is weakened, as Congress retains its full discretion to set the level of funding for all medical care accounts for each fiscal year. Furthermore, Congress can reconsider or amend any advance appropriations bill prior to the start of the fiscal year, to increase it to provide sufficient funding or to limit spending for certain programs or purposes. Congress also retains authority to approve emergency supplemental appropriations for VA medical care, just as it can for any program, if unforeseen circumstances warrant additional spending.

Advance appropriations are regularly used for a number of other federal programs, including the Low Income Home Energy Assistance Program, Head Start, Special Education programs, Employment and Training Administration, Job Corps, Section 8 Housing Vouchers, and the Corporation for Public Broadcasting (CPB). The most recent budget resolutions have contained provisions that provide waivers against points of order against these specified advance appropriations and also have included an overall dollar limitation on all of them except for the CPB. Historically, advance appropriations have been used to make a program function more effectively, better align with funding cycles of program recipients, or provide insulation from annual partisan political maneuvering. By moving to advance appropriations, veterans' health-care programs would accrue all three of these benefits. Veterans' health care could no longer be used as political bargaining chip, either to "bust" budget caps or to carry unrelated spending or legislative provisions. With advance appropriations, veterans' health care could not be held hostage during future federal budget showdowns, which often result in continuing resolutions, emergency spending designations, and other budget gimmicks.

To enhance the budget process even further, the proposed legislation includes provisions to add transparency and oversight of VA's internal budget forecasting model. In recent years, VA has developed a new methodology to estimate its resource needs for veterans' health care, called the Enrollee Health Care Projection Model (model). Developed in collaboration with a leading private sector actuarial firm (Milliman, Inc.) over the past several years, the model has substantially improved VA's ability to estimate its budgetary needs for future years. The model has been thoroughly reviewed by the Office of Management and Budget and approved for use in developing VA's budget. In addition, RAND's Center for Military Health Policy Research recently completed a study on VA's model, concluding that it is "...likely to be valid for short-term budget planning...[and]...represents a substantial improvement over the budgeting methodologies used by the VA in the past...." RAND cautioned that the model's validity and accuracy for short-term budget estimation does not necessarily translate into long-term policy planning and analysis.

The model estimates VA health-care's resource needs by combining estimates of enrollment levels, utilization rates, and unit costs for 58 medical services and more than 40,000 separate enrollee groups, or "cells." Each of the 40,000 cells represents a combination of one geographic sector, age range, and priority level. The model incorporates additional usage trends—such as reliance on and intensity of services—and then separates out spe-

cial populations (such as veterans of Operations Enduring and Iraqi Freedom) and services (such as mental health care) for additional adjustments. While the model relies heavily on Milliman's proprietary Health Cost Guidelines, substantial adjustments are made to account for the unique characteristics of the veteran enrollee population and the VA health-care system. The final result produced by the model provides the most comprehensive, robust, and accurate estimate of what it will cost VA in future years to provide current services authorized in law to the veterans expected to seek those services.

Because of the complex nature of VA's actuarially based model, the proposed legislation would require the GAO to conduct an annual audit and assessment of the model to determine its validity and accuracy, as well as assess the integrity of the process and the data upon which it is based. The GAO would submit public reports to Congress each year at the same time the President submits his budget request. Each report would assess the model and include an estimate of the budget needs for VA's medical care accounts for the next two fiscal years. These GAO reports would provide a valuable tool for Congress as it applies its expertise to considering the President's budget request.

Furthermore, by making the model's data-driven estimates publicly available, Congress and the Administration would be forced to conduct an honest debate on the funding needs of veterans' health care, rather than the political priority of fully funding veterans' medical care programs. The GAO reports would also provide the IBVSOs and other veterans service organizations and interested parties a greater ability to objectively judge whether Congress and the Administration were proposing funding levels for veterans' health care sufficient to meet actual need. In addition, providing Congress with access to the model and its estimates of VA health care's resource needs would provide greater confidence in the accuracy of advance appropriations for veterans' medical care, as well as validate future requests for emergency supplemental appropriations.

Recommendations:

Congress should approve legislation that reforms the VA health-care budget process by authorizing one-year advance appropriations for VA Medical Care Accounts: Medical Services, Medical Support and Compliance, and Medical Facilities. The legislation should also require the Government Accountability Office to regularly audit, assess, and report publicly to Congress on the integrity and accuracy of VA's budget forecasting model and its estimates.

Congress should include language in the budget resolution that provides a waiver for points of order against advance appropriations for VA Medical Care Accounts without setting a dollar limitation on those accounts.

Congress should approve both the FY 2010 appropriations for all VA accounts and an FY 2011 advance appropriations bill for the three VA Medical Care Accounts during the FY 2010 budget cycle.

[32]Testimony submitted before the Sentate Committee on Veterans' Affairs, July 25, 2007.

ACCOUNTABILITY:

The Department of Veterans Affairs must hold its leaders accountable for running high-quality health-care programs and ensure that accountability systems that measure accomplishment of goals are synchronized with the needs of veterans.

Like the private sector, government organizations have seen the need for developing systems of accountability. Accountability is simplified when everyone's goals are shared—for example, goals of for-profit corporations align with maximizing profits and cost savings. However, the process of identifying goals that meet the needs of a government program, such as the Veterans Health Administration (VHA), and satisfy a variety of stakeholders, establishing objectives and measures and assigning responsibility for their suc-

cessful completion, can be extremely challenging.

The federal government has committed to the establishment of practices that demonstrate its effectiveness to taxpayers. For example, the Office of Management and Budget (OMB) has reengineered its operations to focus more resources on managing federal government programs (reviewing performance) and the General Accounting Office has been renamed the Government Accountability Office (GAO) to more accurately reflect the current mission focused on improving the performance and assuring the accountability of the federal government for the benefit of the American people.[33]

Congress has also demonstrated interest in ensuring that the programs it funds are meeting their goals. In 1993, Congress enacted the Government Performance and Results Act (GPRA), which established the framework for the development of strategic plans and performance measurement for the federal government agencies. The GPRA requires each agency to develop a five-year strategic plan, which is to be reviewed every three years. Both the OMB and the GAO attempt to ensure that federally funded programs use resources effectively to meet strategic goals.

The OMB Performance Assessment Rating Tool (PART) for Veterans Health Care found that the VA medical care system was "adequate" in terms of meeting its goals. Goals assessed included targeting resources at lower-income, service-disabled, and veterans with special eligibilities; collecting data to demonstrate effective care, such as use of performance measures, widely accepted clinical indices for managing chronic conditions and preventive measures; and linking medical care budget requests to performance.

Managerial accountability systems encompass several important components: clearly defined, measurable goals that affected parties agree are in the best interest of the organization, accurate tools to measure the goals, and the appropriate and fair assignment of responsibility for achieving the goals.

In accordance with the GPRA, VA developed four broad strategic goals to accomplish the following:

1. Restore to the greatest extent possible the capabilities of veterans with disabilities and improve the quality of their lives.
2. Ensure a smooth transition for veterans from active military service to civilian life.
3. Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the nation.
4. Contribute to the public health, emergency management, socioeconomic well-being, and history of the nation.
5. Deliver world-class service to veterans and their families by applying sound business principles that result in effective management of people, communications, technology, and governance.

The final goal is an "enabling goal," which, if fulfilled, allows VA to meet the first four. Each goal is followed by a series of objectives and each objective by measures that relate to those objectives' fulfillment.

To measure its performance toward fulfilling its mission, VA uses a five-tier performance measurement framework. To achieve its four strategic goals listed above, VA employs 21 strategic objectives, which are broad operational focus areas. In order to evaluate performance and measure progress toward achieving strategic objectives a collective summit was held that included the OMB, GAO, and Congress. VA ultimately identified 138 specific measurable indicators called performance measures that fall under three broad categories: *efficiency* (effective use of time and resources), *outcome* (achieves the desired result), or *output* (numbers produced). Of the 138 performance measures, 25 were identified by VA senior leadership as mission critical.

VA also identified performance and strategic targets associated with specific performance measures to be achieved during a fiscal year. Ideally, quality systems want to ensure that "outcomes" goals are met—for example, rather than counting how many medical records indicated that veterans had been advised not to smoke (an output measure), ideally, an overall reduction in smoking among VA users (an outcome measure) would be a goal.

The Independent Budget veterans service organizations (IBVSOs) agree with the broadly defined strategic goals but have some concern with the objectives or the measures and targets VA used to define success. For example, under strategic goal 3 (Honoring, Serving, and Memorializing Veterans) Objective 3.1 (Delivering Health Care), one key measure is a targeted annual percent increase of noninstitutional long-term care as expressed by the average daily census (ADC). While VA acknowledges that a more accurate measure than using

ADC is needed because it does not accurately measure the amount of care veterans receive, it continues to do so. In fact, VA had planned to report in FY 2005 a combination of workload measures for home-based primary care to include the number of patients treated and the number of visits veterans receive in addition to enrolled days.[34] Currently, this key measure only uses ADC and the number of veterans being cared for under the Care Coordination/Home Telehealth settings.[35]

According to VA, this key performance measure drives expansion of Home and Community Based Care (HCBC), the variety of services, and expansion of geographic access to increase the number of veterans receiving these services. ADC data are used to project the need for services, evaluate existing services, and promote access to required services. In addition, the data are used to establish Veterans Integrated Service Network (VISN) targets and evaluate VISN performance in meeting assigned workload levels in the HCBC area. The IBVSOs believe the current data reporting undermines the Secretary's statement that the performance data presented in VA's FY 2007 and 2008 Performance and Accountability Report are complete and reliable. Equally important, it undermines enforcing accountability at all levels of the VHA in providing noninstitutional long-term-care services and in doing so directly minimizes disabled veterans' opportunity to improve their quality of lives.

Another key measure of success that VA continues to claim it has achieved is access to medical care. In FY 2007 this included measuring the percentage of primary and specialty care patients seen within 30 days of a requested appointment time. This measure tracks the time between when the primary or specialty care appointment request is made (entered using VA's scheduling software) and the date for which the appointment is actually scheduled. The percentage is calculated using the numerator, which is all appointments scheduled within 30 days of desired date (includes both new and established patient experiences), and the denominator, which is all appointments in primary care clinics posted in the scheduling software during the review period. Despite the Office of Inspector General's assertion that VA's data for calculating the percentage are suspect,[36] VA continues to report that there are no data limitations.[37] Two additional key measures were included for FY 2008, and the accuracy of these measures also remains suspect since they share the same data source as the aforementioned key measures. Further, when an individual patient is waiting for more than one appointment, the calculation for one of the new 2008 measures counts only the appointment with the longest wait time.[38] This is particularly important because, in addition to the key measure above, both of these measures constitute half of the reported key performance measures for VA medical care programs.

VA also uses performance measures to assess its leadership's effectiveness in programs, networks, and facilities. It also links their performance to financial bonuses. In 2007 this practice came under scrutiny when some VA officials received financial rewards for "superior" service based on performance measures but had a record of continuing adverse outcomes within their responsibilities. In a government health-care setting, however, it is difficult to assign credit or blame for some outcomes because the officials' authority is limited—often they are not empowered to change factors, such as beneficiary demand, revenues, copayments, hiring practices, or facility design, which they may believe are obstructing the successful execution of their goals and objectives. For example, a facility manager might believe that a new outpatient clinic would increase the efficiency of clinicians and improve waiting times and patient satisfaction ratings. Generally, that manager, however, has no authority over whether that outpatient clinic would be approved and funded.

In government programs, there are often many "uncontrollables" that hinder individuals' ability to achieve desired results—for example, resources are limited, laws and regulations proscribe managerial actions, and demand from beneficiaries may be more or less than systems can accommodate. Additionally, if a network director treats a population of veterans that has increased rates of growth in demand relative to other networks along with a static fiscal year budget, is it fair to expect the director to meet the corporate standard waiting time for primary and specialty care? What if the veterans treated are older and sicker? These are factors that are generally out of the medical center directors' control. Finding the right measures to link "controllable" outcomes to managerial actions, then, is a delicate balance.

The IBVSOs support continued emphasis on establishing greater accountability in government programs. We want to ensure that VA leaders are accountable and that accountability systems measure VA's accomplishment of goals that are synchronized with the needs of veterans.

Recommendations:

The Office of Management and Budget must continue to ensure that beneficiaries' access to high-quality service, benefits, and programs is paramount in all strategic goals, objectives, and measures. Efficiency and cost-effectiveness are also appropriate goals but should be secondary to fulfillment of the mission of the agency.

VA should ensure that objectives and performance measures are directly related to each other and the strategic goal they support.

The Inspector General should periodically audit databases used to manage key performance measures and take steps to ensure that VA confirms the accuracy of its performance measures and, thereby, the integrity of its accountability systems.

VA should replace output measures with outcome measures, and Congress should charge the Government Accountability Office with review of key VA managers' performance to ensure that they are accountable for performance of functions over which they have direct control.

[33]H. Rept. 108-880.
[34]GAO-04-913.
[35]*Fiscal Year 2008 Performance and Accountability Report*, Department of Veterans Affairs, p. 443.
[36]DVA OIG Report No. 07-00616-199, September 10, 2007; DVA OIG Report No. 07-03505-129, May 19, 2008.
[37]*FY 2007 Performance and Accountability Report, Department of Veterans Affairs,* p. 209; *FY 2008 Performance and Accountability Report*, Department of Veterans Affairs, p. 231.
[38]*Fiscal Year 2008 Performance and Accountability Report*, Department of Veterans Affairs, p. 230.

SEAMLESS TRANSITION FROM THE DOD TO VA:

The Department of Defense and the Department of Veterans Affairs must ensure that all service members separating from active duty have a seamless transition from military to civilian life.

As servicemen and -women return from the conflicts in Afghanistan and Iraq, the DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service to successfully integrate into the civilian community as veterans. Though improvements have been made, the transition from the DOD to VA continues to be a challenge for newly discharged veterans. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The problems with transition from the DOD to VA were never more apparent than during the controversy that occurred at Walter Reed Army Medical Center in 2007. While much of the media coverage misrepresented the problems at Walter Reed as being a problem with care for injured service members, the real problems reflected many of the administrative difficulties associated with transitioning from the DOD to VA.

The IBVSOs continue to stress the points outlined by the report of President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), released in May 2003 and reinforced by the President's Commission on Care for America's Returning Wounded Warriors in September 2007, as well as four other major studies[39] regarding transition of soldiers to veteran status. One of the 20 recommendations made by the PTF and those made by the President's Commission is increased collaboration between the DOD and VA for the transfer of personal and health information. Great progress has been made in this area by VA; however, this recommendation remains only partially implemented. A September 2008 Government Accountability Office (GAO) report noted that the DOD and VA are not sharing all electronic health information and that information is still being captured in paper records at many DOD facilities.

Health Information

The IBVSOs believe that the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and bidirectional allowing for a two-way real-time electronic exchange of health information and occupational and environmental exposure data. Such an accomplishment could increase health information sharing between providers, laboratories, pharmacies, and patients; help patients transition between health-care settings; reduce duplicative and unnecessary

testing; improve patient safety by reducing medical errors; and increase our knowledge and understanding of the clinical, safety, quality, financial, and organizational value and benefits of health information technology. Lessons learned from previous wars also indicate that the DOD must continue collecting medical and environmental exposure data electronically while personnel are still in theater, and we applaud the DOD for doing so. But it is equally important that this information be provided to VA.

Electronic health information should also include an easily transferable electronic Certificate of Release or Discharge from Active Duty (DD 214) forwarded from the DOD to VA. This would allow VA to expedite the enrollment into its health-care system and claims process, giving the service member faster access to health care and benefits. According to DOD officials, the Defense Integrated Military Human Resources System (DIMHRS), a Congressionally mandated program with self-service capabilities to improve the delivery of military personnel and pay services is being developed to provide the electronic, computable interface between VA and DOD systems for transmittal and use of an electronic DD 214. The self-service aspects allow service members "view-only" access to their DD 214. According to Defense Secretary Robert M. Gates, the Army is scheduled to implement DIMHRS in March 2009, followed by the Air Force in October. Dates for transitioning by the Navy have not been set; the Marine Corps already has its own integrated pay and personnel system.

The Joint Electronic Health Records Interoperability plan, as agreed to by both VA and the DOD through the Joint Executive Council and overseen by the Health Executive Council, is a progressive series of exchange of related health data between the two departments, culminating in the bidirectional exchange of interoperable health information. While this has occurred on a limited and truncated basis, the current need is for a common standard and governmentwide implementation. In May 2007, the DOD established a Senior Oversight Committee (SOC), chartered and cochaired by the Deputy Secretaries of VA and the DOD, with the goal to identify immediate corrective actions and to review, implement, and track recommendations from a number of external reviews. Because of the recognized need, one of the lines of action identified to be addressed was DOD-VA data sharing. The SOC approved initiatives to ensure health and administrative data are made available. The September 2008 GAO report indicates the DOD and VA have agreed to numerous common standards and are working with federal groups to ensure adherence to such standards and align with emerging standards.

For example, VA and the DOD are sharing selected health information at different levels of interoperability, such as pharmacy and drug allergy data on nearly 19,000 patients that seek care from both agencies. Such information is computable to warn clinicians of a possible drug allergy with a to-be-prescribed medication. The Laboratory Data Sharing Interface Project is a short-term initiative that has produced an application used to electronically transfer laboratory work orders and retrieval of results between the departments in real time. Nonetheless, questions remain regarding the extent to which the VA and the DOD will achieve full interoperability by next year as neither department has yet to articulate an interoperability goal.

According to the GAO,[40] the DOD-VA Information Interoperability Plan that the departments recently completed is supposed to address these and other issues, including the establishment of schedules and benchmarks for developing interoperable health record capability. While the plan is an important accomplishment, on preliminary review, however, the plan's high-level content provides only a limited basis for understanding and assessing the department's progress toward full interoperability by the September 30, 2009, date mandated by the National Defense Authorization Act for FY 2008. Moreover, when fully established, a new interagency program office is to play a crucial role in accelerating efforts. Unfortunately, this office is not expected to be fully operational until the end of 2009, and some milestones in the office's plan for achieving interoperability have yet to be determined.

Care Coordination

Severely injured service members and veterans whose care and rehabilitation are being provided by both VA and the DOD, or are transferring from one health-care system to the other, must have a clear plan of rehabilitation and the necessary resources to accomplish the plan's goals. In response to the provisions of VA's Office of Inspector General (VAOIG) recommendations in a 2006 report examining the rehabilitation of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans suffering from traumatic brain injury (TBI), the Under Secretary for Health stated, "...case managers will provide long-term case management services and coordination of care for polytrauma patients and will serve as liaisons to their families." In October 2007, VA and the DOD partnered to create the Federal Recovery

Coordination Program to improve care management by identifying and integrating care and services between VA and DOD health-care systems, and it subsequently served to satisfy provisions of the Wounded Warrior Act, title XVI of Public Law 110-181. With such resources as the newly developed Federal Individual Recovery Plan, National Resource Directory, Family Handbook, MyeBenefits, and Veterans Tracking Application, the IBVSOs are cautiously optimistic that these coordinators will be able to provide greater oversight for the seamless transition of severely injured service members. While there are only eight federal recovery coordinators serving about 120 severely injured service members across military treatment facilities,[41] and one newly assigned at Dwight D. Eisenhower Army Medical Center, the President's Commission on Care of America's Returning Wounded Warriors reported that more than 3,000 seriously wounded veterans might need the assistance of these coordinators.

For service members and veterans whose injuries allow for more outpatient recovery and rehabilitation, a more extensive network has been created spanning the entire VA health-care system.[42] The Veterans Health Administration (VHA) has assigned part-time and full-time social workers to major military treatment facilities (MTFs) to serve as VHA liaisons between the MTF and VHA facilities. Each VHA facility has selected a point of contact and alternate who work closely with VA-DOD social work liaisons detailed to MTFs and Veterans Benefits Administration (VBA) representatives to ensure a seamless transition and transfer of care. While this initiative pertains primarily to military personnel returning from Iraq and Afghanistan having served in Operations Enduring and Iraqi Freedom, it also includes active duty military personnel returning from other combat theater assignments. It does not include active duty military personnel who are serving in noncombat theaters of operation.

Moreover, in March 2007, VA introduced the concept of transition patient advocates, who focus specifically on the needs of severely wounded veterans from operations in Iraq and Afghanistan. Since then, the VA OIG issued a follow-up report on May 1, 2008, to assess the extent to which VA maintains involvement with service members and veterans who had received inpatient rehabilitative care in VA facilities for traumatic brain injury (TBI). According to the report, VA case management was determined to have improved, while long-term case management is not uniformly provided for these patients, and significant needs remain unmet.

Disability Evaluation

The Independent Budget likewise concurred with the President's Commission recommendation that the DOD and VA implement a single comprehensive medical examination, and the IBVSOs believe that this must be absolutely done as a prerequisite of promptly completing the military separation process. However, we would like to reiterate our belief that if and when a single separation physical becomes the standard, VA should be responsible for handling this duty. VA simply has the expertise to conduct a more thorough and comprehensive examination as part of its compensation and pension process. Moreover, the inconsistencies with the physical evaluation board process from the different branches of the service can be overcome with a single physical administered from the VA's perspective and not the DOD's.

In addition to the President's Commission findings and recommendations, the Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center (IRG) found serious difficulties in administering the Physical Disability Evaluation System caused by a significant variance in policy and guidelines within the military health system. The IRG recommended the Physical Disability Evaluation System be completely overhauled to include changes in the U.S. Code, Department of Defense policies, and service regulations, resulting in one integrated solution.

Consequent to the recommendations from the reports of the Task Force on Returning Global War on Terrorism Heroes, the IRG, the President's Commission, and the Commission on Veterans' Disability Benefits, a single disability pilot project launched by the DOD and VA in November 2007 for service members from Walter Reed Army Medical Center, National Naval Medical Center at Bethesda, and Malcolm Grow Medical Center has more than 200 participants and is a step toward developing this single separation physical. A year after its inception, VA announced, on November 7, 2008, the expansion of the Disability Evaluation System (DES) Pilot Program to 19 military installations, representing all military departments. The initial phase of the expansion began October 1 at Fort Meade, Maryland, and Fort Belvoir, Virginia. The remaining 17 installations[43] will begin upon completion of site preparations and personnel orientation and training, during a seven-month period from November 2008 to May 2009.

By law, the DOD can consider only conditions that deal with "fitness for service" when determining disability ratings, whereas VA determines disability ratings for all service-connected conditions, even those that would not result in a finding of unfitness for service. The DOD uses the VA disability percentages for each condition, but may have a different combined disability rating than VA. While this separation physical is being put into practice in the DES Pilot Program, it is targeted primarily at those considered for medical discharge from the military. It should be considered for all separations. Moreover, issues remain regarding other components of the DES Pilot Program. The IBVSOs were not consulted for feedback or included in deliberations and design of the program and, more important, service members are not being properly educated about their right to counsel by individuals not employed by the DOD or VA or encouraged to seek such counsel throughout the program. Such a situation is aggravated by the current appellate process, which requires a service member to make an immediate decision regarding counsel.

The problem with separation physicals identified for active duty service members is compounded when mobilized reserve forces enter the mix. A mandatory separation physical is not required for demobilizing reservists and in some cases reservists are not made aware of the possibility. Although the physical examinations of demobilizing reservists have greatly improved in recent years, there are still a number of soldiers who "opt out" of the physicals, even when encouraged by medical personnel to participate. Although the expense and manpower needed to facilitate these physicals might be significant, the separation physical is critical to the future care of demobilizing soldiers. We cannot allow for insufficient information to be gathered in separation physicals, particularly among our National Guard and reserve forces, because they do not have the same structure and program for a seamless transition that exist for the active duty force. This would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

In the last several years, the DOD and VA have made good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) handled by the Veterans Employment and Training Service (VETS) is generally the first service that a separating service member will receive. In particular, local military commanders, through the insistence of the DOD, began to allow their soldiers, sailors, airmen, and marines to attend far enough in advance to take greatest advantage of the program. The programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their situations and then seek answers prior to discharge.

The TAP and DTAP programs continue to improve, but challenges remain at some local military installations, at overseas locations, and with services and information for those with injuries. Disabled service members who want to file a claim for VA compensation benefits and other ancillary benefits are dissuaded by the specter of assignment to a medical holding unit for an indefinite period. Furthermore, there still appears to be disorganization and inconsistency in providing this information. Though individuals are receiving the information, the haphazard nature and quick processing time may allow some individuals to fall through the cracks. This is of particular risk in the DTAP program for those with severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center or other specialized health-care services despite still being on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. DTAP has not had the same level of success as TAP, and it is critical that coordination be closer among the DOD, VA, and VETS to improve this function.

Though the achievements of the DOD and VA have been good with departing active duty service members, there is a much greater concern with the large numbers from the reserve and National Guard moving through the discharge system. As a result of the number of troops that are on "stop-loss"—a DOD action that prevents military service personnel from leaving the military at the end of their enlistments during deployments—large numbers of personnel rapidly transition to civilian life upon their return. Both the DOD and VA seem ill prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life.

Unless these soldiers are injured, they may clear the demobilization station in a few days. Little of this time is dedicated to informing them about veterans' benefits and services. Additionally, DOD personnel at these sites are most focused on processing service members with efficiency and dispatch. Lack of space and facilities often allow for limited contact by VA representatives with the demobilizing personnel.

In October 2008, the DOD released its new "Compensation and Benefits Handbook for Seriously Ill and Injured Members of the Armed Forces." This handbook is designed to help service members who are wounded, ill, and injured, as well as their family members, navigate the military and veterans' disability system. The IBVSOs applaud this informative booklet as one more method for service members to understand the transition, but now it will be critical for the DOD to ensure it gets into the hands of transitioning service members.

The IBVSOs believe the DOD and VA have made progress in the transition process. Unfortunately, limited funding and a focus on current military operations interfere with providing for service members who have chosen to leave military service. If we are to ensure that the mistakes of the first Gulf War are not repeated during this extended global war on terrorism, it is imperative that a truly seamless transition be created. With this, it is imperative that proper funding levels be provided to VA and the other agencies providing services for the vast increase in new veterans from the National Guard and Reserves. Servicemen and -women exiting military service should be afforded easy access to the health care and benefits that they have earned. This can only be accomplished by ensuring that the DOD and VA improve their coordination and information sharing to provide a seamless transition.

Recommendations:

The DOD and VA must ensure that service members have a seamless transition from military to civilian life.

The DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. These electronic exchanges should also include an easily transferable electronic DD214.

The DOD and VA must fully establish the Joint Interagency Program Office with permanent staff and clear lines of responsibility, and finalize the draft implementation plan with set milestones and timelines for defining requirements to support interoperable health records.

VA and the DOD must outline the requirements for assigning new or additional federal recovery coordinators to military treatment facilities caring for severely injured service members in concert with tracking workload, geographic distribution, and the complexity and acuity of injured service members' medical conditions.

Severely injured service members and veterans receiving treatment from the DOD and VA must have a clear plan of rehabilitation and the necessary resources to accomplish its goals.

VA and the DOD should make changes to the Disability Evaluation System Pilot Project to meet the needs and protect the rights of severely injured service members.

Congress and the Administration must provide adequate funding to support the Transition Assistance Program and Disabled Transition Assistance Program managed by the Department of Labor's Veterans Employment and Training Service to ensure that active duty, as well as National Guard and reserve, service members do not fall through the cracks while transitioning.

[39]Veterans' Disability Benefits Commission, DOD Task Force on Mental Health, Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, and Task Force on Returning Global War on Terror Heroes.
[40]GAO-08-954.
[41]Walter Reed Army Medical Center, Bethesda National Naval Medical Center, Brooke Army Medical Center, and Naval Medical Center Balboa are being actively recruited as of this writing.
[42]VHA DIRECTIVE 2006-017 April 3, 2006.
[43]Army: Fort Carson, Colorado, Fort Drum, New York; Fort Stewart, Georgia; Fort Richardson, Alaska; Fort Wainwright, Alaska; Brooke Army Medical Center, Texas; and Fort Polk, Louisiana. Navy: Naval Medical Center (NMC) San Diego and Camp Pendleton, California; NMC Bremerton, Washington; NMC Jacksonville, Florida; and Camp Lejeune, North Carolina. Air Force: Vance Air Force Base, Oklahoma; Nellis Air Force Base, Nevada; MacDill Air Force Base, Florida; Elmendorf Air Force Base, Alaska; and Travis Air Force Base, California.

INAPPROPRIATE BILLING:

Service-connected and nonservice-connected veterans and their insurers are continually frustrated by inaccurate and inappropriate billing for services related to conditions secondary to their disability.

The Veterans Health Administration (VHA) continues to bill veterans and their insurers for care provided for conditions directly related to service-connected disabilities. Reports continue to surface of veterans with service-connected amputations being billed for the treatment of associated pain and veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers. Inappropriate billing for secondary conditions forces veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden to both veterans and an already backlogged claims system. Additionally, veterans with more than six service-connected disability ratings are frequently billed improperly as a result of VA's inability to electronically store more than six service-connected conditions in the Compensation and Pension (C&P) Benefits Delivery Network (BDN) master record and the lack of timely and/or complete information exchange about service-connected conditions between the Veterans Benefits Administration (VBA) and the VHA.

VBA has undertaken a five-step approach to change the process by which it electronically shares C&P eligibility and benefits data with the VHA, particularly information about service-connected conditions that exceed the six stored in the C&P BDN. According to VA, because of difficulties in the development and implementation of the first two steps, the plan for improving VBA-VHA sharing of information about veterans' service-connected conditions has been delayed. Furthermore, VA acknowledges that not all these cases, with six service-connected conditions, have been identified under the new plan; however, it will determine the best course of action to take to further address the cases with incomplete service-connected disability information.

Nonservice-connected veterans are also continually frustrated with VA's billing process. Overbilling and inappropriate charging for copayments is becoming the norm rather than the exception. Veterans are experiencing multiple billing episodes for a single medical treatment or health-care visit.

Inappropriate bill coding is causing major problems for veterans subject to VA copayments. Veterans using VA specialized services, outpatient services, and VA's Home Based Primary Care programs are reporting multiple billings for a single visit. Often these multiple billing instances are the result of follow-up medical team meetings at which a veteran's condition and treatment plan are discussed.

These discussions and subsequent entries into a veteran's medical record trigger additional billing. In other instances simple phone calls from VA health-care professionals to individual veterans to discuss their treatment plan or medication usage can also result in copayment charges when no actual medical visit has even occurred.

Recommendations:

The Under Secretary for Health should firmly establish and enforce policies that prevent veterans from being billed for service-connected conditions and secondary symptoms or conditions that relate to an original service-connected disability rating.

The Under Secretary for Health should establish specific deadlines for the action plan to develop methods to improve the electronic exchange of information about service-connected conditions that exceed the maximum of six currently captured in the Compensation and Pension Benefits Delivery Network master record.

VA's cost-recovery system must be reviewed to determine how multiple and inappropriate billing errors are occurring. Billing clerk training procedures must be intensified and coding systems must be altered to prevent inappropriate billing.

HOMELAND SECURITY/FUNDING FOR THE FOURTH MISSION:

The Veterans Health Administration (VHA) is playing a major role in homeland security and bioterrorism prevention. This vital statutory fourth mission will require a budget of more than $300 million in FY 2010.

The Department of Veterans Affairs has four critical health-care missions. The primary mission is to provide health care to veterans. Its second mission is to educate and train health-care professionals. The third mission is to conduct medical research. VA's fourth mission is to "serve as a backup to the Department of Defense (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidents and other major disasters[.]"

VA has statutory authority, under title 38, United States Code, section 8111A, to serve as the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed into law an "Authorization for Use of Military Force," which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. This resolution, P.L. 107-40, satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the DOD.

As part of its fourth mission, VA has a critical role in homeland security and in responding to domestic emergencies. The National Disaster Medical System (NDMS), created by P.L. 107-188 (the Public Health Security and Bioterrorism Preparedness Response Act of 2002), has the responsibility for managing and coordinating the federal medical response to major emergencies and federally declared disasters. These disasters include natural disasters, technological disasters, major transportation accidents, and acts of terrorism including weapons of mass destruction events, in accordance with the National Response Plan.

The NDMS is a partnership comprising the Department of Homeland Security (DHS), VA, the DOD, and the Department of Health and Human Services (HHS). According to the VA website, www.va.gov, some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance, and evaluation of the local NDMS program. VA has also assigned "area emergency managers" to each Veterans Integrated Service Network (VISN) to support this effort and assist local VA management in fulfilling this responsibility.

In addition, P.L. 107-188 required VA to coordinate with HHS to maintain a stockpile of drugs, vaccines, and other biological products, medical devices, and other emergency supplies. In response to this mandate, VA created 143 internal pharmaceutical caches at VA medical centers. Ninety of those stockpiles are large and can supply medications to 2,000 casualties for two days, and 53 stockpiles can supply 1,000 casualties for two days. VA's national acquisition center manages four pharmaceutical and medical supply caches for the DHS and the Federal Emergency Management Agency (FEMA) as a part of their NDMS requirements, and two additional special caches for other federal agencies. The Secretary was also directed to enhance the readiness of medical centers and provide mental health counseling to individuals in communities affected by terrorist activities.

In 2002, Congress also enacted P.L. 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002. This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and would develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary or other explosive weapons, or devices posing threats to the public health and safety. In addition, the centers would provide education, training, and advice to health-care professionals. They would also provide laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care agencies and personnel involved in or responding to a disaster or emergency. These centers, although authorized by law, have not received any funding, and have not been established.

The disasters caused by Hurricanes Katrina and Rita in 2005 more than met the criteria for the fourth mission. VA proved to be fully prepared to care for veterans in the Gulf Coast region affected by the hurricanes. Nearly

10,000 VA employees around the country received recognition for their actions during the hurricanes. This included 73 Valor Awards presented for risking personal safety to prevent the loss of human life or government property and 3,000 official commendations.

In 2004 nearly 800 VA employees from around the country volunteered and were on standby to assist Florida communities damaged by Hurricane Frances. More than 120 VA employees, mostly medical personnel, were dispatched directly to the stricken areas to help with relief efforts in support of FEMA.

As a result of lessons learned during and after Hurricanes Katrina and Rita, VA developed three valuable new assets for deployment during a catastrophe: the deployable medical unit (DMU), the deployable pharmacy unit (DPU), and the response support unit (RSU). The DMU is a self-contained medical unit that can be on the site of an emergency within 24-48 hours. It contains examination and treatment areas and emergency power generation capacity and can withstand category 3 hurricane-force winds. The DPU permits VA pharmacists to fill commonly prescribed medications during an emergency. The unit obtains data on patient prescriptions via satellite communications with the VA prescription database. The RSU serves as a platform to assist a VISN to manage an emergency or support VA personnel deployed as part of a federal response.

The Independent Budget veterans service organizations are concerned that VA lacks the resources to properly fulfill its fourth mission responsibilities. In FY 2002 the funding for homeland security initiatives was $84.5 million. Since that time, VA's expenditures on emergency preparedness and homeland security missions have nearly quadrupled. As such, *The Independent Budget* recommends approximately $325 million for these responsibilities for FY 2010. Without additional funding and resources, VA will have difficulties in becoming a resource in a time of national crisis. VA has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not specifically received any funding to support the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. Homeland security funding—estimated to be more than $300 million in FY 2008—is simply taken from the Medical Care account. This leaves VA with fewer resources with which to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided, already scarce resources will continue to be diverted from direct health-care programs.

VA's fourth mission is vital to our defense, homeland security, and emergency preparedness needs. In light of the natural disasters that have recently wreaked havoc on this country, this fact has never been more apparent. These important roles once again reiterate the importance of maintaining the integrity of the VA system and its ability to provide a full range of health-care services.

Recommendations:

Congress should provide funds necessary in the Veterans Health Administration's FY 2010 appropriation to fund VA's fourth mission.

Because the fourth mission is increasingly important to our national interests, funding for the fourth mission should be included as a separate line item in the Medical Care appropriation.

MENTAL HEALTH ISSUES

MENTAL HEALTH SERVICES:

The Department of Veterans Affairs must deliver on its promise to transform its mental health and substance-use care programs and rise to the challenge of increasing access and quality of care for veterans of prior eras and the latest generation of combat veterans from Afghanistan and Iraq.

VA Mental Health Strategic Plan

This year marks the sixth anniversary of the release of the President's New Freedom Commission on Mental Health Report. Based on the commission's recommendations, the Veterans Health Administration (VHA) undertook a comprehensive and critical review of its mental health and substance use disorder programs and produced its own road map for the future of veterans' mental health care, the Mental Health Strategic Plan (MHSP). The old model of care for mental health focused on management of symptoms and accepted long-term disability as being inevitable. In 2004, VA's MHSP gave veterans hope that mental illness would be treated with the same seriousness as medical illnesses and that care would become more veteran and family-centered. We are pleased that the focus of VA mental health programs is now on recovery.

The VA MHSP includes a number of action items that build on the recommendations of the President's New Freedom Commission and the VA Secretary's Mental Health Task Force. Funding for these actions has been provided through a mental health initiative that supports implementation in four key areas: (1) enhancing capacity and access for mental health services; (2) integrating mental health and primary care; (3) transforming mental health specialty care to emphasize recovery and rehabilitation; and (4) implementing evidence-based care. Funding for the initiative is provided outside of the routine Veterans Equitable Resource Allocation (VERA) model and augments the capitated funding for mental health programs. Changes in guaranteeing *ongoing* funding of these programs occurring in FY 2010 are potentially problematic. We understand that $557 million was allocated to the Mental Health Enhancement Initiative (MHEI) for FY 2009 to continue funding for positions and programs initiated during 2005–2008 from both the initiative and supplemental funding, and to provide support for the implementation of the Uniform Mental Health Services (UMHS) handbook. Also, additional funding has been allocated to each Veterans Integrated Service Network (VISN) to support the implementation of the handbook, and further additional funding will be allocated to support the Secretary's initiative to add substance-use providers to post-traumatic stress disorder (PTSD) programs, and to support both Homeless Grant and Per Diem program staff and Housing and Urban Development VA Supportive Housing case managers. Without a guarantee of these fenced funds beyond the current fiscal year to ensure continuous support and perpetuate these newly established programs, these fledgling programs are in danger of failure. We recommend that the Under Secretary's Office appoint a task group to study funding of mental health programs and whether the VERA model will provide adequate funding for the full continuum of services mandated by the MHEI and UMHS handbook and make recommendations for future funding.

The Independent Budget veterans service organizations (IBVSOs) applaud progress made under these initiatives, including improvements in capacity and access through expansion of mental health services in community-based outpatient clinics, expanded use of telemental health, and enhancements in both treatment and outreach for PTSD. Particularly important are efforts to foster the integration of mental health and primary care programs in more than 100 pilot program sites and the integration of mental health care services for older veterans within home-based primary care. Recovery and rehabilitation programs are being facilitated by developing additional psychosocial rehabilitation programs, expanding residential rehabilitation services, increasing the number of beds and the degree of coordination in homeless programs, enhancing mental health intensive case management, and funding a recovery coordinator in each medical center. These developments are encouraging, and the IBVSOs are hopeful that their promise will be actualized in the near future. We note that integration of mental health into primary care is currently only a series of demonstrations and in some cases involves only one integrated clinic in a facil-

ity. The IBVSOs believe this initiative should be implemented as expeditiously as possible and include all service lines including integration of mental health in geriatrics, women's health programs, Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) programs and all other areas. The UMHS handbook, published in September 2008, requiring a common set of standards for mental health services throughout the VA health-care system, is also a major milestone.

Tracking Progress on the VA Mental Health Strategic Plan

While we congratulate the VHA for the progress in mental health services made to date, we note that recovery programs have had a slow, prolonged start-up period, and program managers have not made consistent efforts to involve veterans and family members locally. Despite clear progress, the current level of effort and provision of services remains inadequate in making treatment planning a true partnership between the veteran, family members, and provider. Additionally, a sustained effort toward reducing stigma and addressing PTSD, concurrent substance abuse and mental health treatment in a wide variety of conditions and settings, and family and marriage counseling, all pointed toward recovery goals, remains inadequate. Therefore, Congress should increase its oversight to ensure that veterans' needs for quality, comprehensive mental health care are met, and the promise of recovery is finally achieved.

Furthermore, the recovery transformation process has some regulatory impediments that need to be addressed. At the heart of the recovery effort is the need to have veterans with mental illness be partners in determining their goals and the interventions necessary to achieve them. This requires a major shift away from the historically paternalistic approach of having clinical providers determine the treatment plan and expecting veterans to adhere to it, with only nominal input from them. This is a major challenge—and transformation of a vast system, such as VHA mental health care, to recovery-oriented services is an unprecedented effort. To make this credible, it is critical to develop recovery partnerships between VA planners, managers, clinicians, and the veteran users themselves. Such partnership groups should exist at every level to ensure proper development of programs that are centered on the needs of veterans so they can effectively meet them. The current interpretations of the Federal Advisory Committee Act (FACA) regulations within VA have made this problematic, as such work groups are now seen as needing to be independently organized by veterans themselves, with VA staff serving only in a liaison function. Many veteran consumer councils have existed for years at the national, VISN, and facility and program levels (i.e., the Committee on Care of Veterans with Serious Mental Illness Liaison Council). Almost every consumer council was initiated by VA staff. If current FACA interpretation had then held sway, few of these groups would exist. Since such FACA interpretation has not prevented the development of general stakeholder groups at the VISN and facility level, organized by VA, it is not clear why mental health stakeholders receive disparate treatment by the VHA under FACA. VHA policy and applicable federal regulations should be modified to encourage VA-veteran health partnerships and recognize the importance of veterans' involvement in their health-care system, especially recovery-based mental health services.

Furthermore, Section 7321 of title 38, United States Code, requires VA to appoint a Committee on Care of Veterans with Serious Mental Illness with clearly defined duties: to identify systemwide problems and specific VA facilities at which program enrichment is needed to improve treatment and rehabilitation and to promote model programs that should be implemented more widely within VA's mental health practice. Since 2006, this committee—a committee that at one time displayed inspired leadership and effectiveness in meeting this Congressional mandate—has seemingly become a functional arm of VA Central Office (VACO) leadership and is no longer an independent voice for better services for the most vulnerable enrolled patient population: the chronically mentally ill.

Progress in VA's crucial mental health reform initiatives is dependent on incorporation of best practices and effective oversight. Oversight is needed to ensure that veterans, family members, and their representatives and advocates are an integral part of a continuous improvement feedback loop: reviewing the effectiveness and satisfaction with current programs; evaluating the development and deployment of new programs; recommending changes in current services; and providing constructive feedback on how to transform these services to provide the highest quality, most veteran-centered programs possible. A formalized, empowered oversight system with consumer representation is urgently needed to replace the current above-noted committee, and therefore the IBVSOs recommend a Secretary of Veterans Affairs–level oversight committee be authorized by law.

The new committee should include experts from both within and outside VA; consumers and consumer advocates, such as veterans service organizations (including the IBVSOs); and mental health associations concerned about VA programs and the veterans they serve. The committee must be adequately staffed and empowered to conduct ongoing reviews of efforts to improve and sustain mental health services in VA, covering the full range of programming from transitional and readjustment primary care to the treatment of chronic mental illnesses. The committee should be required to report periodically and independently to Congress on its evaluations and recommendations, including providing testimony at oversight and legislative hearings of the Committees on Veterans' Affairs. Constructive oversight and feedback to both VA and Congress can help ensure that the finite resources available from Congressional mental health appropriations make the greatest contribution to the recovery and humane care of veterans experiencing the often-devastating mental health effects resulting from their military service to the nation.

VA Mental Health Budget

Final calculations of total spending for VA mental health services for FY 2008 were not available at the time of this writing. However, at the beginning of FY 2009, spending for FY 2008 was estimated to be between $3.4 billion and $3.5 billion, mostly to be derived through VERA. This figure was higher than the "no less than $2.9 billion" spending requirement for mental health services in the FY 2008 Appropriations Act. Prior to the start of FY 2009, mental health spending was estimated to be $3.86 billion, modestly above the "no less than $3.8 billion" requirement that was subsequently included in the FY 2009 Appropriations Act. For FY 2009 and FY 2010, VA's challenge will be to execute the budget increases effectively and allocate its resources wisely. VA's Office of Mental Health has undertaken a monumental transformation of its programs and services and is under tremendous pressure to ensure implementation of the MHSP and UMHS package; fill existing gaps in mental health and substance-use disorder care; integrate mental health services throughout primary care and other service lines; and enhance targeted mental health services. It must be noted that since the MHSP was first drafted, before the current OEF/OIF operations, many circumstances have changed and the challenge to provide comprehensive mental health services continues to grow in scope and complexity. For these reasons, the IBVSOs urge Congress to provide concentrated oversight of spending on mental health services and require VA to provide a full accounting and breakdown of resource allocation, distribution and outcomes of the initiative goals discussed above. We are concerned there is great possibility for manipulation of data and "creative accounting" that can reflect a picture that is not truly representative of the status of this agenda.

Oversight of these programs will be critical to their success. In November 2006, the Government Accountability Office (GAO) issued a report on resources allocated to VA's MHSP initiatives. The GAO documented that VA did not spend the entire allocated budget planned for new FY 2005 mental health initiatives. Additionally, the GAO found that VACO did not inform network and medical center officials that funds were to be used for specific mental health priorities and therefore it is likely that the funding was spent on other health-care needs. The VHA noted that it is aware of concerns about spending of funds from the mental health initiative in FY 2005 and FY 2006 and has made adjustments to its processes to better track the use of these funds. According to the Mental Health Strategic Health Care Group, these funds have been used to improve capacity and approve the hiring of 4,000 new mental health providers to date. However, the IBVSOs continue to hear reports from mental health practitioners in the field that the difficulty of recruiting and retaining behavioral health staff is a major contributing factor for the delay in spending mental health funding. The lengthy, burdensome hiring process, which includes advertising, recruiting, interviewing, and problematic credentialing and privileging requirements, in some cases can take four or five months between tentative offer and on-duty status.

There is a national shortage of behavioral health personnel that makes these issues doubly important. VA needs to improve its succession planning in mental health to address the professional field shortages, recruitment, and retention challenges. VA should also establish a new employee education and mentoring program to overcome the practical problems new staff have in establishing and implementing new programs and policies, when they are unfamiliar with VA or federal procedures. VACO has been slow to develop new policies and procedures to manage these programs while maintaining the flexibility needed to make adjustments. Past experience indicates that it will take several years to fully implement even relatively straightforward changes and longer when more complex culture change is required. Congressional scrutiny is vital to ensure effective and efficient use of these dedicated mental health funds, continuous progress on all facets of the MHSP, and improvements in mental health services and outcomes.

Although the IBVSOs are extremely pleased about the UMHS initiative, we are extremely concerned about the estimated timeline, resources, and staffing levels necessary to establish the initiative. The IBVSOs were informed by VA mental health leadership that the field facilities were consulted about the staffing needed to fulfill the goals outlined in the UMHS handbook. We understand the number of full-time employee equivalents reported necessary by each VISN to carry out the initiative was significantly higher than the level approved by mental health leadership. Field sources also noted that even if all the funds were to appear in their budgets on day one of FY 2009, there would be no practical way all the staff could be hired and programs developed and put in place by the end of the fiscal year as expected. In addition, there are many features of the UMHS package that require transformations, such as recovery-oriented care that clinicians believe will take years to accomplish. Another critical concern to the IBVSOs is the apparent lack of development of a population based demand model, with projections of impact on VA mental health resource requirements presented by returning veterans from Afghanistan and Iraq. It is recognized that these newly returning veterans are challenged by a number of post-deployment mental health issues requiring specialized and evidence-based treatments for a variety of combat-related conditions, including depression, anxiety, PTSD, substance-use disorders, relationship counseling, and risk of suicide. To our knowledge there is no official VA estimate of this impact, other than a generalized number in the budget. It is disconcerting that VA officials often describe this increase as easily able to be absorbed within existing resources, without any adequate data to support their claims. Such a population-based demand model, combined with a set of realistic productivity standards for the various disciplines within specific program settings, would seemingly help to ensure the field has adequate resources to meet the mental health needs of *all* enrolled veterans, including the newest generation of war veterans.

In November 2007, the Institute of Medicine (IOM) published *Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress, vol. 6.*[44] The IOM committee studied literature covering World War II, the Korean War, the Vietnam War, the 1991 Persian Gulf War, and OEF/OIF. Potential health effects considered included both physiological and psychological effects, including PTSD, anxiety disorders, depression, substance abuse, and psychosocial effects, such as marital conflict and incarceration.

In reviewing the scientific evidence, the IOM found the evidence to be sufficient to conclude an association between deployment to a war zone and the following conditions: PTSD, anxiety disorders, depression, alcohol abuse, suicidal ideation, and accidental death in early years after deployment, as well as marriage and family conflict. In addition, the committee found that there was suggestive evidence of an association between deployment stress and drug abuse, chronic fatigue syndrome, fibromyalgia and other pain syndromes, gastrointestinal symptoms and functional disorders, skin disorders, increased symptom reporting, and unexplained conditions, as well as incarceration. The IOM committee noted that there was insufficient investigation by VA or the Department of Defense (DOD) to allow them to draw cause-and-effect conclusions regarding the effects of deployment stress on physiological, psychological, and psychosocial conditions. To remedy this problem, the committee recommended further epidemiologic studies and enhanced predeployment screening to identify exposures most stressful to the veteran and regular longitudinal reassessments at five-year intervals thereafter to identify long-term health and psychosocial health effects. Considering the importance of these findings to all combat veterans and the urgency to develop effective programs for OEF/OIF veterans, the IBVSOs strongly urge VA and the DOD to move rapidly to develop health policy and research inquiries that are responsive to these important recommendations. Additionally, we urge VA to review and propose regulations to establish presumptive service connection based on the above noted findings for the conditions that meet the threshold established by VA for other previously established presumptive conditions.

VA's Specialized PTSD Programs

According to VA data, the Department operates a network of more than 190 specialized PTSD outpatient treatment programs nationwide, including specialized PTSD teams or a PTSD specialist at each VA medical center (VAMC). VA has indicated that treating PTSD among returning veterans is one of its highest priorities. VA and DOD studies have indeed verified that veterans with combat exposure in Afghanistan and Iraq had the expected increased risk for PTSD and other mental health concerns postdeployment. Since the beginnings of OEF/OIF, 868,717 service members have been discharged and become eligible for VA health care. Through August 2008, VA reported that of the 347,750 separated OEF/OIF veterans who have sought VA health care since FY 2002 a total of 147,744 unique patients had received a diagnosis of a possible mental health disorder (not including in-

formation on PTSD from VA Vet Centers or data from veterans not enrolled for VHA health care). Nearly 76,000 enrolled OEF/OIF veterans had a probable diagnosis of PTSD; nearly 60,000 OEF/OIF veterans have been diagnosed with depression; and nearly 13,000 received a diagnosis of alcohol dependence syndrome.[45] These data are generally consistent with DOD and other studies of U.S. military service members who served in Iraq. However, VA data does not track early indications of alcohol and other drug misuse, hazardous use, and early abuse, which DOD studies indicate are a problem in between 11 percent and 23 percent of service members surveyed.

An IOM expert committee studied the evidence for treatments proven effective for PTSD and reported that there is sufficient evidence to conclude that exposure to cognitive behavior therapies is effective in treatment of PTSD.[46] The IOM noted that there may be important treatment response differences between civilians and veteran populations with PTSD, as well as differences between older and younger veterans. The IOM committee was not convinced that the evidence is sufficient regarding efficacy of the currently used pharmacological interventions and cautioned that evidence regarding the effectiveness of group therapy is inadequate. The committee made important recommendations to improve VA's ability to provide evidence-based treatments. Of particular note is the committee's finding that available research has significant gaps in evaluation of the efficacy of treatment interventions in the subpopulation of veterans with comorbid traumatic brain injury, major depression, and substance abuse and in women, racial and ethnic minorities, and older individuals. The IBVSOs are pleased with the increased federal investments in PTSD research, and we commend Congress for providing those funds and the mandate to do so; however, we believe there should be greater attention to these specific areas of study as recommended by the IOM. It is disheartening to learn that despite widespread recognition of the importance of deployment stress and PTSD in veterans the committee found "it striking that so few of the studies were conducted in populations of veterans."[47]

VA has been a leader in research on efficacious interventions for severe PTSD, but, as documented by the IOM report, these effective approaches are complex, expensive, and time consuming. Prolonged exposure therapy, an intensive specialized counseling treatment, was highlighted in the IOM report as being one of the few proven effective treatments supported by evidence-based research studies. The IBVSOs are concerned that VA does not currently have the capacity to deliver these intensive exposure therapy programs in every VAMC and to all appropriate veterans with PTSD across the nation. VA needs to immediately increase its funding for such programs and conduct more translational research on how best to disseminate this state-of-the-art care across the VA mental health system. This translational research must include an analysis of the barriers to dissemination, including resources and structural and cultural barriers. Translation of research studies to ready availability of effective treatment programs across the VA healthcare system is a daunting task, but the need is urgent and early intervention is critical to prevent diminished quality of life and well-being for those who have served their country in combat. Prevention of chronic PTSD and recovery should be among the highest priorities for the VHA as it serves the mental health needs of veterans of recent and prior wars.

In 2007 investigators published a study using VA administrative data indicating that between 1997 and 2005 total patients served by VA mental health programs increased by almost 300,000 unique veterans, a 56 percent increase. In addition, the number of veterans diagnosed with PTSD doubled, while the number who received mental health diagnoses other than PTSD increased by 40 percent. The largest numbers of veterans (80 percent) were from earlier eras; however, the largest proportionate increases occurred in veterans who were born after 1972. During this period the number of clinic contacts per veteran per year declined steadily, resulting in a cumulative decline of 37.5 percent. Declines were observed in both PTSD and other mental health diagnoses. The total number of mental health clinic visits showed real number reductions of 2.7 percent from 10.18 visits in FY 1997 to 9.91 visits in FY 2005. The study noted that during the period after the beginning of combat in Iraq, the rate of increase in PTSD and other mental health patient workloads grew further. Mental health service use among both Gulf War era and older veterans increased progressively while service intensity declined steadily. This suggests that increasing demand was met by compressing the allowable number of visits per veteran. Clinicians believe these changes cannot be explained by improvements in evidence-based treatment protocols; therefore, it is likely that the reported declines were accompanied by reductions in continuity of care.[48]

Although VA has increased funding to specialized care programs, the IBVSOs are extremely concerned that care be taken to immediately reverse the above-reported trends so that veterans may benefit from the highest quality men-

tal health care available. We recognize that counseling and evidence-based therapies require intensive training and mentorship to be effectively delivered. Additionally, these treatments are labor intensive and require numerous sessions and increased time with clinicians. In the absence of real-time field experience with these evidence-based PTSD treatments, it is often assumed by VACO planners that the 12-session cognitive processing therapy and the equally brief prolonged exposure therapy will result in veterans no longer requiring ongoing supportive services for PTSD. This is contrary to what clinicians in the field have been observing. These intensive services result in new clinicians having their caseloads rapidly filled, with ongoing need for additional staff, which is not possible with the resources allocated for new mental health providers this year. This yet again points to the need for realistic productivity standards and population-based demand models for these key interventions. Given the likelihood of a surge in combat veterans returning to their communities in the next 12 to 24 months, this needs to happen immediately. We believe these data justify a rigorous study of whether VA has, indeed, purposefully reduced the intensity of care for certain of its enrolled patients in mental health programs in order to generate capacity to absorb newer arrivals with more acute needs. If this study corroborates these observations, VA should be required to shift this trend back toward higher quality and more continuous care for *all* the veterans it serves in mental health programs.

Readjustment Counseling Service

The Readjustment Counseling Service (RCS) currently provides counseling and readjustment services to veterans at 232 Vet Centers, located throughout the nation. The RCS will be expanding the number of Vet Centers to 271 by the end of 2009. Vet Centers provided more than 1.1 million visits by more than 167,000 unique combat veterans from all service eras in FY 2008, including more than 69,000 veterans that were seen through outreach efforts.

In addition to the expansion of Vet Center sites already noted, these centers have also expanded the depth and range of services provided. Vet Centers have been innovative in using technology to expand services, including use of telehealth linkages with VA medical centers. Use of telehealth has increased geographic access to mental health service delivery in remote areas to underserved veteran populations. Since their inception, Vet Centers have provided a recovery focus and an alternative to conventional access for mental health care that some veterans may be reluctant to seek in traditional VA medical centers and clinics. They serve as a model for veterans' psychosocial readjustment and rehabilitation, and support ongoing enhancements under the VA Mental Health Strategic Plan. Also, since 2003, the Vet Centers have provided bereavement services to surviving family members of service members killed while serving on active duty. This successful new program has provided support to more than 2,100 family members of more than 1,400 fallen warriors, most of whom were killed in action in OEF/OIF. Some of these family members may require treatment for depression or anxiety in response to their grief reactions, but there is no current legislative authority for the provision of such care. We urge VA to establish collaborative relationships with community providers for those family members who do not qualify for TRICARE and needed mental health benefits.

The Vet Center program is one of the few VA programs to address a veteran's full range of readjustment and reintegration needs with their families and communities. Family counseling is provided when needed for the readjustment of the veteran. Families provide the "front line" of support network for returning veterans. Spouses are often the first to identify readjustment issues and facilitate veterans' evaluation and treatment when concerns are identified. Repeated deployments, financial hardships, long absences from home, and the stresses of reintegration with family routines have put a tremendous strain on OEF/OIF veterans' marriages. The most recent survey of more than 3,000 soldiers, conducted while they were serving in Afghanistan and Iraq, indicates that by the midpoint of deployment 30 percent were considering divorce.[49] We are pleased that Public Law 110-387 clarified VA's authority to provide marriage and family counseling and establish a limited pilot program to assess the feasibility and advisability to provide readjustment and transition assistance to veterans and their families in cooperation with Vet Centers. We encourage VA to expand this program to provide routine support and relationship counseling services for all combat veterans and their families. We believe these services should be made available in all major VA care sites. Vet Center staff and VA mental health professionals in VA medical centers should work to improve collaboration between their respective program services to ensure appropriate care coordination and quality care for veterans. In the near term, VAMCs should increase their coordination with Vet Center staff to increase access and referrals for veterans needing

family counseling; increase distribution of outreach materials to family members with tips on how to better manage the dislocation and improve reintegration of combat veterans who are returning from a deployment; and provide information on identifying warning signs of suicidal ideation so veterans will be more likely to seek help with readjustment issues. Also, in cases of referrals from Vet Centers to VA medical centers, information of record on patient counseling at Vet Centers should be made available to mental health practitioners to aid them in the continuing care of these veterans.

Substance-Use Disorders Treatment

In the past, population-based surveys have strongly confirmed that veterans report higher rates of alcohol abuse than nonveterans and are more likely to meet criteria for alcohol abuse and dependence. Recent studies have demonstrated no reduction in overall veteran need for substance-use disorder services and have shown an increase in alcohol concerns expressed by or about OEF/OIF veterans.

Army investigators recently published the first longitudinal study of health concerns among soldiers serving in Iraq. The study found that questionnaires administered immediately after completing redeployment underestimate the physical health, mental health, and substance-use burden on service members who served in Iraq. Surveys conducted later showed increased reporting of both physical health and mental health concerns and increased referrals to care. In this particular study, although 11.8 percent of soldiers reported alcohol misuse, only 0.2 percent of those individuals were subsequently referred for treatment. Moreover, of those referred, only a small number received care within 90 days of screening.[50]

The number of veterans who received specialized outpatient substance abuse treatment services in VA declined between FY 1998 and FY 2005 by 18 percent. The IBVSOs believe the overall decline in supply of substance-use disorder services occurred despite stable or increasing veterans' demand for such services. However, we note that during the past year VA conducted an analysis of gaps in service for substance abuse care and has begun to fund new programs, particularly intensive outpatient treatment programs, to fill critical gaps in access to care. This is an important first step in rebuilding VA substance abuse treatment programming and assuring equity of access across the system to critical services. However, VA data show that the numbers of veterans who received specialty care for substance-use disorders during FY 2006 as 121,926, but in FY 2007 it was a mere 127,402.[51] These minimal increases do not begin to address veterans' treatment requirements or reverse the 15 percent to 18 percent decreases in VA substance abuse treatment in the decade between 1996 and 2006.

In its UMHS handbook, the VHA mandates that all VA health-care facilities develop a full continuum of care for substance-use disorders, including more consistent and universal periodic screening of OEF/OIF combat veterans in all its health-care facilities and programs. Screening, especially in primary care clinics and Vet Centers, is essential for early intervention and prevention of chronic substance-use disorders. The IBVSOs are pleased with the new policy and look forward to its speedy implementation across all VA sites of care. Outpatient substance misuse counseling and pharmacotherapy should be available at all larger VA community-based outpatient clinics at a minimum. At more extensive VA medical centers, short-term outpatient counseling including motivational interventions, intensive outpatient treatment, residential care for those most severely disabled, detoxification services, ongoing aftercare and relapse prevention, self-help groups, opiate substitution therapies, and newer drugs to reduce cravings should be made more widely available. We note that, traditionally, VA substance abuse services have been primarily focused on service for veterans who have a severe and chronic substance abuse or dependence. This has resulted in neglect of programs that could help veterans early and prevent consequent disruption of family, employment, and community relationships. We believe this is a significant issue, especially with respect to the newest generation of war veterans exhibiting these early symptoms of alcohol and other drug misuse. For these reasons, we strongly recommend that VA focus intensive efforts to improve and increase early intervention and the prevention of substance abuse in the veteran population.

Recovery and Disability Compensation

In the 110th Congress, legislation was proposed that attempted to link the disability compensation system with "recovery." The use of the term recovery created unnecessary confusion with mental health recovery concepts and the VHA's focus of transforming its mental health services through recovery-based programs and principles. The legislative proposal, which would have delayed veteran access to VA's Disability and Compensation claims process, created a sense of suspicion and fear among service-connected veterans who believed that the government's focus on the hope of recovery from se-

rious mental illness was simply a cynical effort to reduce or eliminate their entitlement benefits. The IBVSOs do not believe this to be the case; however, to truly achieve the greatest outcome for disabled veterans, this issue must be addressed. We acknowledge that fear of loss of compensation benefits (and reality of the current regulations) is a serious barrier to some of the most important aspects of recovery transformation. The urgent need to realign the disability regulations with recovery transformation is particularly compelling due to the large numbers of veterans returning from OEF/OIF, who are frequently torn between competing priorities of seeking treatment and recovery, returning to work and self-sufficiency (which almost all want to do), and having disability compensation that provides financial security to them during their difficult journey to recovery. First, there should be an adjustment to the disability compensation rating schedule that ensures parity between mental health disabilities and physical disabilities. Second, it is critical that compensation and treatment not be contingent or linked. These issues should be decoupled to eliminate the potential barriers and conflicts for maximizing employment under the recovery/rehabilitation model of care. Veterans service organizations (VSOs) and disabled veterans should be involved in all efforts to realign the disability rating system for mental health disorders to ensure that programs are designed to maximize every veteran's ability to fully participate in the recovery/rehabilitation model of care without being denied the ability to file a claim for benefits and without fear of loss of established disability compensation. A task force, composed of experts from the Veterans Benefits Administration (VBA), VHA mental health staff, VSOs, and disabled veterans should be assembled to appropriately align the disability compensation system with recovery-oriented care.

Designation of Seriously Ill and Injured Veterans and Case Management

Over the past decade, the VHA has emphasized the critical importance of a coordinated continuum of care for seriously ill and injured veterans. This includes the initial transition between the DOD and VA health-care systems. After managing the initial "hand-off" between federal health-care programs, VA has developed systems of care to ensure that high-quality, accessible health-care services continue to be provided to these individuals.

The President's Commission on Care for America's Returning Wounded Warriors made many recommendations for improvements in VA care. The commission recognized the importance of integrated care management to provide "...patients with the right care and benefits at the right time in the right place by leveraging all resources appropriate to their needs. For injured service members—particularly the severely injured—integrated care management would build bridges across health-care services in a single facility and across health-care services and benefits provided by DOD and VA."

To implement the commission's recommendations and ensure every veteran receives the care he or she requires, VA created the OEF/OIF Case Management Program for veterans and service members with serious injuries or illnesses. VA has professed that its case management and coordination strategy has allowed it to meet the needs of returning seriously injured veterans. This case management program is designed to provide lifelong care to those individuals who are designated as seriously ill and injured veterans. However, the IBVSOs have become aware that the case management programs treat veterans with physical injuries and mental health injuries and illness in a disparate manner. OEF/OIF combat veterans being discharged with serious mental illness without an accompanying physical injury are not included in this program. Because of this disparity, case managers and mental health staff are left to cobble together locally developed databases and programs for OEF/OIF veterans with serious or complex mental health problems that clinically require case management. Because the programs are unique to each VAMC, there is no national tracking or monitoring of this important patient population. VAMCs have no means to report case management workload or resources to the national program office required for these efforts. We recommend that VA immediately correct case management program deficiencies and begin to treat psychological injury and illness in veterans with the same intensity that it treats serious physical injuries.

Suicide Prevention

The IBVSOs are pleased that over the past year VA has stepped up its efforts and made suicide prevention a priority. VA has developed a broad program based on increasing awareness, prevention, and training of health-care staff to recognize suicide risk. A national suicide prevention hotline has been established and suicide prevention coordinators have been hired in each VA medical center. Research into the risk factors associated with suicide in veterans and prevention strategies is under way. While recognizing the advances in suicide prevention programs made by VA, the IBVSOs believe

strongly that the most effective investments will be those that VA makes to improve the screening, diagnosis, and treatment for PTSD, depression, substance abuse, and other mental health disorders. Evidence is clear that those conditions, left untreated or poorly treated, can lead to increases in suicide attempts and suicide rates. For these reasons we believe VA must redouble its efforts to reduce the stigma associated with seeking mental health care and to encourage veterans to seek treatment. Case management for veterans at high risk for suicide should be sized adequately to meet the needs, and when the veteran also has a care manager for OEF/OIF issues, that care manager needs to be equally well trained in suicide risk management to avoid duplication or working at cross purposes. There should be clearly delineated role functions for OEF/OIF case managers since they may naturally cross over into clinical management.

OEF/OIF Veterans

There is growing concern that the special needs of new veterans of the conflicts in Afghanistan and Iraq have received insufficient advance planning and inconsistent attention since the first deployments began in Afghanistan in October 2001. Because of the importance of stepping up efforts directly on behalf of OEF/OIF veterans, the IBVSOs have included a separate section in this *Independent Budget*, titled "The Challenge of Caring for Our Newest War Veterans."

Summary

The IBVSOs recognize the unprecedented efforts made by VA to improve the safety, timeliness, and effectiveness of mental health-care programs for veterans. We are especially pleased that VA has expressed its intent and commitment through the national Mental Health Strategic Plan to reform its mental health programs, moving from the traditional treatment of symptoms to embrace potential recovery of every patient under VA care. We also appreciate the will of Congress in continuing to insist that VA dedicate sufficient resources in pursuit of full VA coverage of the mental health needs of veterans. The IBVSOs have concerns, nevertheless, that these laudable goals will be unfulfilled unless VA adopts and enforces mechanisms to ensure its policies at the top are reflected as results in the field. In that regard we are deeply concerned that substance-use disorder programs in VA, currently focused on chronic and severe addictions, are woefully inadequate given that there are consistent indications of substance-use disorder problems in the OEF/OIF population.

We believe the conflicts inherent in VA's disability compensation system for mental health disorders and recovery-based care for mental illness need to be addressed by VA. No veteran should fear compensation penalty from health improvement. The current practices between the VBA and the VHA may be working at cross purposes and should be more closely examined by a VA benefits-health task group involving veterans organizations, including the IBVSOs. We also urge closer cooperation and coordination between VA medical centers and Vet Centers within their areas of operations. We recognize that the Readjustment Counseling Service is independent from the VHA by statute and conducts its readjustment counseling programs outside the traditional "medical model." We respect that division and do not intend to undermine it. However, in addition to having concerns about VA's ability to coordinate with community providers in caring for veterans at VA expense, we believe veterans will be best served if better ties and mutual goals govern the relationship of Vet Centers to VA medical centers.

The development of the MHSP and the new Uniform Mental Health Services package provide an excellent road map for the VHA's transformation of its mental health services to veterans. However, throughout this section, the IBVSOs have expressed continued concern about the pace of implementation of the mental health clinical, education, and research programs. There are also significant gaps that need to be closed, especially in oversight of mental health programs and in the case management programs for OEF/OIF combat veterans. VA needs to fulfill its promises to treat mental illness with the same intensity as physical illness and to deliver on veterans' hope for recovery from mental illness.

The IBVSOs urge strong oversight by the Committees on Veterans' Affairs to ensure VA's mental health programs and the reforms we have outlined in this *Independent Budget* meet their promise—not only for those coming back from war now, but for those already here.

Recommendations:

Congress should provide oversight to ensure that VA maintains a full continuum of mental health-care services across the system and enhance its efforts for oversight of VA's mental health transformation and implementation of VA's National Mental Health Strategic Plan and Uniform Mental Health Services delivery initiative.

VA should appoint a task group to study and recommend a budget appropriate to support the UMHS. The task group should determine whether the Veterans Equitable Resource Allocation model will provide adequate funding for the full continuum of services mandated by the UMHS handbook and make recommendations for future funding of mental health services.

VA should provide frequent periodic reports that include a facility-level accounting of the use of mental health enhancement funds, as well as an accounting of overall mental health expenditures, to Congressional staff, veterans service organizations, and the Consumer Liaisons Council of the VA Advisory Committee on the Care of Veterans with Serious Mental Illness.

In keeping with the National Mental Health Strategic Plan, Medical Services funding to support the Mental Health Enhancement Initiative should be provided on a recurring "earmarked" basis, outside of the VERA system, until such time that VA is confident that the programs within the initiative are sustainable. At a minimum, *The Independent Budget* veterans service organizations believe a five-year period for such protection is necessary.

Given the urgency of ensuring the implementation of the UMHS package, consideration should be given to holding Congressional oversight hearings as soon as possible on the implementation strategy employed by the VA Central Office for this initiative. Congress should require VA to provide an assessment of resource requirements, as well as a completion date for full implementation of the UMHS package.

VA must increase access to veteran and family-centered mental health-care programs, including family therapy and marriage counseling. These programs should be available at all VA health-care facilities.

Veterans and family consumer councils should become routine standing committees at all VA medical centers. These councils should include the active participation of veteran health-care consumers, their families, and their representatives.

A task force, composed of experts from the Veterans Benefits Administration, Veterans Health Administration mental health staff, veterans service organizations, and disabled veterans, should be assembled to explore potential barriers and disincentives to mental health care and the VA disability compensation system.

VA and the Department of Defense should track and publicly report performance measures relevant to their mental health and substance use disorder programs. VA should focus intensive efforts to improve and increase early intervention and the prevention of substance abuse in the veteran population.

The VA Advisory Committee on the Care of Veterans with Serious Mental Illness should be redesignated as a secretarial-level committee on mental health, armed with independent reporting responsibility to Congress.

VA and the Department of Defense must ensure that veterans and service members receive adequate screening for mental health needs. When problems are identified with screening, providers should use nonstigmatizing approaches to enroll them in early treatment in order to mitigate the development of chronic illness and disability.

VA should invest in research on effective stigma reduction, readjustment, prevention, and treatment of acute post-traumatic stress disorder in combat veterans; increase its funding for evidence-based PTSD treatment programs; and conduct translational research on how best to disseminate this state-of-the-art care across the system. VA should conduct an assessment of the current availability of evidence-based care, including for PTSD, identify shortfalls by site of care, and calculate the resources necessary to provide universal access to evidence-based care.

VA should conduct an assessment of the current availability of evidence-based care for PTSD, identify shortfalls by site of care, and calculate the resources necessary to provide universal access to these specialized treatments.

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OEF/OIF ISSUES

The Challenge of Caring for Our Newest War Veterans

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

Since October 2001, approximately 1.8 million military service members have deployed to Afghanistan and Iraq in Operations Enduring and Iraqi Freedom (OEF/OIF). Many service members have participated in multiple deployments and been subjected to a number of serious threats, including mortar attacks, suicide bombs, and exposure to repeated blasts from improvised explosive devices (IEDs). Current studies indicate that multiple exposures to IED blasts and the stress of these deployments in general are exacting a toll on the fighting force, resulting in a variety of seemingly "invisible" wounds, including post-traumatic stress disorder (PTSD), major depression, and cognitive impairments as a result of milder forms of traumatic brain injury. Military medicine has advanced to unprecedented levels of excellence that have resulted in a 90 percent survival rate among wounded veterans.[52] However, within the DOD and VA health-care systems, gaps remain in the recognition, diagnosis, treatment, and rehabilitation of these less-visible injuries.

The DOD and VA share a unique obligation to meet the health-care and rehabilitative needs of veterans who have been wounded during military service or who may be suffering from postdeployment readjustment problems as a result of combat exposure. The DOD, VA, and Congress must remain vigilant to ensure that federal programs aimed at meeting the needs of the newest generation of combat veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older veterans who served and were injured in earlier military conflicts. Congress must also remain apprised of how VA spends the significant new funds that have been provided and earmarked specifically for the purpose of meeting postdeployment mental health and physical rehabilitation needs.

The Independent Budget veterans service organizations (IBVSOs) are grateful that VA has adopted the principles of the President's New Freedom Commission on Mental Health. The commission's ultimate goal is the eradication of the stigma that surrounds mental health challenges and the opportunity for full recovery for people facing those challenges. The commission's framework for achieving this important goal should be the guiding beacon for VA mental health planning, programming, budgeting, and clinical care for veterans of OEF/OIF service and of all military service periods. Optimal recovery is also the goal for those with severe physical injuries.

Invisible Wounds of War

The RAND Corporation Center for Military Health Policy Research recently completed a comprehensive study titled *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* RAND found that the effects of TBI are still poorly understood, leaving a gap in knowledge related to how extensive the problem is or how to handle it.[53] The study evaluated the prevalence of mental health and cognitive problems of OEF/OIF service members; the existing programs and services available to meet the health-care needs of this population; the gaps that exist in these programs and what steps need to be taken to improve these services; and the costs of treating or not treating these conditions.

The study found rates of PTSD, major depression, and probable TBI are relatively high when compared to the U.S. civilian population.[54] RAND estimated that approximately 300,000 of the 1.64 million OEF/OIF service members who had been deployed as of October 2007 suffer from PTSD or major depression, and that about 320,000 individuals experienced a probable TBI during deployment.[55] Additionally, about one-third of those previously deployed have at least one of those three conditions, and about 5 percent report symptoms of all three.

According to RAND, 57 percent of those reporting a probable TBI had *not* been evaluated by a physician for brain injury. About 53 percent of those who met the criteria for PTSD or major depression had sought help from

a physician or mental health provider in the past year.[56] It was noted, however, that even when individuals sought care, few received *quality* care—with only half having received what was considered minimally adequate treatment. A number of barriers to care were identified by survey participants as reasons for not getting treatment. RAND concluded there is a need for increased access to confidential, evidenced-based psychotherapy and that the prevalence of PTSD and major depression will likely remain high unless efforts are made to enhance systems of care for these conditions.[57]

Finally, the study evaluated the costs of these mental health and cognitive conditions to the individual and society. Suffering from these conditions can impair relationships, disrupt marriages, affect parenting, and cause problems in children of veterans.[58] RAND determined the estimated financial costs associated with mental health and cognitive conditions related to OEF/OIF service would be substantial ($4 billion to $6 billion over a two-year period for PTSD and major depression, and $591 million to $910 million for TBI within the first year of diagnosis).[59]

Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. However, DOD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of these powerful detonations and that signs and symptoms are often not readily recognized but can include chronic headache, irritability, behavioral disinhibition, sleep disorders, confusion, memory problems, and depression.

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

On July 12, 2006, the VA Office of the Inspector General (OIG) issued *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation.* The report found that better coordination of care between DOD and VA health-care services was needed to enable veterans to make a smooth transition. The OIG Office of Health Care Inspections conducted follow-on interviews to determine changes since the initial interviews conducted in 2006. The OIG concluded that three years after completion of initial inpatient rehabilitation, many veterans with TBI continue to have significant disabilities and, although case management has improved, it is not uniformly provided to these patients.[60]

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

Research is urgently needed to identify the most sensitive and specific screening tools for TBI: improved TBI classification and prognostic tools; effective prevention, neuroprotective agents, and treatment programs; and enhanced understanding of the natural history of multiple concussions. While VA and the DOD are investing heavily in research related to blast injury and mild TBI, the quality and outcome of this research is being negatively affected by lack of exposure data concerning the blast magnitude and the circumstance of the service member's injury. The DOD should declassify this information and make it available to federally funded researchers doing Institutional Review Board–approved studies.

Polytrauma System of Care

As a result of the conflicts in Afghanistan and Iraq, VA has coordinated the transfer of more than 6,800 OEF/OIF severely injured or ill active duty service members and veterans from DOD to VA care and services—many with multiple injuries, including TBI, amputations,

serious burns, spinal cord injury, and blindness.[61] VA's terminology for the care to veterans with multiple and serious injuries is "polytrauma" care. Veterans with injuries to more than one physical region or organ system generally require extensive rehabilitation and lifelong personal and clinical support, including neurological, medical, and psychiatric services, as well as physical, psychosocial, occupational, and vocational therapies. VA has four established polytrauma rehabilitation centers (PRCs) collocated with lead centers for TBI in Tampa; Richmond, Virginia; Palo Alto, California; and Minneapolis, and announced last year it will also provide specialized polytrauma care in San Antonio. In addition, each of VA's networks has established a lead center for follow-up care of polytrauma and TBI patients referred from the four lead centers or directly from military treatment facilities. The goal of the polytrauma rehabilitation centers is to offer a comprehensive, interdisciplinary approach to meeting the goals of an individualized treatment plan to return each injured veteran to optimal function. VA has not yet met its goal of comprehensive services at each PRC and should enhance the PRC programs to ensure that each center can provide at least care for spinal cord injury, amputation, and TBI, as well as blind rehabilitation and specialized mental health services for both men and women.

Just as other "special emphasis" rehabilitation programs (e.g., spinal cord injury, blind rehabilitation, and amputation care programs) have evolved their acute care programs for newly injured veterans into comprehensive programs that provide a full continuum of lifelong care and services, VA's polytrauma centers must likewise ensure that they offer a coordinated continuum of follow-up care, rehabilitation, respite, and long-term care to address the lifetime care needs of seriously injured veterans. The IBVSOs plan to carefully monitor the evolution of these special programs to ensure that they continue to meet the needs of this vulnerable population of veterans throughout their lifetimes.

Caregivers of Traumatically Injured Veterans

While a miraculous number of our veterans are surviving what surely would have been fatal wounds in earlier periods of warfare, some are grievously wounded and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal supports. Eventually most of these veterans will be able to return to their families, at least on a part-time basis, or be moved to an appropriate therapeutic residential setting, but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them substitute for the dramatic loss of physical, mental, and emotional capacities as a consequence of their injuries. Immediate families of newly and severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical and emotional problems of the severely injured veteran, deal with the complexities of the systems of care on which these veterans must rely—all while struggling with disruption of their family life, interruptions of personal goals and employment, and often the dissolution of other "normal" support systems most people take for granted.

The IBVSOs believe a strong case management system is necessary to ensure a smooth and transparent handoff of severely injured and ill veterans and their family caregivers between DOD and VA programs of care. This case management system should be held accountable to ensure uninterrupted support as these veterans and family caregivers return home and attempt to rebuild their lives. A severely injured veteran's spouse is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. Spouses must often give up their personal plans (resign from employment, withdraw from school, etc.) to care for, attend, and advocate for the veteran. They often fall victim to bureaucratic mishaps in the shifting responsibility for conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation), upon which they must rely for subsistence in absence of other personal means. For many younger, unmarried veterans who survive their injuries, their primary caregivers remain their parents, who have limited eligibility for military assistance and have virtually no current eligibility for VA benefits or services of any kind.

Research shows that family members suffer from a number of negative health consequences associated with the caregiver role. The 1996 National Caregiver Survey documented that caregivers report great impacts on employment, caregiver strain, mental and physical health problems, time for leisure and other family members, and family conflict. Family caregivers who provide 36 or more hours of care per week are more likely than noncaregivers to experience symptoms of depression or anxiety; for spouses the symptom rate is six times as high.[62] Studies also demonstrate that family caregivers report having a chronic health condition at more than twice the rate of noncaregivers.[63] In addition, studies indicate that when family caregivers experience extreme stress, they age prematurely and this level of stress can take as much as 10

years off a family caregiver's life.[64] This research suggests that VA and the DOD should do more to mitigate the health effects and provide care for the family caregivers of seriously injured veterans.

VA has limited authorization and capacity to provide mental health and relationship counseling services to family members—an important component of the rehabilitation process for veterans and their families. However, the IBVSOs have been informed by a few local VA officials that they are providing a significant amount of training, instruction, counseling, and other services to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the possible absence of legal authority to provide these services and that scarce resources are being diverted to these needs without recognition of their cost within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are penalizing themselves in doing so, but they clearly have recognized the urgency and validity of this need.

The IBVSOs believe Congress should authorize, and VA should provide, a full range of psychological counseling and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum this benefit should include relationship and marriage counseling, family counseling, training of family members in skills to care for and maximize the recovery of the seriously injured family member, and related assistance for the family coping with the stress and continuous burden of caring for a severely injured and permanently disabled veteran. Also, we believe VA should establish a new national program to make periodic respite services more readily available to all severely injured veterans and caregivers. The IBVSOs believe VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating physician to approve respite care in excess of 30 days, making more flexible the number of hours/days available for use, providing overnight and weekend respite care to veterans and their caregivers, and eliminating applicable long-term-care copayments. A separate section on caregivers, "Family and Caregiver Support Issues Affecting Severely Injured Veterans," discusses these complex issues in greater detail.

VA's Specialized PTSD Programs

Without question, the Veterans Health Administration (VHA) has the most comprehensive mental health program in the nation to treat veterans with readjustment problems stemming from military combat, including combat stress and acute and chronic PTSD. The VHA employs a cadre of highly skilled, dedicated clinicians and researchers who specialize in and are dedicated to helping veterans deal with the unique mental health challenges they face as they return to civilian life from a military combat deployment.

However, a recent analysis of current research on the effectiveness of treatment for PTSD conducted by the Institute of Medicine (IOM) underscores how much still needs to be done to ensure that all veterans with PTSD receive state-of-the-art treatment for this problem, which was a direct result of their military service. VA has led in researching the most efficacious interventions for severe PTSD, but as documented in the Institute of Medicine report, these effective approaches are complex, expensive, and time consuming. Intensive programs, such as those in the successful efficacy studies noted by the IOM, are not readily available to many veterans across the nation.[65] VA needs to immediately increase its funding for such programs, and to conduct more translational research on how to best disseminate this state-of-the-art care across the system. This translational research must include an analysis of the barriers to dissemination, including resources and structural barriers. Translation of effective treatment methods from research studies to ready availability across the system is a daunting task, but the need is now and early intervention is critical for the recovery and well-being of those who have served.

Stigma and Outreach

Currently no comprehensive data are collected from returned OEF/OIF veterans on their personal perceptions of barriers to care. However, one of the most serious hurdles OEF/OIF veterans face in getting mental health care is overcoming the stigma associated with mental health problems. More than 50 percent of soldiers and marines in Iraq who test positive for a mental health problem are concerned that they will be seen as weak by their fellow service members, and almost one in three of these troops worries about the effect of a mental health diagnosis on his or her career.[66] To help reduce stigma associated with seeking mental health services, the DOD should develop a screening tool to assess cognition, psychological functioning, and overall psychological readiness for every active duty service member, reservist, and guardsman as part of a routine annual primary care examination. VA has already adopted a screening tool that is part of its primary care preventive health assessment process. We con-

cur that in both settings trained mental health technicians should be accessible to interpret responses and mental health professionals should be immediately available to receive appropriate referrals.[67]

The DOD has acknowledged its need to incorporate some of the recommendations of its Task Force on Mental Health, including conducting appropriate screenings in private environments, identifying options for screening active duty, Reserve, and National Guard annually, and ensuring that its mental health assessment tools are valid and reliable. The IBVSOs will continue to monitor progress of this initiative.

The barriers to seeking mental health care are formidable; however, there is much that we do not currently know about these barriers. While VA's current patient satisfaction data provide some information on those who have successfully entered care, patient satisfaction data tell us little about those who were frustrated in their attempts to access services. VA should conduct comprehensive surveys of samples of all OEF/OIF veterans—not just those who have successfully accessed VA care—to identify barriers to care and formulate solutions to eliminate these barriers. Although VA has taken some steps to improve outreach to veterans, it must continue to proactively identify this population's unmet needs for postdeployment mental health services. In addition to making phone calls, sending letters, and conducting debriefings at demobilization sites following deployments, VA must initiate an aggressive outreach campaign to inform veterans and their families of risk factors for mental health problems post deployment and programs available to meet veterans' needs. The IBVSOs believe this should involve modernizing the VA website and developing listservs to communicate with veterans through email, electronic bulletin boards, sponsored chat rooms, and other innovative means of communicating to the ".com" generation, in addition to traditional methods, such as telephone calls and letters.

The DOD has recently instituted a number of anti-stigma measures and resiliency programs for active duty members. The IBVSOs applaud the courage of a high-ranking Army official, injured during his 2004 and 2005 tours in Iraq, who recently came forward to speak of his experiences. In so doing, he broke the military's code of silence in seeking psychiatric counseling for PTSD and then publically spoke out about it. In a recent interview he said that he is promoting open attitudes in both the Reserves and the National Guard "...to reduce the stigma associated with soldiers coming forward. We want them to come forward early, before problems are even greater."[68] The IBVSOs recognize the fortitude it took for him to do this and encourage other military leaders to follow his example. VA also needs to embrace this open attitude, treat mental health with the same seriousness that it treats physical health, and enhance its anti-stigma messages to veterans.

VA clinicians believe outreach efforts should emphasize that it is normal to have a psychological reaction to intense or repeated stress, that some people may need help in readjusting, and that it is good to seek such help. Media outreach campaigns in particular should attempt to normalize the process, and not overly stress mental health diagnoses or focus on pathology. The goal should be to get the veteran to seek immediate assistance, at which time further evaluations can be conducted if more severe problems are suspected. Such an outreach program must be viewed as a crucial early prevention effort, an effort to identify problems before they compound and exact a high social and economic price on the veteran, his or her family, and society. These efforts can only succeed if VA offers readily accessible services for the type of problems that are often the first sign of trouble, including marital and relationship counseling and interventions for hazardous use of alcohol and other drugs. Upgrading current prevention efforts and user-friendly access to early intervention services must be an immediate priority for VA.

Substance-Use Disorder Treatment

Another issue having an impact on newly returning service members, veterans, and their families is substance-use disorders. There are multiple consistent indications from both the DOD and VA that the misuse of alcohol and other substances will continue to be a significant problem for many OEF/OIF service members and veterans. An untreated substance-use disorder can result in a number of health consequences for the veteran and family, including a marked increase in health-care expenditures, additional stresses on families, social costs from loss of employment, and additional, avoidable costs to the legal system. We urge VA and the DOD to continue research into this critical area and to identify the best treatment strategies to address substance abuse and other mental health and readjustment issues collectively.

Over the past decade VA drastically reduced its substance-use treatment and related rehabilitation services; however, during the past year VA conducted an analysis of gaps in service for substance abuse care, and has begun to fund new programs, particularly intensive outpatient treatment programs, to fill critical gaps in access to care. This is an important first step in rebuilding VA substance abuse

treatment programming and ensuring equity of access across the system to these critical services. Because substance misuse is often the first symptom of even greater psychological problems to be evident to veterans and their families and employers, access for early intervention services will help ensure that problems are identified at an early stage and reduce the negative impact on veterans and their families. The IBVSOs urge VA to closely monitor the implementation phase of its newly approved Uniform Mental Health Services policy to ensure a full continuum of care for substance-use disorders and include additional screening in all its healthcare facilities and programs, especially in primary care. Congress must provide continued oversight to ensure these specialized programs are fully restored, readily accessible, and focused on meeting the unique needs of this population.

The IBVSOs are pleased that VA has developed a comprehensive strategy to address suicides and suicidal behavior in the veteran population, but we encourage Congress to provide oversight to ensure proper focus and attention are paid to this issue. It is clear that without proper screening, diagnosis, and treatment, postdeployment mental health problems can lead distressed individuals to attempt to take their own lives. VA must focus on delivering comprehensive, high-quality, timely mental health and substance-use disorder care to all appropriate veterans. Ready access to robust mental health and substance abuse treatment programs, which must include screening and early intervention, is the most critical component of any effective suicide prevention effort.

Specialized Readjustment Counseling Service

The Readjustment Counseling Service (RCS) currently provides counseling and readjustment services to veterans at 232 Vet Centers, located throughout the nation. Since their inception, Vet Centers have provided a recovery focus and an alternative to traditional access for mental health care that some veterans may be reluctant to seek in VA medical centers and clinics that used traditional medical models of care focused on symptom reduction. According to VA, the RCS will be expanding the number of Vet Centers to 271 by the end of 2009. Vet Centers provided more than 1.1 million visits to more than 167,000 unique combat veterans from all service eras in FY 2008, including more than 69,000 veterans that were seen through outreach efforts.

Since 2003, the Vet Centers have provided bereavement services to surviving family members of service members killed while serving on active duty. This successful new program has provided support to more than 2,100 family members of more than 1,400 fallen warriors, most of whom were killed in action in OEF/OIF. However, some of these family members may require treatment for depression or anxiety in response to their grief reactions, but there is no current legislative authority for the provision of such care. We urge VA to establish collaborative relationships with community providers for family members who do not qualify for TRICARE and needed mental health benefits.

The Vet Center program is the one of the few VA programs to address the veteran's needs within family and community. Families provide the "front line" of a support network for returning veterans, and spouses are often the first to identify readjustment issues and facilitate veterans' evaluation and treatment when concerns are identified. Repeated deployments, financial hardships, long absences from home, and the stresses of reintegration with family routines have put a tremendous strain on OEF/OIF veterans' marriages. The most recent survey, conducted of more than 3,000 soldiers while they were serving in Afghanistan and Iraq, indicates that by the midpoint of deployment, 30 percent were considering divorce.[69] We are pleased that Public Law 110-387 clarified VA's authority to provide marriage and family counseling and established a pilot program to assess the feasibility and advisability to provide readjustment and transition assistance to veterans and their families in cooperation with Vet Centers. We encourage VA to expand its support and counseling services for veterans and families, and we believe that optimally this expansion should occur in all major VA care sites.

Vet Center staff and VA mental health professionals in VA medical centers (VAMCs) should work to improve collaboration between their respective program services to ensure appropriate care coordination and quality care for veterans. The Vet Center and VAMC programs are synergistic, and there can be great benefit to veterans from increased coordination of services. In the near term, VAMCs should increase coordination with Vet Centers to obtain consultations for family counseling; increase distribution of outreach materials to family members with tips on resiliency; improve the reintegration process of returning combat veterans into their family, civilian job, and community; and provide information on identifying warning signs of readjustment problems, including suicidal ideation so veterans will more likely seek early help.

Work Life Rehabilitation Services

Veterans suffering from mental and substance-use disorders often experience disruptions in their work life. Comprehensive rehabilitation must include assistance in successfully reentering the workforce. This is needed not only by those eligible for rehabilitation services due to service-connected disabilities, but also for many other veterans seeking care. While some VA facilities offer comprehensive rehabilitation services for patients recovering from mental disorders, many do not. The goal of recovery/rehabilitation must be to return the veteran to a productive family, social, and work life. VA should carefully assess the availability of complete rehabilitation services across the system and take action to assure that all veterans have access to this critical portion of the rehabilitation process. This is especially important since OEF/OIF veterans today are returning to an economic environment that is unusually challenging.

Women Veterans

The numbers of women now serving in our military forces are unprecedented in U.S. history, and today women are playing extraordinary roles in the conflicts in Afghanistan and Iraq. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, and military police officers and serve in many military occupational specialties that expose them to the risk of combat, serious injury, and death. To date, more than 100 women have been killed in action, and women service members have suffered grievous injuries including multiple amputations. The current rate of enrollment of women in VA health care constitutes the second most dramatic growth of any subset of veterans. In fact VA projects the number of women veterans coming to the Department for health-care services is likely to double in two to four years. According to VA, since 2002, more than 42 percent of women who deployed in OEF/OIF and have since been discharged from military service have enrolled in VA health care.

As the population of women veterans undergoes exponential growth over the next decade, VA must act now to prepare to meet the specialized needs of the women who served. Overall, the culture of VA needs to be transformed to be more inclusive of women veterans and must adapt to the changing demographics of its women veteran users—taking into account their unique characteristics as young working women with child care and elder care responsibilities. VA needs to ensure that women veterans' health programs are enhanced so that access, quality, safety, and satisfaction with care are equal for women and men. A separate section on women veterans, "Women Veterans Health and Health-Care Programs," is included in this *Independent Budget* for further discussion on this issue.

Summary

Emerging evidence suggests that the health-care burden for OEF/OIF veterans will be heavy and that the current wars are presenting new challenges to the DOD and VA health-care systems. Utilization rates for health-care and mental health services presage an increasing requirement for such services in the future. The devastating effects of polytrauma, PTSD, TBI, blindness, limb loss, burns, sexual assault, and other postdeployment mental health injuries can lead to serious health catastrophes, including occupational and social disruption, personal distress, and even suicide if not treated. A stable, robust VA health-care system dedicated to the unique needs of the nation's veterans—one that is there now for aging veterans of World War II, Korea, and Vietnam, and that will remain viable for the newest generation of veterans who will need specialized medical and mental health care for decades to come—must be ensured. Congress must remain vigilant to ensure that research and treatment programs are authorized and sufficiently funded.

The DOD and VA have taken the first steps toward improving mental health services for active duty members and veterans of OEF/OIF. The IBVSOs do commend the DOD and VA for attempting to deal with the issue of suicide, stigma, and the barriers that prevent service members and veterans from seeking mental health services. Although we recognize and acknowledge both agencies' efforts, the DOD and VA are still far from meeting the mental health needs of OEF/OIF veterans and achieving the universal goal of "seamless transition."

The unprecedented challenges of the protracted war on terror, including increasing, frequent deployments by an all-volunteer force; the heavily utilization of reserve components; and unprecedented proportions of women service members in harm's way, demand swift and comprehensive change in how we deliver health-care services to veterans. This change must be fully informed by the targeted recipients of care and their representatives. The changing needs of veterans and their families must drive VA's ongoing efforts to modernize its services for veterans. This can only occur if veterans, family members, and their representatives are an integral part of an active feedback loop: recommending changes in current services and new services; evaluating the development and de-

ployment of these changes; and providing feedback on how best to adjust these services over time.

To accomplish this goal, a formalized, empowered oversight system with consumer representation is needed. A Secretary of Veterans Affairs–level oversight committee that includes experts from both within and outside of VA, consumers, and consumer advocates, such as veterans service organizations, is needed. The committee should be adequately staffed and empowered to conduct ongoing reviews of efforts to improve mental health services in VA and required to report periodically to Congress on its evaluations and recommendations. Constructive oversight and feedback will ensure that the finite resources available have the greatest impact on the recovery of veterans experiencing psychological aftermaths of their service to the country.

Meeting the challenges of delivery of mental health-care to our nation's veterans will require an unprecedented level of interagency cooperation. Nevertheless, the IBVSOs believe with proper resources, clearly defined goals, and determination to overcome stigma and other institutional, cultural, and social barriers, our government can fulfill its commitment to providing the best available health-care and rehabilitation services to service members and veterans with combat-related physical and mental health injuries.

Recommendations:

The Departments of Defense and Veterans Affairs must invest in research for individuals who suffer from postdeployment mental health challenges and traumatic brain injury, to close information gaps and plan more effectively. Both agencies should conduct more research into the consequences of TBI and develop best practices in its screening, diagnosis, and treatment.

VA should work more effectively with the DOD to establish a seamless transition of early intervention services to obtain effective treatments for war-related mental health problems, including substance-use disorders, in returning service members.

Congress should formally authorize, and VA should provide, a full range of psychological and social support services, including strong, effective case management, as an earned benefit to family caregivers of veterans with service-connected injuries or illnesses, especially for brain-injured veterans.

The VA system must continue to improve access to specialized services for veterans with mental illness, posttraumatic stress disorder, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.

VA should initiate surveys and other research to assess the variety of barriers to VA care for veterans of Operations Enduring and Iraqi Freedom, with special emphasis on reservists and guardsmen returning to veteran status after combat deployments, rural and remote veterans, and women veterans. These surveys should assess barriers among *all* OEF/OIF veterans—not only the subset who actually enroll or otherwise contact VA for health care or other services.

The DOD and VA must increase the number of providers who are trained and certified to deliver evidenced-based care for postcombat PTSD and major depression.

The DOD and VA should increase outreach efforts to include Internet options and amend current policies to encourage service members and veterans to seek the care they need without fear of stigma.

VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on women who have served in OEF/OIF.

The DOD and VA should align policies and procedures to maximize information sharing while protecting the privacy and confidentiality of service members' and veterans' health records.

The DOD should declassify information on military occupational exposures, especially those experienced during combat deployments. The DOD should immediately release data on blast events and injuries that could result in TBI.

The President and Congress should sufficiently fund DOD and VA health-care systems to ensure these systems *adapt* to meet the unique needs of the newest generation of combat service personnel and veterans and continue to address the needs of previous generations of veterans with PTSD and other combat-related postdeployment mental health challenges.

[52]Goldberg, M.S., "Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan," Congressional Budget Office testimony before the House Committee on Veterans Affairs, October 17, 2007 (www.cbo.gov/ftpdocs/87xx/doc8710/10-17-VA-Admin_Testimony.pdf).

[53]T. Tanielian and L. Jaycox, eds., Executive Summary, in *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corp., Center for Military Health Policy Research, 2008), p. xx.
[54]Ibid., p. xxi.
[55]Ibid.
[56]Ibid.
[57]Ibid., p. xxii.
[58]Ibid.
[59]Ibid., p. xxiii.
[60]DVA OIG, *Follow-up Health Care Inspection: Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans After Traumatic Brain Injury Rehabilitation,* Report No. 08-01023-119, May 1, 2008, p. 8.
[61]Daniel Cooper, VA Under Secretary for Benefits, "DOD and VA Disability Rating Systems and the Transition of Service Members from DOD to VA," testimony before the U.S. Senate, Committees on Veterans' Affairs and Armed Services, April 11, 2007.
[62]C. C. Cannuscio, C. Jones, et al., "Reverberation of Family Illness: A Longitudinal Assessment of Informal Caregiver and Mental Health Status in the Nurses' Health Study," *American Journal of Public Health* 92 (2002): 305–11.
[63]Department of Health and Human Services (DHHS), *Informal Caregiving: Compassion in Action* (Washington, DC: DHHS, 1998); (http://aspe.hhs.gov/daltcp/Reports/carebro2.pdf).
[64]Peter S. Arno, "Economic Value of Informal Caregiving" (paper presented at the DVA Care Coordination and Caregiving Forum, Bethesda, Maryland, January 25–27, 2006).
[65]Institute of Medicine, NIH,*Treatment of PTSD: An Assessment of the Evidence,* October 2007.
[66]Office of the Surgeon, Multi-National Force-Iraq; Office of the Command Surgeon; and Office of the Surgeon General; United States Army Medical Command; Mental Health Advisory Team IV Final Report; Operation Iraqi Freedom 05-07: Iraq; Operation Enduring Freedom 05-07: Afghanistan, November 17, 2006.
[67]Ibid.
[68]Rod Lamkey Jr., "Military Marches Toward Mental Health," *Washington Times,* December 2, 2008.
[69]Office of the Surgeon, Multi-National Force-Iraq; Office of the Command Surgeon; and Office of the Surgeon General; United States Army Medical Command, Mental Health Advisory Team V Final Report; Operation Iraqi Freedom 06-08: Iraq; Operation Enduring Freedom 8: Afghanistan, February 14, 2008.

ACCESS ISSUES

TIMELY ACCESS TO VA HEALTH CARE:

The Veterans Health Administration (VHA) needs to improve data systems that record and manage waiting lists for VA primary care and improve availability of some clinical programs to minimize unnecessary delay in scheduling specialty VA health care.

In 1996, Congress passed the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104-262, which changed eligibility requirements and the way health care was provided to veterans. As a result of this landmark legislation and a number of other factors, greater numbers of veterans chose to access the VA health-care system. The shift allowed VA to close thousands of unnecessary hospital beds while establishing new facilities called community-based outpatient clinics to provide greater numbers of veterans with more convenient access to care. VA outreach, through its Veterans Integrated Service Networks, encouraged veterans to enroll in a reformed VA health-care system. As a result, millions of veterans enrolled in VA health care for the first time in their lives. A decade later, VA health care has become a remarkable success story.

In 2002, VA placed a moratorium on its facilities' marketing and outreach activities to veterans and determined there was a need to give the most severely service-connected disabled veterans a special priority for care. This was necessitated by VA's realization that demand was seriously outpacing available funding and other resources and that service-connected veterans were being pushed aside rather than being VA's highest priority. At its zenith, in the summer of 2002, VA reported that 310,000 veterans were waiting at least six months for their first appointment for primary care. On January 17, 2003, the VA Secretary announced a "temporary" exclusion from enrollment of veterans whose income exceeded geographically determined thresholds and who were not enrolled before that date. This decision denied health-care access to 164,000 so-called "priority group 8" veterans in the first year alone. Since 2003, VA notes that more than 400,000 priority group 8 veterans had sought access to VA health care but were denied.

According to the Agency for Healthcare Research and Quality, access is a measure of patients' ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Access to medical care depends greatly on whether the VA health-care system has the capacity to meet the demand. The time to "third next available" appointment is the preferred measure of capacity and is used to determine how long patients have to wait for an appointment. The third appointment is featured be-

cause the first and second appointments may reflect openings created by patients canceling appointments, working patients into the schedule, or other events, and this does not accurately measure true accessibility.[70]

Several years ago, in an attempt to better manage patient access to care, VA began a process of reengineering its clinic patient flow through the "Advanced Clinic Access Initiative" developed by the Institute for Healthcare Improvement (IHI). The strategy emphasizes managing demand in order to improve patient flow and thus access to services. The core principle of Advanced Clinic Access is that patients calling to schedule a physician visit are offered an appointment the same day. Notably, Advanced Clinic Access is not sustainable if patient demand for appointments is permanently greater than physician capacity to offer appointments. Three key concepts supported by10 elements of advanced access are important in its application: shape the demand (work down the backlog, increasing system ability to reduce demand); match supply and demand (understand supply and demand, reduce appointment types, plan for contingencies); and redesign the system to increase supply (manage the constraint; optimize the care team; synchronize patient, provider, and information; predict and anticipate patient needs at time of appointment; and optimize rooms and equipment).

More specifically, the IHI principles identify "bottlenecks," such as limited clinical staff, care space, clerical staff, and equipment) in order to ensure that the process was optimally efficient. One important element of the IHI strategy is to allow patients to always see the same care provider. This allows a personal relationship to develop between the patient and provider, thus dispensing with the need to repeat medical background at each visit. The strategy apparently yielded good results in reducing waiting times; however, questions remain about the accuracy of data collected to confirm these reductions. Moreover, although these principles are powerful, they are counter to deeply held beliefs and established practices in health-care organizations. Accordingly, adopting these principles requires strong leadership investment and support.

To assess its success in reducing waiting times, the VHA used scheduling software developed in the 1970s, supplemented by electronic waiting lists. Initially, the VHA produced data for six monitored clinic stops nationwide (primary care, urology, cardiology, audiology, orthopedics, and ophthalmology) that demonstrated steady declines in waiting times. Today the Veterans Health Information Systems and Technology Architecture (VistA) collects waiting time data from 50 high-volume clinic stops throughout the system. Since FY 2002, the VHA has measured waiting times for primary and specialty care separately.

Over time, new functionality and enhancements were made to scheduling software.[71] The VHA maintains a number of reports to track and manage outpatient waiting times under three major categories: Missed Opportunities Report, which includes cancellations and no-shows; Completed Appointments Report; and the Electronic Waiting List Report. VA's FY 2007 Performance and Accountability Report[72] contains key performance measures to track its progress in accomplishing its overall mission. Under VA's third strategic goal, VA measures the percentage of primary and specialty care appointments scheduled within 30 days of a patient's desired date with a target of 96 and 95 percent, respectively.

However, the IHI recommends utilizing four outcomes measured in concert with Advanced Access: (1) third next available appointment; (2) future capacity (used for primary care only), the percentage of appointment slots that are open and available for booking patients over the next four weeks; (3) office visit cycle time, the amount of time in minutes that a patient spends at an office visit where the cycle begins at the time of arrival and ends when the patient leaves the office; and (4) percentage of no-show appointments. Of these four measures the VHA is measuring and reporting systemwide the percentage of no-show appointments through its "Missed Opportunities Report." Also, the VHA is tracking the third next available appointment but not publicly reporting it, which would foster consistency and allow performance comparison using external benchmarks.

There is a lot of truth to the old adage, "You can't improve what you can't measure." Furthermore, the quality of resulting data can influence the ability to improve. Unfortunately, the data the VHA utilizes to report to the public remain suspect as the Department has repeatedly failed to ensure that established protocols for scheduling appointments are followed. VA Office of Inspector General (OIG) reports in 2005, 2007, and 2008 found reported outpatient waiting times to be unreliable because of data integrity concerns associated with VHA's scheduling system. The September 2007 report "Audit of the Veterans Health Adminis-

tration's Outpatient Waiting Times" challenges VA's assertion that in FY 2006, 96 percent of all veterans seeking primary care and 95 percent of all veterans seeking specialty care were seen within 30 days of their desired appointment time. The VHA claimed even better results for FY 2007 and 2008: 97.2 and 98.7 percent of primary care, and 95 and 97.5 percent of specialty care patients, respectively, fall within the 30-day time frame.

The OIG is particularly concerned that the VHA has repeatedly failed to accurately document the "desired date"—the baseline of calculating a "waiting time"—for an appointment. The discrepancies found by the OIG between requested appointment times documented in medical records and in the databases, and incomplete waiting lists are attributed to patient preference or the scheduler's use of inappropriate scheduling procedures. This occurs despite the explicit policy prescribed by VHA Directive 2006-055 for schedulers to maintain documentation for every patient who requests a specific appointment date that is different than the date specified by the provider in the medical records. Specifically, the scheduler should annotate why the date was used in the "Other Info" section in the VistA scheduling package. This discrepancy of unsupported documentation to validate the "desired date" led the OIG to report that the VHA waiting times are significantly understated.

The VHA non-concurred with the 2007 findings due to disagreements with the OIG's methodology and consequently contracted with Booz Allen Hamilton in December 2007 to perform a thorough analysis and assessment of its scheduling and wait times reporting system. Its analysis revealed what was peripherally discussed during the December 12, 2007, joint hearing before the House Committee on Veterans' Affairs Subcommittee on Health and Oversight and Investigation on Outpatient Waiting Times. Specifically, due to VHA's archaic scheduling software and its cumbersome administration, Booz Allen Hamilton found VHA's measurement of outpatient care waiting times, "not sufficiently accurate for public reporting on systemwide performance."[73]

Since the first *Independent Budget* issue article in 2002, *The Independent Budget* veterans service organizations (IBVSOS) have consistently recommended that the VHA "identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide." Starting at its zenith in 2002 when more than 310,000 veterans were waiting six months or more for care,[74] to a high in January 2008 of 109,970 veterans waiting more than 30 days to be seen, the VHA's measurement system for outpatient waiting times has always lacked credibility.

The IBVSOs believe the VHA has made tremendous effort to significantly reduce waiting times over the last several years and is in the forefront by even attempting to measure clinical waiting times for such a vast healthcare enterprise, whereas most providers only use proxies, such as patient satisfaction or clinicians' estimates, to determine patient dissatisfaction and adverse clinical outcomes affecting quality of care. However, the VHA both developed its own measures and compared itself to no one else but itself, which weakens external perceptions regarding quality of care. Further, the IBVSOs and VA's OIG have raised questions about the validity of the VHA's reportable data, one of which concerns the metrics used that have been redefined over the years.

The IBVSOs believe VHA made a progressive step forward having contracted Booz Allen Hamilton to conduct an independent review of its scheduling process and metrics. The report made 52 strategic recommendations (including 9 regarding measurement) to improve the timeliness of care, supported by 78 action items that describe intermediate steps to achieve the goals articulated by the major recommendations. We disagree with some but agree with many of these recommendations. For example, we disagree with the report's recommendation for VA to discontinue the measurement of follow-up wait times for established patients citing the "desired date" of an appointment to be the main culprit (as indicated by VA's OIG reports) and aggravated by lack of compliance despite training efforts. Another reason for the recommendation is that "patient panels effectively match supply to demand, making delays less likely."

First and foremost, the OIG report highlighting weaknesses in VA data due to the ambiguity of the "desired date" included recommendations[75] that the VHA has yet to complete, which address, among other things, training, compliance, monitoring, and oversight of use of correct procedures. Regarding the basis for the recommendation about patient panel size meeting the demand, the IBVSOs believe if capacity indeed matches the demand, making delays less likely, the monthly average number of patients waiting longer than 30 days would not exceed 76,000. Moreover, as indicated

above, access is a measure of the patients' ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit, such as a routine follow-up.

The VHA has indicated it will eventually address all the recommendations of the Booz Allen Hamilton report. In the short-term, only 7 of the 52 strategic recommendations and 3 of the 72 action items will be implemented.[76] Notably, despite numerous questions raised regarding the validity of VHA's data, the report only makes nine major recommendations for modifying and improving the measurement and reporting of care timeliness. Further, of the seven strategic recommendations to be implemented by the VHA, only one will address the future measurement of the timeliness of care.

Equally disturbing is that despite the OIG's assertion that VA's data for calculating the percentage are suspect,[77,78] VA continues to report that there are no data limitations.[79] Compounding the issue further, two more key measures were added in FY 2008 that also use the same questionable data. Moreover, one of the new measures by design would depress actual waiting times by calculating only the longest wait time even if the patient has multiple appointments.[80]

The concern of the veteran community remains unmet, having identified such barriers as inadequate funding, unaddressed infrastructure capacity, limited human capital, poor communication with stakeholders and veteran patients, archaic technology, and unmanageable business processes. The IBVSOs believe timely access is the VHA health-care system's capacity to provide health care quickly after a need is recognized and is crucial to the quality of care delivered. Prevalent delays for appointments result in patient dissatisfaction, higher costs, and possible adverse clinical consequences.[81] As the Institute of Medicine identified "timeliness" as one of the six key "aims for improvement" in its major report on quality of health care,[82] we believe the VHA must take a more aggressive stance than currently to ensure veterans are receiving timely access to care. The VHA must make external comparisons to measuring its success because the perception of VHA's quality is important to its very existence.

Recommendations:

The Veterans Health Administration should make external comparisons to measuring its performance in providing timely access to care.

The VHA should fully implement complementary aspects of the Institute for Healthcare Improvement's Advanced Clinic Access principles and measures for primary and specialty care to maximize productivity of clinical care resources by identifying additional high-volume clinics that could benefit.

VA should consider implementing complementary recommendations contained in the Booz Allen Hamilton "Patient Scheduling and Waiting Times Measurement Improvement Study."

The VHA should certify the validity and quality of waiting time data from its 50 high-volume clinics to measure performance of networks and facilities.

The VHA should complete implementation of the eight recommendations for corrective action in the July 8, 2005, report by VA's Office of Inspector General.

VA must ensure that schedulers receive adequate annual training on scheduling policies and practices in accordance with the Inspector General's recommendations.

[70]Thomas Bodenheimer and Kevin Grumbach, *Improving Primary Care: Strategies and Tools for a Better Practice,* (New York: Lange Medical Books/McGraw Hill, 2006), p. 104.
[71]VHA Directive 2002-068, November 13, 2002; *Primary Care Management Module Unassign Inactive Patient Primary Care Providers, Release Notes,* December 2006; *Electronic Wait List for Scheduling and Primary Care Management Module User Manual,* November 2002 (revised October 2008).
[72]P.L. 103-62, *Government Performance and Results Act of 1993; P.L. 106-531, Reports Consolidation Act of 2000.*
[73]Executive Summary, *Final Report on the Patient Scheduling and Waiting Times Measurement Improvement Study* (Washington, DC: Booz Allen Hamilton, July 22, 2008).
[74]VHA survey conducted in July 2002. Senate Report 107-222, 107th Cong., 2nd Sess. (2002).
[75]DVA OIG Report No. 04-02887, July 8, 2005; DVA OIG Report No. 07-00616-199, September 10, 2007; and DVA OIG Report No. 07-03505-129, May 19, 2008.
[76]Strategic Recommendations A1, B1, C1, C2, C3, L1, M2; Action Items L1a, E1b, E1c.
[77]DVA OIG Report No. 07-00616-199, September 10, 2007.
[78]DVA OIG Report No. 07-03505-129, May 19, 2008.
[79]*FY 2007 Performance and Accountability Report,* p. 209; *FY 2008 Performance and Accountability Report,* Department of Veterans Affairs, p. 231.
[80]*FY 2008 Performance and Accountability Report,* Department of Veterans Affairs, pp. 230, 445.
[81]M. Murray and C. Tantau, "Must Patients Wait?" *Journal on Quality Service Improvement* 24(8) (1998): 423–25.
[82]Institute of Medicine, NIH, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academies Press, 2001).

COMMUNITY-BASED OUTPATIENT CLINICS:

While* The Independent Budget *veterans service organizations (IBVSOs) support VA-operated community-based outpatient clinics (CBOCs), if the Department of Veterans Affairs finds it necessary to contract for CBOC operations, these contracts should be consolidated at either the medical center or network level.

Veterans Health Administration (VHA) community-based outpatient clinics provide a VHA presence in the communities where veterans live. These free-standing clinics are an integral part of the host VA medical center (VAMC) of which they are a part, whether staffed by VA employees or those of a contractor. Since first authorized, CBOCs have expanded in number and in services offered. As of the third quarter of FY 2008, VA was operating 745 CBOCs with plans to establish 44 new ones in 21 states. Of that number, 353 CBOCs are doing real-time video conferencing (predominantly telemental health), while 130 CBOCs are performing teleretinal imaging, which greatly enhances patient care and drastically cuts down on patient travel. The IBVSOs applaud the VHA for improving veterans' access to quality care.

Although the IBVSOs applaud the VHA's intention to spread primary and limited specialty care access for veterans to more areas, enabling additional veterans access to a convenient VA primary care resource, we urge that the business plan guiding these decisions generally first emphasize the option of VA-operated and staffed facilities. When geographic or financial conditions warrant (e.g., rural, scarceness, remoteness, etc.), we do not oppose the award of contracts for CBOC operations or leased facilities, but we do not support the general notion that VA should rely heavily or primarily on contract CBOC providers to provide providing care to veterans.

While all CBOCs provide similar capabilities and services to veterans, each serves as an extension of a particular VA medical center. Therefore, each VAMC establishes its own clinical requirements for its CBOCs, based on the VAMC's capabilities and community-based needs.

Regarding the contracted CBOCs, this growth has been achieved primarily through separate solicitations and multiple contracts, often with different performance measures and pricing models within an individual catchment area. The result is a more complex, less efficient contract administration structure, creating extra work for already overburdened contracting officials and delivering an uneven benefit to those veterans who access those CBOCs for their primary care.

As the need for veterans' health-care access continues to grow, the ability to address those needs in an efficient, effective, and consistent manner also will grow. As many organizations, including VA, have already realized, consolidation of contracts at the medical center or network levels is one strategy that can create efficiencies and improve performance. Consolidating VA CBOC contracts would offer many benefits to both VA and the veterans its serves, offering VA a way to standardize the health-care benefits to veterans served by individual VAMCs and providing greater efficiencies and cost savings to help meet the ever-increasing health-care needs of veterans in both rural or underserved areas and areas not directly served by a VA medical facility.

Specific benefits of consolidated CBOC contracting include the following:

- *Greater continuity of care and uniformity of benefit*. Because a single contractor would operate these consolidated CBOCs, similar practices and procedures would be utilized at each CBOC and, in some cases, even the same providers. This consistent treatment would help to provide veterans with greater continuity of care and ensure all veterans served by a specific VAMC would receive the same health benefit options in all contracted CBOCs serving their VAMC.
- *Simplified contract administration and oversight*. Contracting officers spend much of their time dealing with multiple contracts and different points of contact for each contracted CBOC. Under a consolidated approach, VA would have a single contract and a single point of contact to handle all issues related to multiple (two to four) CBOCs in a defined area.
- *More efficient contracts*. A consolidated approach to CBOC contracting would minimize duplication of resources and services, driving contract efficiencies. Consolidation would enable the contractor to share appropriate resources across multiple CBOCs. For example, the contractor could use a regional registered nurse (RN) supervisor to provide oversight of each CBOC instead of having an

individual RN manager at each separate location, or the contractor could hire floating providers or staff to address surge or backfill requirements.
- *Easier access.* In times of heavy volume, the CBOC could move staff from one location to another to address the need most efficiently.
- *Consistent, uniform services.* Having a single contractor operate multiple CBOCs would result in consistent policies and procedures at each location, which can conform to the policies and procedures of VA-run CBOCs within the same VAMC.
- *Procurement efficiencies.* Many Veterans Integrated Service Networks have well more than 20 CBOCs, which translates to several under each VAMC. In most cases, there is a separate procurement and contract for each CBOC. This process limits the opportunity to benefit from efficiencies from both an operations and a contracting perspective. Depending on the number of CBOCs associated with a VAMC, significant efficiencies would be realized by combining these procurements into a single request for proposals.
- *Consolidated training on VA programs and procedures, including use of Veterans Health Information Systems and Technology Architecture (VistA).* Under a consolidated model, post-award training and such tasks as VistA training could be completed for all sites in one catchment area on a single day, rather than VA having to conduct separate training sessions for each new CBOC.
- *Standardized CBOC reporting.* Reporting requests, both from VA and the contractor, could be standardized for the region, making it easier for VA to review the reports and to track performance at each CBOC.
- *Mental health providers.* By using a consolidated model, each CBOC could have a licensed clinical social worker, with a regional psychiatrist who travels from CBOC to CBOC for oversight and pharmaceutical prescribing. Using one psychiatrist would offer consistency to the mental health model for each VA medical center.

Additionally, VA still needs to increase access to care in underserved geographic areas. With ever-growing demand for health-care services in rural areas, particularly as the result of the redeployment of so many National Guard and Reserve service members, CBOCs will have to be a critical component to VA's meeting this demand. VA can also further explore sharing initiatives with Department of Defense health-care facilities and coordinating services with other health-care providers.

The IBVSOs also remain concerned that many CBOCs do not comply with Section 504 of the Rehabilitation Act, regarding physical accessibility to medical clinics. This is a common complaint among veterans who receive their care in VA CBOCs. In some cases, severely disabled veterans are completely unable to access basic services in the CBOCs because of this problem. VA needs to take more active steps to overcome this barrier to access, both in its own CBOCs and in those for which VA contracts.

Recommendations:

The Veterans Health Administration should consider consolidating contracted community-based outpatient clinics at the VA medical center or network levels. This would ensure consistent requirements, pricing, and performance measurements, along with simplified contract administration. Aggregating CBOC contracting would allow VAMCs and the VHA to derive increased efficiencies within the CBOC program while simultaneously furthering VHA efforts to ensure clinical excellence in contracted CBOCs. Moreover, this approach would deliver a number of benefits to veterans including enhanced access, greater continuity of care, and a more standardized primary care benefit.

The VHA must ensure that CBOCs are staffed by clinically appropriate providers capable of meeting the needs of veterans.

The VHA must develop and use clinically specific referral protocols to guide patient management in cases in which a patient's condition calls for expertise or equipment not available at the facility at which the need is recognized.

The VHA must ensure that all CBOCs fully meet the accessibility standards set forth in Section 504 of the Rehabilitation Act.

VETERANS' RURAL HEALTH CARE:

The Department of Veterans Affairs should continue to improve access to VA health-care services for veterans living in rural areas, without diminishing existing internal VA health-care capacities to provide specialized services.

The Independent Budget veteran service organizations (IBVSOs) believe that after serving their country veterans should not experience neglect of their health-care needs by VA because they live in rural and remote areas far from major VA health-care facilities. In the previous year's *Independent Budget,* we detailed pertinent findings dealing with rural health care, disparities in health, rural veterans in general, and the circumstances of newly returning rural service members from Operations Enduring and Iraqi Freedom (OEF/OIF). Those conditions remain relatively unchanged:

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and concerns for stress, depression, suicide, and anxiety disorders as major rural health concerns.[83]
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas.[84] The smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services.[85]
- Nearly 22 percent of our elderly live in rural areas; rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the acute care and long-term-care systems. In rural areas some 7.3 million people need long-term-care services, accounting for one in five of those who need long-term care.[86]

Given these general conditions of scarcity of resources it is not surprising or unusual, with respect to those serving in the U.S. military and to veterans, that—

- There are disparities and differences in health status between rural and urban veterans. According to the VA's Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans "have worse physical and mental health related to quality of life scores. Rural/Urban differences within some VISNs [Veterans Integrated Service Networks] and U.S. Census regions are substantial."
- More than 44 percent of military recruits, and those serving in Iraq and Afghanistan, come from rural areas.
- More than 44,000 service members have been evacuated from Iraq and Afghanistan as a result of wounds, injuries, or illness, and tens of thousands have reported readjustment or mental health challenges following deployment.
- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.
- Among all VA health-care users, 40.1 percent (nearly 2 million) reside in rural areas, including 79,500 from "highly rural" areas as defined by VA.

Currently VA operates 153 hospitals and more than 750 community-based outpatient clinics (CBOCs). In June 2008, VA announced plans to activate 44 additional CBOCs during FY 2009. VA staffs 540 clinics, and the remainder of these CBOCs are managed by contractors. At least 333 of VA's CBOCs are located in rural or highly rural areas as defined by VA. In addition, VA is expanding its capability to serve rural veterans by establishing rural outreach clinics. Currently 12 VA outreach clinics are operational, and more are planned.

In August 2008, VA announced the establishment of three "Rural Health Resource Centers" for the purpose of improving understanding of rural veterans' health issues; identifying their disparities in health care; formulating practices or programs to enhance the delivery of care; and developing special practices and products for implementation VA systemwide. According to VA these centers will serve as satellite offices for VA's Office of Rural Health. They are sited in VA medical centers in White River Junction, Vermont; Iowa City, Iowa; and Salt Lake City.

In the FY 2009 appropriations act, Congress provided VA additional funding to increase the beneficiary travel mileage reimbursement allowance authorized under section 111 of title 38, United States Code, and intended to benefit certain service-connected and poor veterans as an access aid to VA health care. VA recently announced it has issued this higher rate, at 41.5 cents per mile. While we

appreciate this development and applaud both Congress and the VA for raising the rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by private conveyance, and provides only limited relief to those who have no choice but to travel long distances by automobile for VA health care.

The IBVSOs understand that VA's intended strategic direction in rural care is of necessity to enhance noninstitutional care solutions. VA provides home-based primary care as well as other home-based programs and is using telemedicine and telemental health—but on a limited basis in our judgment—to reach into veterans' homes and community clinics, including Native American tribal clinics. Expansion of telehealth would allow VA to directly evaluate and follow veterans without their needing to personally travel great distances to VA medical centers. VA has reported it has also begun to use a special Internet site providing information to veterans in their own homes, including up-to-date research information, access to their health records, and online ability to refill prescription medication. The IBVSOs believe that the use of technology, including the World Wide Web, telecommunications, and telemetry, offer VA a great but still unfulfilled opportunity to improve rural veterans' access to VA care and services. We urge VA management, through the VISNs, the Office of Patient Care Services, the Office of Rural Health (ORH), and other appropriate entities, to pursue additional ways of using technology to reach and care for rural veterans.

As described by VA, the mission of the ORH is to develop policies and identify and disseminate best practices and innovations to improve health-care services to veterans who reside in rural areas. VA maintains that the office is accomplishing this by coordinating delivery of current services to ensure the needs of rural veterans are being considered. VA also attests that the ORH will conduct, coordinate, promote, and disseminate research on issues important to improving health care for rural veterans. With confirmation of these stated commitments and goals the IBVSOs believe the Veterans Health Administration (VHA) would be beginning to incorporate the unique needs of rural veterans as new VA health-care programs are conceived and implemented; however, the ORH is a relatively new function within the VA Central Office (VACO), and it is only at the threshold of tangible effectiveness, with many challenges remaining. Given the lofty goals, we are concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning rather than closer to the operational arm of the VA system. Having to traverse the multiple layers of the VHA's bureaucratic structure could frustrate, delay, or even cancel initiatives established by this staff office. Rural veterans' interests would be better served if the ORH were elevated to a more appropriate management level in VACO, with staff augmentation commensurate with these stated goals and plans.

The VHA has established VA rural care designees in all its VISNs to serve as points of contact and liaisons with the ORH. While the IBVSOs appreciate that the VHA designated the liaison positions within the VISNs, we remain concerned that they serve these purposes only on a part-time basis, along with other duties as assigned. We believe rural veterans' needs, particularly those of the newest war veteran generation, are sufficiently crucial and challenging to deserve full-time attention and tailored programs. Therefore, in consideration of other recommendations dealing with rural veterans' needs put forward in this *Independent Budget*, we urge VA to establish at least one full-time rural liaison position in each VISN and more if appropriate, with the exception of VISN 3 (urban New York City).

Without question, section 213 of Public Law 109-461 could be a significant element in meeting the health-care needs of veterans living in rural areas, especially those who have served in Afghanistan and Iraq. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. In that connection, VA is required to collaborate with employers, state agencies, community health centers, rural health clinics, Critical Access Hospitals (as designated by Medicare), and local units of the National Guard to ensure that returning veterans and Guard/Reserve members, after completing their deployments, can have ready access to the VA health benefits they have earned by that service. Given this mandate is more than two years old, the IBVSOs urge VA's Office of Intergovernmental Affairs to move forward aggressively on this outreach effort—and that any outreach under this authorization be closely coordinated with VA's ORH to avoid duplication and to maintain consonance with VA's overall policy on rural health care. To be fully responsive to this mandate, VA should report to Congress the degree of its success in conducting effective outreach and the result of its efforts in public-private and intergovernmental coordination to help rural veterans.

Stimulated by concerns about the health status of OEF/OIF veterans, several legislative proposals were introduced during the 110th Congress to provide rural veterans more access to VA-sponsored care, but exclusively through private providers. One such proposal, an

amended form of H.R. 1527, was enacted as a demonstration project in Public Law 110-387, the Veterans' Mental Health and Other Care Improvements Act of 2008. The act directs the Secretary of Veterans Affairs to conduct a three-year pilot program under which a highly rural veteran who is enrolled in the system of patient enrollment of the Department of Veterans Affairs and who resides within a designated area of a participating VISN may elect to receive covered health services through a non-VA health-care provider at VA expense. The act defines a "highly rural veteran" as one who (1) resides more than 60 miles from the nearest VA facility providing primary care services, more than 120 miles from a VA facility providing acute hospital care, or more than 240 miles from a VA facility providing tertiary care (depending on which services a veteran needs); or (2) otherwise experiences such hardships or other difficulties in travel to the nearest appropriate VA facility that such travel is not in the best interest of the veteran. During the three-year demonstration period the act requires an annual program assessment report by the Secretary to the Committees on Veterans' Affairs, to include recommendations for continuing the program.

While we applaud the sponsors' intentions, measures such as this one could result in unintended consequences for VA, unless carefully administered. Chief among these is the diminution of established quality, safety, and continuity of VA care for rural and highly rural veterans. It is important to note that VA's specialized health-care programs, authorized by Congress and designed expressly to meet the specialized needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably impacted by the loss of veterans from those programs. Also, the VA's medical and prosthetic research program, designed to study and, hopefully, cure the ills of injury and disease consequent to military service, could lose focus and purpose were service-connected and other enrolled veterans no longer physically present in VA health care. Additionally, title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when Public Law 104-262 was enacted in 1996. Unfortunately some of that capacity has dwindled.

We believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with sophisticated health problems such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health-care programs may only exacerbate the problems currently encountered.

In light of the escalating costs of health care in the private sector, to its credit VA has done a remarkable job of holding down costs by effectively managing in-house health programs and services for veterans. While some service-connected veterans might seek care in the private sector as a matter of personal convenience as a result of enactment of vouchering and privatization bills, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic health record, and bar code medication administration. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, ones that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

As stated elsewhere in this *Independent Budget,* in general, current law places limits on VA's ability to contract for private health-care services in instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract to obtain the services of scarce medical specialists in VA facilities. Beyond these limits, there is no general authority in the law (with the exception of the new demonstration project described above) to support broad-based contracting for the care of populations of veterans, whether rural or urban.

The IBVSOs urge Congress and the VA ORH to closely monitor and oversee the development of the new rural pilot demonstration project from Public Law 110-387, especially to protect against any erosion or diminution of VA's specialized medical programs and to ensure participating rural and highly rural veterans receive health-care quality that is comparable to that available within the VA health-care system. Especially we ask VA in implementing this demonstration project to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state or other federal

agencies) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care. To the greatest extent practicable, VA should coordinate these demonstrations and pilots with interested health professions' academic affiliates. We recommend the principles of our recommendations from the "Contract Care Coordination" section of this *Independent Budget* be used to guide VA's approaches in this demonstration and that it be closely monitored by VA's Rural Veterans Advisory Committee. Further, we believe the ORH should be designated the overall coordinator of this demonstration project, in collaboration with other pertinent VHA offices and local rural liaison staff in VHA's rural VISNs selected for this demonstration.

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the IBSVOs believe that these veterans, too, should have access to specialized services offered at VA's Vet Centers. Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers present the primary access points to VA programs and benefits for nearly 25 percent of veterans who receive care at the centers. This core group of veteran users primarily receives readjustment and psychological counseling related to their military experiences. Building on the strength of the Vet Centers program, VA should establish a pilot program for mobile Vet Centers that could help reach veterans in rural and highly rural areas where there is no other VA presence.

Health workforce shortages and recruitment and retention of health-care personnel are a key challenge to rural veterans' access to VA care and to the quality of that care. *The Future of Rural Health* report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health-care professionals working in rural areas. To this end, VA's deeper involvement in education in the health professions for future rural clinical providers seems appropriate in improving these situations in rural VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health sciences students from 1,000 schools, including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners, receive training in VA facilities. These relationships of VA facilities to health profession schools should be put to work in aiding rural VA facilities with their health personnel needs. The VHA Office of Academic Affiliations, in conjunction with ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

VA should examine and establish creative ways to collaborate with ongoing efforts by other agencies to address the needs of health care for rural veterans. VA has executed agreements with the Department of Health and Human Services (HHS), including the Indian Health Service and the HHS Office of Rural Health Policy, to collaborate in the delivery of health care in rural communities, but we believe there are numerous other opportunities for collaboration with Native American tribal organizations, state public health agencies and facilities, and some private practitioners as well, to enhance access to services for veterans. The ORH should pursue these collaborations and coordinate VA's role in participating in them.

The Independent Budget for FY 2009 expressed the concern that rural veterans, veterans service organizations, and other experts needed a seat at the table to help VA consider important program and policy decisions such as those described here, ones that would have positive effects on veterans who live in rural areas. The IBVSOs were disappointed that Public Law 109-461 failed to include authorization of a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans service organizations, and other rural health experts to recommend policies to meet the challenges of veterans' rural health care. Therefore, we applaud the Secretary of Veterans Affairs for having responded to the recommendation in the FY 2009 *Independent Budget* to use VA's existing authority to establish such a committee. That new federal advisory committee has been formed and has held its initial meeting. We hold high expectations that the new Rural Veterans Advisory Committee will be a strong voice of support for many of the ideas we have expressed here, in testimony before Congress, and in previous *Independent Budgets*.

The IBVSOs believe VA is working in good faith to address its shortcomings in rural areas but still faces major challenges. In the long term its methods and plans offer rural and highly rural veterans potentially the best opportunity to obtain quality care to meet their specialized

health-care needs. However, we vigorously disagree with proposals to privatize, voucher, and contract out VA health care for rural veterans on a broad scale because such a development would be destructive to the integrity of the VA system, a system of immense value to veterans and to the IBVSOs. Thus, we remain concerned about VA's new statutory mandate to privatize services in selected rural VISNs and will closely monitor those developments.

Recommendations:

VA must ensure that the distance veterans travel, as well as other hardships they face, be considered in VA' s policies in determining the appropriate location and setting for providing direct VA health-care services.

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans.

The Office of Rural Health should seek and coordinate the implementation of novel methods and means of communication, including use of the World Wide Web and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health-care facilities, providers, technologies, and therapies, including greater access to their personal health records, prescription medications, and primary and specialty appointments.

The ORH should be organizationally elevated in VA's Central Office and be provided staff augmentation commensurate with its responsibilities and goals.

The Veterans Health Administration should establish at least one full-time rural liaison position in each Veterans Integrated Service Network, and more if appropriate, with the exception of VISN 3 (urban New York City).

In cognizance of section 213 of Public Law 109-461, VA should be required to report to Congress the degree of its success in conducting effective outreach and the results of its efforts in public-private and intergovernmental coordination to help rural veterans.

VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 be closely coordinated with the ORH.

Additional mobile Vet Centers should be established to provide outreach and counseling for veterans in rural and highly rural areas.

Through its affiliations with schools of the health professions, VA should develop a policy to help supply health profession clinical personnel to rural VA facilities and practitioners to rural areas in general. The VHA Office of Academic Affiliations, in conjunction with the ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

Recognizing that in areas of particularly sparse veteran population and absence of VA facilities, the VA ORH should sponsor and establish demonstration projects with available providers of mental health and other health-care services for enrolled veterans, taking care to observe and protect VA's role as coordinator of care. The projects should be reviewed and guided by the Rural Veterans Advisory Committee. Funding should be made available to the ORH to conduct these demonstration and pilot projects outside of the Veterans Equitable Resource Allocation system, and VA should report the results of these projects to the Committees on Veterans' Affairs.

At highly rural VA community-based outpatient clinics, VA should establish a staff function of rural outreach worker to collaborate with rural and frontier non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available or VA-authorized care by other agencies.

Rural outreach workers in VA's rural CBOCs should receive funding and authority to enable them to purchase and provide transportation vouchers and other mechanisms to promote rural veterans' access to VA health-care facilities that are distant to their rural residences. This transportaion program should be inaugurated as a pilot program in a small number of facilities. If successful as an effective access tool for rural and highly rural veterans who need access to VA care and services, it should be expanded.

[83]L. Gamm, L. Hutchison, et al., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010,* vol. 2 (College Station, Texas: Texas A&M University System health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003).
[84]President's New Freedom Commission on Mental Health, "Achieving the Promise: Transforming Mental Health Care in America," July 2003 (www.mentalhealthcommission.gov/reports/FinalReport/downloads/downloads.html).
[85]Institute of Medicine, NIH, Committee on the Future of Rural Health Care, *Quality Through Collaboration: The Future of Rural Health* (Washington, DC: the National Academies Press, 2005).
[86]L. Gamm, L. Hutchison, et al., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010,* vol. 3. (College Station, Texas: Texas A&M University System, Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003).

VA's New Health-Care Facility Leasing Program:

The Independent Budget *veterans service organizations remain skeptical of the VA's intentions with regard to the proposed Health Care Center Facility Leasing Program because it could have significant long-term negative impacts on the provision of health care to veterans.*

In the spring of 2008, VA announced a new Health Care Center Facility (HCCF) leasing initiative to obviate the need for major construction of new and replacement facilities. The rationale for the HCCF initiative is that it reflects changes in medical care from an inpatient model to an outpatient model. Additionally, VA admitted to the existing and growing backlog of unmet construction requirements that are the result of past years' underfunding for improvements and replacements of VA health-care facilities. This initiative has caused deep concern within the veterans' community and is viewed as a major step in moving VA from being a health-care provider to a purchaser of medical care for veterans.

The initial project targeted by the HCCF initiative is the replacement hospital slated for construction in Veterans Integrated Service Network (VISN) 19 at Denver. This project, identified as a priority under the Capital Asset Realignment for Enhanced Services (CARES) plan, was in its design phase when abruptly halted in early 2008, and an entirely new plan was unveiled in April. The new plan called for the construction of a greatly expanded ambulatory care center and the leasing of inpatient beds from the University of Colorado Medical Hospital located on the former Fitzsimmons Army Medical Center campus. The proposal was put forth without adequate notification of either Congress or the local veterans' community and was met with strong opposition.

Subsequent inquiries as to the origins and reasons for the revised approach by both members of Congress and the veterans' community have resulted in unsatisfactory responses. Assurances that all stakeholders will be involved have yet to be fulfilled, leading to continued uncertainty and deep concern for the future direction of the VA health-care system. VA has revealed that an additional 22 locations were considered for the application of leasing rather than construction to maintain needed infrastructure.

Specific issues continue to remain unresolved to the satisfaction of veterans, among them: What priority will veterans have in access to care in leased facilties? How will lines of authority be maintained from the Under Secretary of Health through non-VA health-care providers and management? What procedures are in place for the maintenance of privacy and confidentiality of electronic medical records? How will VA guidance specified in directives and handbooks be implemented, ensuring continuity throughout the health-care system? The status of current VA employees in locations that may be shifted to leased facilities also remains unresolved.

The announced HCCF initiative is viewed with skepticism and concern because it appears to replace the established CARES program that was the result of years of consideration and study in addressing the future facility needs of the VA health-care system. The failure of VA to be transparent in developing this future direction for the health-care system can only lead to additional delays in needed infrastructure replacement and modernization.

Recommendations:

Congress must exercise its oversight authority in determining the rationale for the departure from the Capital Asset Realignment for Enhanced Services and the implementation of the Health Care Center Facility initiative.

Congress must continue to adequately fund needed VA construction projects and work to eliminate the existing backlog of projects that are the result of previous years' underfunding.

VA must establish a more transparent and open system that involves all stakeholders in addressing future construction initiatives.

Waiver of Health-Care Copayments and Fees for Catastrophically Disabled Veterans:

Veterans in priority group 4 should not be subject to copayments.

In the current VA health-care system, priority group 4 includes veterans who have been catastrophically disabled from nonservice-connected causes and who have incomes above means-tested levels. Catastrophically disabled veterans were granted this heightened priority for VA health-care eligibility in recognition of the unique nature of their circumstances and need for complex, specialized health care. The higher priority 4 enrollment category also protects these veterans from being denied access to the system should VA health-care resources be curtailed and they, under usual circumstances, be considered to be in the lower priority group 8 or priority group 7.

The addition of nonservice-connected catastrophically disabled veterans to priority group 4 was in recognition of the distinct needs of these veterans and the VA's vital role in providing their care. However, access to VA services is only part of the answer to providing quality health care to catastrophically disabled veterans. Exempting these veterans from all health-care copayments and fees completes this quality health-care equation. Current VA regulation stipulates that catastrophically disabled veterans are to be considered priority 4, for the purpose of enrollment, because of their specialized needs; however, they still have to pay all health-care fees and copayments as though they were still in the lower eligibility category.

Catastrophically disabled veterans are not casual users of VA health-care services; they require a great deal of care and a lifetime of services because of the nature of their disabilities. Private insurers do not offer the kind of sustaining care for spinal cord injuries found in the VA system even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. In most instances, VA is the only, as well as the best, resource for a veteran with a catastrophic disability; yet these veterans, supposedly placed in a priority enrollment category, have to pay fees and copayments for every service they receive as though they had no priority at all. This creates great financial hardship on the catastrophically disabled veterans who need to use far more VA health-care services to a far greater extent than the average VA health-care user. The catastrophically disabled most often fall within lower income brackets among veterans, while incurring the highest annual health-care costs. In many instances, fees for medical services equipment and supplies can climb to thousands of dollars per year.

The hardship endured by a catastrophic injury or disease is unique and devastating to the veteran and the family who may be responsible for his or her care. At a time when the veteran is in need of specialized assistance to regain some independence and quality of life, the financial burden of medical bills should be lifted. Any veteran determined by VA to be catastrophically disabled and therefore placed in priority group 4 should be afforded Aid and Attendance benefits to eliminate medical/prescription copayments and should be provided assistance with travel for his or her care.

Financial Income Thresholds for VA Health Care
Financial Test Year 2008

Veteran with:	Free VA prescription and travel benefits	Free VA health care: 0% and nonservice-connected	Medical expense deductible: 5% of maximum allowed pension rate from previous year
0 dependents	$ 11,180	$ 28,429	$ 559
1 dependent	$ 14,642	$ 34,117	$ 732
2 dependents	$ 16,551	$ 36,026	$ 828
3 dependents	$ 18,460	$ 37,935	$ 923
4 dependents	$ 20,369	$ 39,844	$1,019
For each additional, add	$ 1,909	$ 1,909	5% max. allowable pension rate
Medicare deductible	$ 1,024	Income & Asset (I&A) net worth: $80,000	I&A net worth: $80,000

The need for this policy change was recognized in 2008 with the introduction of H.R. 6445, the Veterans' Health Care Policy Enhancement Act of 2008, a bill that would have prohibited the collection of copayments and other fees from catastrophically disabled veterans. This legislation even had the support of the Department of Veterans Affairs. However, while the House of Representatives overwhelmingly approved the measure, the Senate failed to act, leaving these veterans to continue to bear this financial burden.

It is certainly a tribute to these individuals to have sought gainful employment to support themselves and their families despite the nature of their catastrophic disabilities. Far too often veterans with such disabilities give up opportunities to lead productive lives, falling back on low-income veterans' pensions and other federal and state support systems. In so doing, they fall within the complete definition of priority group 4 health-care enrollment and are exempt from all fees and copayments. Yet, because of a veteran's ambition and employment, which brings annual income above means-test levels, he or she is unduly penalized by exorbitant fees (see table previous page). The current VA regulation that requires catastrophically disabled veterans to pay all health-care fees and copayments does little to reward or provide an incentive for these veterans to maintain employment and a productive life.

NOTE: VA health-care debates and arguments for health-care rationing decisions consistently refer to veterans above the means-test threshold levels as "high-income" veterans. *The Independent Budget* veterans service organizations believe it is important to recognize that even though some veterans have incomes above means-test levels many of these veterans should certainly not be considered as "high-income" individuals.

Recommendation:

Veterans designated by VA as being catastrophically disabled veterans for the purpose of enrollment in health-care eligibility priority group 4 should be exempt from all health-care copayments and fees.

NON-VA EMERGENCY SERVICES:

Enrolled veterans are being denied reimbursement for non-VA emergency medical services as a result of restrictive eligibility requirements.

Recently enacted legislation[87] amended sections 1725 and 1728 of title 38, United States Code, which now requires the Department of Veterans Affairs to reimburse for emergency treatment of VA patients outside VA facilities when these veterans believe a delay in seeking care will seriously jeopardize their lives or health. In addition, VA's definition of "emergency treatment" under both statutes now conforms to a term commonly known as the "prudent layperson" standard, which has been widely used in the health-care industry.

This long overdue change is intended to reverse VA's current practice of denying payment for emergency care to the veteran or emergency care provider based on the "prudence" in seeking emergency care. Oftentimes the diagnosis at discharge rather than the admitting diagnosis is used by VA to judge whether the emergency treatment provided to the veteran meets the "prudent layperson" standard.

Intended to complete a VA health-care benefits package comparable to that of many managed-care plans, Congress initially directed this benefit at "regular users" of VA facilities: Veterans who were enrolled, had used some kind of VA care within the past two years, and had no other claim to coverage for such care. Congress intended, after the veteran has been stabilized, VA to follow up with these veterans and transfer them to the nearest VA medical facility for any necessary care following episodes of emergency care.

Many veterans have filed claims for reimbursement of emergency treatment and for the post-stabilization care that is often necessary in the wake of medical emergencies. However, the strict conditions of eligibility for reimbursement have prohibited VA from paying many veterans who file claims. Moreover, *The Independent Budget* veterans service organizations (IBVSOs) understand that there have also been significant delays in VA's reimbursement of approved claims. Delayed reimbursements can damage veterans' credit—by definition of the eligibility criteria,[88] the veteran is liable for these costs—with no means of redress. The IBVSOs believe all enrolled veterans should qualify for reimbursement for non-VA emergency care when necessary without the caveat of having been seen at VA facilities within the past 24 months.

Recommendations:

Congress should eliminate the requirement for veterans to have used VA health-care services within the past 24 months to trigger reimbursement of emergency treatment claims of enrolled veterans who would otherwise be eligible.

Congress should provide oversight on the claims processing for non-VA emergency care reimbursement to determine if claims are generally paid timely and if rates of denials for such claims are adjudicated similar to the claims applicable to the policies of the Centers for Medicare and Medicaid Services and other payers who operate under "prudent layperson" standards.

[87] P.L. 110-387, *Veterans' Mental Health and Other Care Improvements Act of 2008*, § 402.
[88] 38 U.S.C. § 1725(b).

SPECIALIZED SERVICES

Prosthetics and Sensory Aids

CONTINUATION OF CENTRALIZED PROSTHETICS FUNDING:

Continuation of centralized prosthetics funding is imperative to ensuring that the Department of Veterans Affairs meets the specialized needs of veterans with disabilities.

The protection of Prosthetics and Sensory Aids Service (PSAS) funding by a centralized budget for the PSAS continues to have a major positive impact on meeting the specialized needs of disabled veterans. *The Independent Budget* veterans service organizations (IBVSOs) applaud Veterans Health Administration (VHA) senior leadership for remaining focused on the need to ensure that adequate funding is available, through centralization and protection of the PSAS budget, to meet the prosthetics needs of veterans with disabilities and is available for current and future expansion of services.

The IBVSOs fully support the decision to distribute FY 2009 prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures, utilization reporting, and expansion of programs, such as surgical implants funding. This decision continues to improve the budget reporting process.

The IBVSOs believe the requirement for increased managerial accountability through extensive oversight of the expenditures of centralized prosthetics funds through data entry and collection, validation, and assessment has had positive results and should be continued. This requirement is being monitored through the work of VHA's Prosthetics Resources Utilization Workgroup (PRUW). The PRUW is charged with conducting extensive reviews of prosthetics budget expenditures at all levels, primarily utilizing data generated from the National Prosthetics Patients Database (NPPD). As a result, many VISN prosthetic representatives are now aware that proper accounting procedures will result in a better distribution of funds.

NPPD Expense Costs		
Prosthetic Item	**Total Cost Spent in FY 08**	**Projected Expenditure in FY 09**
Wheelchairs & Access	$ 163,217,275	$ 182,803,348
Artificial Legs	$ 89,393,059	$ 100,120,226
Artificial Arms	$ 6,491,050	$ 7,269,976
Orthosis/Orthotics	$ 43,633,076	$ 48,869,045
Shoes/Orthotics	$ 34,937,778	$ 39,130,311
Sensori-Neuro Aids	$ 218,940,274	$ 245,213,106*
Restorations	$ 4,329,151	$ 4,848,649
Oxygen & Respiratory	$ 206,505,755	$ 231,286,445
Medical Equip & Supplies	$ 203,207,497	$ 227,592,396
Medical Supplies	$ 19,588,142	$ 21,938,719
Home Dialysis	$ 1,282,400	$ 1,436,288
HISA	$ 6,013,390	$ 6,734,996
Surgical Implants	$ 387,045,033	$ 445,101,787**
Other Items	$ 19,358,422	$ 21,681,432
Total	**$ 1,403,942,302**	**$ 1,584,026,724**

*DALC data now added to NPPD, no longer a separate line item.
**15% increase since biological implants will be purchased by PSAS in FY 2009.

The IBVSOs support senior VHA officials implementing and following the proper accounting methods while holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate prediction of the prosthetics needs for the future.

FY 2008 expenditures exceeded the projected budget of $1.36 billion by $42.6 million. The 2009 proposed budget allocation for prosthetics is $1.6 billion. Funding allocations for FY 2009 were based primarily on FY 2008 NPPD expenditure data, coupled with Denver Acquisition and Logistics Center (DALC) billings, and other pertinent items, such as expansion of funding for the addition of biological implants to the existing program of surgical implants, the Amputation System of Care, and advancements in new technology.

Listed in the table above are NPPD costs in FY 2008 with projected new and repair equipment costs for FY 2009.

Recommendations:

The Veterans Health Administration must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled veterans, including the latest advances in technology so that funding shortfalls do not compromise other programs. The Administration must allocate an adequate portion of its appropriations to prosthetics to ensure that the prosthetics and sensory aids needs of veterans with disabilities are appropriately met.

The VHA should continue to utilize the Prosthetics Resources Utilization Workgroup to monitor prosthetics expenditures and trends.

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the National Prosthetics Patient Database, as well as program expansion needs.

VHA senior leadership should continue to hold field managers accountable for ensuring that data are properly entered into the NPPD.

Assessment of "Best Practices" to Improve Quality and Accuracy of Prosthetic Prescriptions:

National contracts for single-source prosthetic devices may potentially lead to inappropriate standardization of prosthetic devices.

The Independent Budget veterans service organizations (IBVSOs) continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Our concern with the PCMP is that this program could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

The IBVSOs are concerned with the procedures that are being used as part of the PCMP process to award single-source national contracts for specific prosthetic devices, primarily the high compliance rates contained in the national contracts. The typical compliance rate, or performance goal, in the national contracts awarded thus far as a result of the PCMP has been 95 percent. This means that for every 100 devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased "off-contract" (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such high compliance rates is that inappropriate pressure may be placed on clinicians to meet these goals due to a counterproductive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe national contract awards should be multiple sourced. Additionally, compliance rates, if any, should be reasonable. National contracts need to be designed to meet individual patient needs. Extreme target goals or compliance rates will most likely be detrimental to veterans with special needs. The high compliance rates set thus far appear arbitrary and lack sufficient clinical trial.

Under VHA Directive 1761.1, prosthetic items intended for direct patient issuance are exempted from VHA standardization efforts because a "one-size-fits-all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. Yet despite this directive, the PCMP process is being used to standardize the majority of prosthetic items through the issuance of high compliance rate national contracts. This remains a matter of grave concern for the IBVSOs, and we remain opposed to the standardization of prosthetic devices and sensory aids.

Significant advances in prosthetics technology will continue to dramatically enhance the lives of disabled veterans. In our view, standardization of the prosthetic devices that VA routinely purchases threatens future advances. Formulary-type scenarios for standardizing prosthetics will likely cause advances in prosthetic technologies to stagnate to a considerable degree because VA has such a major influence on the market.

A 2008 VA quality report card identified some disparities in services and treatment for women veterans. Based on these findings, the IBVSOs believe measures should be taken to address the special needs of female veterans within all VA programs, including the Prosthetics and Sensory Aids Service (PSAS). We are pleased to learn that VA has taken a proactive approach regarding this matter with the formulation of a Prosthetics Women's Workgroup to address the unique needs of our deserving female veterans.

Another problem with the issuance of prosthetic items relates to surgical implants. Although funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device, coronary stints, cochlear implants), the surgical costs associated with implanting the devices come from local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule the implant surgeries or are limiting the number of surgeries because of the costs involved. If true, the consequences to those veterans would be devastating and possibly life threatening.

Currently, the PSAS must compete with all other information technology (IT) requests within the VHA for funding. This has resulted in delaying numerous critcal IT projects and inadequate funding for the PSAS with IT applications and enhancements required to support the ever-changing requirements and needs to maintain

health information of this special emphasis group. This has not improved under the centralization of IT.

Recommendations:

The Veterans Health Administration should continue the Prosthetics Clinical Management Program provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

The VHA must continue to exempt certain prosthetic devices and sensory aids from standardization efforts. National contracts must be designed to meet individual patient needs, and single-item contracts should be awarded to multiple vendors/providers with reasonable compliance levels.

The VHA should ensure that clinicians are allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical condition, not based on costs associated with equipment and services. VHA clinicians must be permitted to prescribe devices that are "off-contract" without arduous waiver procedures or fear of repercussions.

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent with standard practices of care and defined services including prescribing, ordering, and purchasing items based on patient's needs—not cost considerations.

The VHA must ensure that new prosthetic technologies and devices that are available on the market are appropriately and timely issued to veterans.

The VHA should continue ongoing evaluation of the purchasing and inventory guidelines necessary to provide timely and appropriate appliances for female veterans.

Congress should investigate any reports of VHA facilities withholding surgeries for needed surgical implants because of cost considerations.

VA should increase funding for Prosthetics and Sensory Aids Service IT systems projects. VA should consider dedicating full-time resources to PSAS IT systems to ensure these functions are enhanced in a timely manner.

RESTRUCTURING OF PROSTHETICS PROGRAMS:

The Prosthetics program continues to lack consistent administration of prosthetics services throughout the Veterans Health Administration (VHA).

The VHA must require all Veterans Integrated Service Networks (VISNs) to adopt consistent operational standards in accordance with national prosthetics policies. The current organizational structure has resulted in the VHA national prosthetics staff trying to respond to various local interpretations of VA policy. This leads to inconsistent administration of prosthetics services throughout the VHA. VISN directors and VHA central office staff should be accountable for implementing a standardized prosthetics program throughout the health-care system.

To improve communication and consistency, VA must ensure that every VISN has a qualified VISN prosthetics representative (VPR) to be the technical expert responsible for ensuring implementation and compliance with national goals, objectives, policies, guidelines, and regulations on all issues of interpretation of the prosthetics policies, including administration and oversight of VHA's Prosthetics and Orthotics Laboratories. With the VPR serving as the main source of direction and guidance for implementation and interpretation of prosthetics policy and services, prosthetics staff can focus on delivering quality care and services.

Recommendations

VA must make certain that Veterans Integrated Service Network prosthetics representatives have a direct line of authority over all prosthetics' employees throughout the VISN, including all prosthetics and orthotics personnel.

The Veterans Health Administration should ensure that VISN prosthetics representatives do not have collateral duties as prosthetics representatives for local VA facilities within their VISNs.

The VHA must provide a single VISN budget for prosthetics and ensure that the VPR has control of and responsibility for that budget.

The VHA should set and enforce a five-day notification for a denial of prosthetics requests to the veteran.

FAILURE TO DEVELOP FUTURE PROSTHETICS STAFF:

The Veterans Health Administration (VHA) continues to experience a shortage in the number of qualified and trained prosthetics staff available to fill current or future vacant positions.

In 2004 the VHA developed and requested 12 training slots for the National Prosthetics Representative Training Program. The program was initiated to ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. The national program provides training for prosthetic representatives responsible for management of all prosthetics services within their assigned health-care system. With only 12 training slots in the national program, vacancies within the VHA continue to grow. As a result of this ongoing shortage, there are Veterans Integrated Service Networks (VISNs) that have developed their own prosthetics representative training programs. Although *The Independent Budget* veterans service organizations (IBVSOs) support local VISNs conducting prosthetics representative training to enhance the quality of health-care services within the VHA system and increase the number of qualified applicants, we believe that local VISNs must also support and strongly encourage participation in the annual National Prosthetics Representative Training Conference for a one-week intense prosthetics forum. The IBVSOs believe that local VISN prosthetics training should be a supplement to and consistent with the national training program.

Additionally, each prosthetics service within the Department of Veterans Affairs must have trained certified professionals that can advise other medical professionals on appropriate prescription, building/fabrication, maintenance, and repair of all devices. This is extremely important as new programs in polytrauma, traumatic brain injury, and amputation system of care are implemented in the VHA.

As the conflicts continue in Afghanistan and Iraq, service members are returning home with complex injuries and in need of highly technological prosthetic devices. The IBVSOs believe the future strength and viability of VA's prosthetics program depends on the selection of high caliber leaders in the Prosthetics and Sensory Aids Service. To do otherwise could lead to grave outcomes and the inability to understand the complexity of the prosthetics needs of veterans.

Recommendations:

VA must fully fund and support its National Prosthetics Representative Training Program, expanding the program to meet current shortages and future projections, with responsibility and accountability assigned to the chief consultant for Prosthetics and Sensory Aids.

VA must establish a full-time national training coordinator for the PSAS to ensure standardized training and development of personnel for all occupations within the Prosthetics service line. This will ensure successful career path development.

The Veterans Health Administration must work to increase the number of training slots in the National Prosthetics Training Program to keep pace with the number of

vacancies within the VHA for prosthetics representatives. The VHA and its Veterans Integrated Service Network directors must ensure that prosthetics departments are staffed by certified professional personnel or contracted staff who can maintain and repair the latest technological prosthetic devices.

The VHA must require VISN directors to reserve sufficient training funds to sponsor prosthetics training conferences, meetings, and online training for all service line personnel.

The VHA must ensure that the PSAS Program Office and VISN directors work collaboratively to select candidates for vacant VISN prosthetic representative positions who are competent to carry out the responsibilities of these positions.

The VHA must assess functional statements of all hybrid title 38 prosthetics employees to meet the complexities of programs throughout the VHA and must attract and retain qualified individuals.

PROSTHETICS SENSORY AIDS AND RESEARCH:

VA Research and Development (R&D) should maintain a comprehensive research agenda to address the deployment-related health issues of the newest generation of veterans while continuing research to help improve the lives of previous generations of veterans needing specialized prosthetics and sensory aids.

Many of the wounded soldiers returning from the conflicts in Afghanistan and Iraq have sustained polytraumatic injuries requiring extensive rehabilitation periods and the most sophisticated and advanced technologies, such as hearing and vision implants and computerized or robotic prosthetic items, to help them rebuild their lives and gain independence.

According to VA's R&D program, approximately 6 percent of wounded soldiers returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetics and sensory aids has increased by more 70 percent since 2000.

Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. The Veterans Health Administration (VHA) is still competitive in this type of research, from funding research to assisting with clinical trials for new devices. As new technologies and devices become available for use, the VHA must ensure that these products are made available to all veterans with a prescription and that funding is available for timely issuance of such items.

Recommendation:

The Department of Veterans Affairs must maintain its role as a world leader in prosthetics research and ensure that VA Research and Development and the Prosthetics and Sensory Aids Service work collaboratively to expeditiously apply new technology development and transfer to maximally restore a veteran's quality of life.

AMPUTATION SYSTEM OF CARE:

The Independent Budget ***veterans service organizations (IBVSOs) strongly support full implementation of VA's new amputation system of care and encourage Congress to provide adequate resources for staffing and training of this specialized program.***

In September 2006, the Department of Veterans Affairs formed an interdisciplinary amputation care working group with the primary objective to rebuild and improve its amputation care. The working group developed a proposed system of care made of four major components: regional amputation centers, polytrauma amputation network sites, amputation clinic teams, and amputation point of contacts. The goal was to create a system of care that would improve access to and the quality of amputation care.

The proposal was approved for funding in June 2008, and plans are under way to develop and implement the system of care proposed by the working group. Ultimately, the plan includes seven regional amputation centers (RACs) located in Bronx, New York; Denver; Minneapolis; Palo Alto, California; Richmond, Virginia; Seattle; and Tampa.

The RACs will provide expertise in clinical care and prosthetic concepts, and work closely with polytrauma rehabilitation centers and military treatment facilities. The amputation network sites will coordinate amputation care across Veterans Integrated Service Network sites, and provide surgical support, long-term-care needs, and case management. There will be 15 network sites located across the country, and the seven RACs will dually serve as polytrauma/amputation network sites. The proposal includes creation of a veteran amputation registry and utilization of new telehealth technology to monitor the amputation rehabilitation process. For example, the amputation clinic teams will use telehealth technology to coordinate veterans' amputation care with the RACs. The amputation care plan also includes 100 amputation clinic teams that will provide rehabilitation and prosthetic care within network sites with implementation and management of the amputation system of care overseen by an amputation rehabilitation coordinator. When facilities do not have expertise or the capacity to provide amputation rehabilitation, amputation point of contacts will serve as resource guides to direct veterans to community facilities that can best provide the specific amputation care that is needed. The overall goal of this initiative is to provide consistent quality amputation care to veterans throughout the VA health-care system and ensure that all veterans in need of amputation care have access to the proper services.

Recommendations:

The Independent Budget veterans service organizations strongly support full implementation of VA's new amputation system of care and encourage Congress to provide adequate resources for staffing and training of this important program.

VA should expeditiously implement the proposed system of amputation care providing proper staffing levels and training to ensure VA provides superior health services for aging and newly injured veterans who need these unique services.

HEARING LOSS AND TINNITUS:

The Veterans Health Administration (VHA) needs to provide a full continuum of audiology services.

As our brave men and women in uniform return from the conflicts in Afghanistan and Iraq, they are facing adversity in returning to civilian life. Many have been wounded by roadside bombs leaving them with both visible and unseen injuries, such as loss of limbs, traumatic brain injury (TBI), and spinal cord injury. The federal government has recognized the need for improved healthcare services for these members of the military. Although the medical care component of the VA budget has increased by 83 percent since President Bush took office,[89] it still does not cover the urgent growing needs of our veterans—past, present, and future. Estimates for long-term health care for this new generation of veterans are in the trillions and increase by the week.

Acoustic trauma has been part of military life since muskets and cannons were part of the arsenal, and Operations Enduring and Iraqi Freedom (OEF/OIF) are some the noisiest battlegrounds yet. Roadside bombs—the signature weapon of the insurgency—regularly hit patrols, rupturing eardrums, which leads to hearing loss and tinnitus. In addition, TBI, one of the signature wounds of these conflicts, is producing a whole new generation of soldiers with both mild and severe head injuries that are often accompanied by tinnitus.

The VA Polytrauma Center in Tampa reports that even those soldiers with no measurable hearing loss have tinnitus in conjunction with milder forms of TBI. Head and neck trauma is the second most frequently reported cause of tinnitus. Additionally the VA's own statistics show that tinnitus is currently the *most prevalent* service-connected disability of OEF/OIF veterans.[90] One of the newest research findings from VA, conducted at the James H. Quillen Veterans Affairs Medical Center Tinnitus Clinic, in Mountain Home, Tennessee, noted the increasing association between those with tinnitus and post traumatic stress disorder (PTSD). Of the first 300 patients enrolled at the clinic, 34 percent also carried a diagnosis of PTSD.[91]

These indications of the direct connections between tinnitus and TBI, as well as tinnitus and PTSD, point to the urgent need to address any gaps in research and treatment modalities provided by both the Department of Defense (DOD) and VA, to military personnel and veterans sustaining blast injuries. It is also indicative of the increasing incidence and severity of these conditions caused by combat injuries. It is imperative that all polytraumatic injuries be researched and treated in tandem to provide state-of-the-art care for America's veterans sustaining auditory system and related injuries that can lead to a life of debilitation from combat.

Invisible Injury

Many service members returning from war are physically disabled. Those types of injuries are easily seen by a physician and are often easily diagnosed and treated. Soldiers exposed to blasts from roadside bombs often suffer internal injuries that are not as easy to detect and treat. One of the most prevalent disabilities from exposure to IEDs (improvised explosive devices) and the many other faces of combat is an injury that is one of the hardest to detect—and even harder to treat—"tinnitus."

Tinnitus is defined as the perception of sound in the ears where no external source is present. Some who have tinnitus describe it as "ringing in the ears," but people report hearing all kinds of sounds, such as crickets, whooshing, pulsing, ocean waves, or buzzing. For millions of Americans, tinnitus becomes more than an annoyance. Chronic tinnitus can leave an individual feeling isolated and impaired in their ability to communicate with others. This isolation can cause anxiety, depression, and feelings of despair. Tinnitus affects an estimated 50 million, or more, people in the United States to some degree. Ten million to 12 million are chronically affected and 1 to 2 million are incapacitated by their tinnitus.[92] It is estimated that 250 million people worldwide experience tinnitus.[93]

Adding to the Rolls Every Year

The number of veterans who are receiving disability compensation for tinnitus has risen steadily over the past 10 years and spiked sharply in the past 5. Since 2001, service-connected disability for tinnitus has increased alarmingly by 18 percent per year. Based on that five-year trend, the total cost of veterans receiving service-connected disability compensation for tinnitus will be near $1 billion by year 2011. Veterans with tinnitus may be awarded up to a 10 percent disability, which currently equals about $117 a month. Though it is considered a

"disease of the ear" according to title 38, United States Code, only one "ear" is considered in determining disability rating for tinnitus.

Translated into economic terms, the government paid out nearly $600 million in disability compensation for tinnitus in 2007. If you couple that dollar amount with what was paid out for hearing loss disability compensation, the total is more than $1.6 billion for FY 2007. If tinnitus continues on the upward trend seen over the past five years, which as of 2006 was $539 million, the cost to taxpayers for tinnitus disability claims will reach $1.1 billion annually by 2011 and top $2 billion annually by 2020, if not sooner. This is one of the many reasons why the federal government needs to begin addressing this epidemic from an effective medical research and prevention standpoint. With an already existing patient pool of veterans there needs to be a collaborative and robust research effort on the part of VA, the DOD, and the National Institutes of Health.

Noise Levels—Common Military Operations

Type of Artillery	Position	Decibel Level (dBA) (Impulse Noise)
105mm Towed Howitzer	Gunner	183
Hand Grenade	At 50 Feet from Target	164
Rifle	Gunner	163
9 mm Pistol	N/A	157
F18C Handgun	N/A	150
Machine Gun	Gunner	145

Noise-Induced Hearing Loss and Tinnitus

Although tinnitus has a number of different causes, one of the primary causes among military personnel is noise exposure. Service members are exposed to extreme noise conditions on a daily basis during both war and peacetime. During present-day combat, a single exposure to the impulse noise of an IED can cause tinnitus and hearing damage immediately. An impulse noise is a short burst of acoustic energy, which can be either a single burst or multiple bursts of energy. Most impulse noises, such as the acoustic energy emitted from an IED, occur within one second. However, successive rounds of automatic weapon fire are also considered impulse noise.

According to the National Institute for Occupational Safety and Health prolonged exposure from sounds at 85+ decibel levels (dBA) can be damaging, depending on the length of exposure. For every 3-decibel increase, the time an individual needs to be exposed decreases by half, and the chance of noise-induced hearing loss and tinnitus increases exponentially. A single exposure at 140+ dBA may cause tinnitus and damage hearing immediately. The chart shows a few common military operations and associated noise levels, all exceeding the 140 dBA threshold.[94]

It's no surprise that service members using weaponry that emits such high decibel levels, in training or combat, are at greater risk of this type of disability than their civilian counterparts. So what's being done to help our military? Hearing conservation programs have been in place since the 1970s to protect and preserve the ears of our soldiers. However, a study released by the Institute of Medicine in 2005 reviewed these hearing conservation programs and concluded they were not adequately protecting the auditory systems of service members.

Additional studies conducted to assess the job performance of those exposed to extremely noisy environments in the military concluded that the noise not only caused disabilities, but put the overall safety of the service member and their team at risk. Reaction time can be reduced as a result of tinnitus, thus degrading combat performance and the ability to understand and execute commands quickly and properly.

Many soldiers develop tinnitus and other hearing impairments prior to active combat as a result of training. If a soldier is disabled prior to combat, his or her effectiveness already may be compromised at the beginning of active duty. A study in *Tank Gunner Performance and Hearing Impairment* concluded that hearing impairments may delay a soldier's ability to identify their target by as much as 50 seconds.[95]

The same study concluded that people with hearing impairments who were operating tank artillery were 36 percent more likely to hear the wrong command, and 30 percent less likely to correctly identify their target. Further, service members with hearing impairments only hit the enemy target 41 percent of the time, whereas those without hearing impairments hit the enemy target 94 percent of the time. Finally, the article stated that those with hearing impairments were 8 percent more likely to take the wrong target shot and 21 percent more likely to have their entire tank crew killed by the enemy. According to the study, hearing impairments, such as tinnitus, can very much be a life-or-death situation in the military.

The Role of Medical Research

Research has increased our knowledge on hearing loss and how it occurs, while less has been discovered about tinnitus. Tinnitus is a condition of the auditory system, originating in the brain. This points to the connection between TBI and tinnitus and may help explain why this population of veterans is experiencing tinnitus in record numbers. Of 692 TBI patients at Walter Reed Army Medical Center between January 2003 and March 2006, nearly 90 percent had nonpenetrating head injuries.[96] The extent and epidemiology of how tinnitus and TBI are affecting each other will remain unknown unless the federal government funds more medical research as encouraged by *The Independent Budget*.

Even though tinnitus research has come a long way, especially in recent years, much more needs to be learned. With so many veterans being added to the rolls every year for service-connected tinnitus, VA and the DOD need to continue working collaboratively to emerge as leaders in tinnitus research.

As of November 2007, nearly 70,000 OEF/OIF veterans had been awarded service-connected disability for tinnitus. Prior to that, there were nearly half a million veterans from previous conflicts already on the rolls for tinnitus. VA estimates show that it is likely that the actual number of veterans who have tinnitus sustained from combat and active duty injuries is more like 3–4 million,[97] showing the condition is more prevalent than records actually show.

Recommendations:

The Veterans Health Administration must rededicate itself to the excellence of program for hearing loss and tinnitus as well as other auditory processing disorders.

The VHA must continue its work with networks, to restore clinical staff resources in both inpatient and outpatient audiology programs, and develop tinnitus components to existing audiology facilities.

Congress must continue to work for increased funding for VA and the Department of Defense to prevent, treat, and cure tinnitus.

[89](www.gpoaccess.gov/usbudget/fy08/pdf/budget/veterans.pdf).
[90]VBA Office of Performance and Analysis, Audiology Care in the VA. Presented by Dr. Lucille Beck, chief consultant, Rehabilitation Services and Director, Audiology and Speech Pathology Service, November 2007, Washington, D.C.
[91]Marc A. Fagelson, "The Association between Tinnitus and Posttraumatic Stress Disorder," *American Journal of Audiology* 16 (2007): 107–17.
[92]Scott Campbell Brown, edited by Robert C. Johnson and Dorothy L. Smith *Older Americans and Tinnitus: A Demographic Study and Chartbook*, 1990.
[93]Munna Vio and Ralph H. Holme, "Hearing Loss and Tinnitus: 250 million people and a U.S. $10 Billion Potential Market." *Drug Discovery Today.* 10(19):1263–5, Oct 1, 2005.
[94]U.S. Army Center for Health and Preventative Medicine. (http://chppm-www.apgea.army.mil/)
[95]Georges Garinther and Leslie Peters, "Tank Gunner Performance and Hearing Impairment," *Army RD&A Bulletin* January-February (1990):1–5.
[96]Neil Shea, "Iraq War Medicine—The Heroes, The Healing: Military Medicine from the Front Lines to the Home Front," *National Geographic* [archives], December 2006 (nationalgeographic.com).
[97](ncrar.research.va.gov).

Special Needs Veterans

BLINDED VETERANS:

A full continuum of vision rehabilitation services is needed from the Veterans Health Adminstration.

The VA Blind Rehabilitation Service (BRS) is well known worldwide for its excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. Currently VA operates 10 comprehensive residential blind rehabilitation centers (BRCs) with plans for three new BRCs in Biloxi, Mississippi; Long Beach, California; and Cleveland, but these are now pending construction projects with openings not expected until 2011. Approximately 46,877 blind veterans were enrolled in FY 2007 with the Visual Impairment Service Team (VIST) coordinators' offices, and projected demographic data estimate that by 2012 the VA system could sustain a rise to approximately 53,000 enrolled blind or low-vision-impaired veterans, according to the VHA Blind Rehabilitation Service. National demographic studies estimate that there are 158,000 blinded veterans in America.

Age-related eye diseases, however, affect more than 35 million Americans age 40 and older. The most common eye diseases in that age group are macular degeneration, glaucoma, diabetic retinopathy, and cataracts; of these an estimated 1 million Americans over the age of 40 are legally blind.[98] While only 4.3 percent of the 65 and older population live in nursing homes, 16 percent of those who are visually impaired and 40 percent of those who are blind reside in nursing homes. Training programs that allow safe daily independent living functions reduce these long-term-care costs and prevent injuries from falls and other accidents.

The Independent Budget emphasizes that in addition to the previously mentioned blinded veterans from previous wars and conflicts already enrolled, recent data compiled by both the Department of Defense (DOD) and VA sources reported that 13.9 percent of all wounded and evacuated from Iraq had experienced eye injuries. As of December 2008, more than 1,348 eye injured or eye wounded (395 blinded in one eye) had sustained serious enough wounds requiring evacuation, but this grew to more than 1,500 by July 2008.[99] The VA article "Putting Polytrauma Care 'On the Map'" reported that in reviewing all Operating Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans enrolled in the VHA, the most common traumatic injury affecting some 63 percent of them was hearing loss, followed by vision injuries, with 27.9 percent of all OEF/OIF veterans identified; these range from mild, to moderate, to severe visual injuries.[100] Approximately 80 blinded OEF/OIF service members have attended one of the 10 blind rehabilitation centers, with VIST tracking 112 total, and some of these are in the process of being referred for BRC admission. Nevertheless, *The Independent Budget* veterans service organizations (IBVSOs) fear that some reserve members with severe eye injuries are unaccounted for and have not been tracked while in the DOD TRICARE system.

As of September 14, 2008, the VHA reported 8,774 traumatic brain injury (TBI) cases diagnosed, with another 7,390 cases having further diagnostic and specialty screening,[101] but by several estimates this number is probably low for TBI exposure. Although VA has been stepping up their TBI screening of all OEF/OIF service members entering the VA system, those who are diagnosed with TBI should have specialized vision screening to determine if they have vision impairments related to the blasts.

TBI vision research published from the Palo Alto VA Medical Center Poly Trauma Center showed that 75 percent of veterans treated there have visual complaints and have been diagnosed with the following types of disorders: diplopia, field loss, accommodation insufficiency, convergence disorder, and ocular-motor dysfunction. Of those, 55 percent are unable to interpret print, and 4 percent of all disorders result in legal blindness.[102] Other sites have found similar results in TBI screening, of between 68 percent to 70 percent incidence of patients complaining of visual disorders, again ranging from mild, to moderate, to severe.[103] Similar to the returning wounded with hearing loss complaining of tinnitus, reports are that some 70 percent of TBI patients complain of photophobia (light sensitivity), and for those patients experiencing both symptoms, visual dysfunction screening must occur. Various complications of these traumatic eye injuries include traumatic cataracts, glaucoma, and retinal detachments, and more follow-up research is needed on all of these. The IBVSOs request that Congress exercise greater oversight on tracking of these combat-wounded eye injured veterans. Those with duel sensory hearing and vision loss must have outcome studies.

According to the Office of VA Research, serious combat eye trauma from OEF/OIF has climbed to the second most common injury from these conflicts behind only hearing loss. The IBVSOs are frustrated that long delays occurred in establishing the military Vision Centers of Excellence during this past year because the necessary $5 million was never included by Congress in the Defense appropriations for FY 2009 to begin staffing at all four designated military Vision Centers of Excellence medical centers. We request that Congress include in the Defense appropriations for FY 2010 $6.5 million for the continued implementation of the joint DOD/VA Vision Centers of Excellence as intended in the National Defense Authorization Act (NDAA) of FY 2009, section 1623, P.L. 110-181.

Historically, the residential BRC program has been the primary option for severely visually impaired and blinded veterans to receive services. The VHA this past year transitioned to approximately 44 more VA outpatient continuum of care programs, improving health-care delivery going into 2010.[104] VHA Ophthalmology, Optometry, and BRS need to continue to make the same effort for veterans in the next couple years to complete the plans for all new services.[105] For those catastrophically disabled non-service-connected veterans who require residential services at a blind rehabilitation center, they often cannot afford the copayments for their admissions, plus beneficiary travel is also not provided for those who are not a direct transfer from one VA medical center to a blind rehabilitation center, adding another burden.

Currently, approximately 1,144 blinded veterans are waiting an average of 12 weeks for entrance into 1 of the 10 VA BRCs—progress from 2004 when 2,400 blinded veterans waited almost 5 months. The IBVSOs encourage directed funding of an additional $9.5 million in FY 2010 for these new models of blind rehabilitation outpatient services and low-vision optometric programs. By encompassing the full spectrum of visual impairment services, blind rehabilitative outpatient specialists (BROS), and intermediate and advanced low-vision outpatient programs, these new services could screen service members with TBI for visual complications while serving the eye disease population of aging blinded and low-vision veterans.

Congressionally mandated capacity must be maintained, and the BRS must continue to provide for critical full-time employee equivalents within each BRC to increase capacity to provide comprehensive residential blind rehabilitation services. Other critical BRS positions—such as the 98 full-time VIST coordinators and the current number of 45 BROS, with 35 currently vacant—must be increased. VIST and BROS teams are essential full-time positions, which, in addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a BRC or a new continuum of care outpatient program, also facilitate blind rehabilitation training support in veterans' homes and provide new technology when veterans return from a BRC.

Recommendations:

The Veterans Health Administration must restore the bed capacity and full staffing levels in the blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

The VHA must continue its three-year plan for full continuum of care outpatient programs for blinded and low-vision veterans that Secretary Nicholson promised in January 2007. Congress should ensure the program's implementation by providing $9.5 million in FY 2010 for completion of 54 new sites.

In implementing DOD/VA Vision Centers of Excellence and the joint eye trauma registry created by the National Defense Authorization Act of 2008, the Department of Defense and VA must ensure electronic exchange of essential information between all eye care professionals in order to establish a seamless transition of eye care and improve long-term outcomes through vision research. As it included in FY 2009 MILCON-VA appropriations to establish this registry, Congress should again provide $2 million for FY 2010 to complete this eye trauma registry.

In implementing DOD/VA Vision Centers of Excellence and the joint eye trauma registry created by the National Defense Authorization Act of 2008, the Department of Defense and VA must ensure electronic exchange of essential information between all eye care professionals in order to establish a seamless transition of eye care and improve long-term outcomes through vision research.

Defense appropriations for FY 2010 must include $6,780,000 for further implementation of the four Vision Centers of Excellence located at Bethesda National Naval Medical Center, Brooke Army Medical Center, Madigan Army Medical Center, and San Diego NNMC, and Armed Services/VA Committee hearings on this joint program for eye injured and hearing impaired must be held.

The Congressionally directed Peer Medical Research Program must continue to include eye and vision research in Defense appropriations, and DOD research funding on eye trauma must be increased in FY 2010 to $8 million.

The VHA must require the networks to restore clinical staff resources in inpatient blind rehabilitation centers and increase the number of full-time Visual Impairment Services Team coordinators.

Although the House of Representatives passed H.R. 6445 in the 110th Congress, Congress should reintroduce and enact legislation amending title 38, United States Code to prohibit the VA Secretary from collecting certain copayments from veterans who are catastrophically disabled.

Congress should amend title 38 to provide beneficiary travel reimbursement for catastrophically disabled veterans who need to attend an inpatient rehabilitation center.

[98]www.silverbook.org/visionloss; Silver Book@agingresearch.org.
[99]"Pentagon Numbers U.S. Military OIF/OEF Warriors Eye Injuries (JTTR, Oct 2002–Aug 2007). Internal report.
[100]Diane Cowper Ripley, "Putting Polytrauma Care on the Map," *VA Research Currents*, October 2008, p. 5.
[101]Barbara Sigford, "Update on Health Care: VA Traumatic Brain Injury (TBI) Screening Program, PowerPoint presentation to veterans service organizations, September 2008.
[102]Greg Goodrich, *Summary of Polytrauma Eye Research and Treatment Study Seen at VA Palo Alto Rehabilitation Network Site,* VA Palo Alto Center report, March 2008.
[103]Hines VA Medical Center, Low Vision Screening, TBI Clinic, August 2008. Unpublished report.
[104]Visual Impairment Advisory Board Minutes, VHA Blind Rehabilitation Service Office, October 2008.
[105]VA Visual Impairment Advisory Board Full Continuum of Care Recommendations," VHA briefing to veterans service organizations, September 2007.

SPINAL CORD DYSFUNCTION:

The continuum of care model for quality health care delivered to the patient with spinal cord dysfunction continues to be hindered by the lack of trained staff to support the mission of the spinal cord injury/dysfunction (SCI/D) program.

SCI/D Leadership

The continuum of care model for the treatment of veterans with SCI/D has evolved over a period of more than 50 years. SCI/D care in the Department of Veterans Affairs has been established in a "hub-and-spokes" model. This model has shown to work very well as long as all patients are seen by qualified SCI/D trained staff. Because of staff turnover and a general lack of understanding in outlying "spoke" facilities, however, not all SCI/D patients have the advantage of referrals, consultations, and annual evaluations in an SCI/D center.

This situation is further complicated by confusion as to where to treat patients with spinal cord disorders, such as multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease). Some SCI/D centers treat these patients while others deny admission. It is recognized that there is an ongoing effort to create a continuum of care model for MS and that this model should be extended to encompass MS and other diseases involving the spinal cord, such as ALS. Although admission in an SCI/D center may not be appropriate for all veterans with spinal cord disorder, a care model must be developed to follow these veterans through their illness with a protocol that meets the treatment needs of the patient.

Nursing Staff

VA is experiencing delays in admission and bed reductions based upon availability of qualified nursing staff. *The Independent Budget* veterans service organizations continue to contend that basic salary for nurses who provide bedside care is not competitive with community hospital nurses. This results in high attrition rates as these individuals leave VA for more attractive compensation in the community.

Recruitment and retention bonuses have been effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans and nursing staff morale. Unfortunately, facilities are faced with the local budget dilemma when considering the offering of any recruitment or retention bonus. The funding necessary to support this effort is taken from the local budget, thus shorting other needed medical programs. Because these efforts have only been used at local or regional facilities, there is only a partial improvement of a systemwide problem.

A consistent national policy of salary enhancement should be implemented across the country to ensure that qualified staff is recruited. Funding to support this initiative should be made available to the medical facilities from the network or VA Central Office to supplement their operating budgets.

Patient Classification

VA has a system of classifying patients according to the amount of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of injury, amount of time spent with the patient, technical expertise, and clinical needs of each patient. A category III patient, in the middle of the scoring system, is the "average" SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of full-time employee equivalents (FTEEs) needed for continuous coverage. This formula covers *bedside nursing care hours* over a week, month, quarter, or year. It is adjusted for net hours of work with annual, sick, holiday, and administrative leave included in the formula.

The emphasis of this classification system is based on *bedside nursing care*. It does not include administrative nurses, non-bedside specialty nurses, or light-duty nursing personnel because these individuals do not or are not able to provide full-time labor-intensive bedside care for the SCI/D patient. According to the *California Safe Staffing Law,* dealing with registered nurses (RN)-to-patient staffing ratios, "Nurse administrators, nurse supervisors, nurse managers, and charge nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those administrators are providing direct patient care."

Nurse staffing in SCI/D units has been delineated in Veterans Health Administration (VHA) Handbook 1176.1 and VHA Directive 2005-001. The figure was derived on 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. Currently, nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

VHA Directive 2005-001 mandates 1,347.6 bedside nurses to provide nursing care for 85 percent of the available beds at the 23 SCI/D centers across the country. This nursing staff consists of RNs, licensed vocational/practical nurses, nursing assistants, and health technicians.

At the end of FY 2007, nurse staffing was 1,315. This number is 32.6 FTEEs short of the mandated requirement of 1,347.6. Considering that some facilities are staffed to meet the actual acuity level (above minimum levels), the real shortage is 67.9 nursing staff for the remaining centers to meet minimum staffing levels. The 1,315 FTEE includes nursing administrators and non-bedside RNs (79.5) and light duty staff (39). Removing the administrators and light duty staff makes the total number of nursing personnel 1,183.2 FTEEs to provide *bedside nursing care*. This coupled with the shortage of 67.9 FTEEs reveals a shortfall of 186.4 nursing FTEEs.

The regulation calls for a staff mix of approximately 50 percent RNs. Not all SCI/D centers are in full compliance with this ratio, however. There are 509.9 RNs working in SCI/D. Out of that, 79.5 are in non-bedside or administrative positions, leaving 430.4 RNs providing bedside nursing care. With 1,315 nursing personnel and 509.9 of those RNs, this leaves an RN ratio of 39 percent to provide bedside nursing care. If the non-bedside RNs were excluded, the percentage of RNs drops to 35 percent. These numbers are well below the mandated 50 percent RN ratio.

SCI/D facilities recruit only to the minimum nurse staffing required by VHA Directive 2005-001. As shown above, when the minimal staffing levels include non-bedside nurses and light-duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with lower levels of nurses.

The low percentage of professional RNs providing bedside care and the high acuity of SCI/D patients puts SCI/D veterans at increased risk for complications secondary to their injuries. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their condition. A 50 percent RN staff in the SCI/D service is crucial in promoting optimal outcomes.

This nursing shortage is manifested in the fact that VA facilities have begun to restrict admissions to SCI/D wards. Reports of bed consolidations or closures have been received due to nursing shortages. Such situations create a severe compromise of patient safety and continue to stress the need to enhance the nurse recruitment and retention programs.

Proposed Bifurcated Spinal Cord Injury Center in Denver

In the spring of 2008, VA announced a revised plan for replacing the Denver VA Medical Center. Under the Capital Asset Realignment for Enhanced Services (CARES) plan, the existing, antiquated VA hospital in Denver was scheduled to be replaced with a new tertiary care facility that included a 300-bed spinal cord injury center needed to serve veterans in the Rocky Mountain region. The revised plan drastically modified the proposed CARES-driven project calling for an expanded ambulatory care center and the leasing of bed space at the to-be-constructed new University of Colorado Medical School hospital (see the section "VA's New Health-Care Facility Leasing Program in this *Independent Budget*). Included in this proposal was the division of the 30-bed SCI center between the two facilities with 12 beds designated as acute care to be located in the university hospital and 18 beds designated as rehabilitative to be located in the ambulatory care center.

This proposal has met with great opposition, most notably from the perspective that it contradicts the VA internal guidance regarding SCI care contained in VA Handbook 1176.1. The proposed split center creates obstacles to coordinated patient care, will lead to inefficient and/or ineffective utilization of staff, and create undue burdens and risks for patients being required to move from one facility to the other for necessary care. It is the position of the IBVSOs that this new approach is not in

the best interest of veterans with SCI/D and is, in fact, untenable and will lead to the diminution of quality care.

Recommendations:

The Veterans Health Administration should ensure that the spinal cord injury/dysfunction continuum of care model is available to all SCI/D veterans across the country. VA must also continue mandatory national training for "spoke" facilities.

VA should develop a comprehensive continuum of care model for SCI/D patients that includes other diseases of the neurological system, such as multiple sclerosis and amyotrophic lateral sclerosis.

The VHA needs to centralize policies and funding for systemwide recruitment and retention bonuses for nursing staff.

Congress should appropriate funding necessary to provide competitive salaries and bonuses for SCI/D nurses.

Congress should establish a specialty pay provision for nurses working in spinal cord injury centers.

VA should cease work on the revised plan involving the division of the SCI service in Denver and continue moving forward with the plan outlined by the CARES process.

PERSIAN GULF WAR VETERANS:

The Department of Veterans Affairs must aggressively pursue answers to the health consequences of veterans' Gulf War service. VA cannot reduce its commitment to Veterans Health Administration (VHA) programs that address health care and research or Veterans Benefits Administration (VBA) programs in order to meet other important and unique needs of Gulf War veterans.

In the first days of August 1990, in response to the Iraqi invasion of Kuwait, U.S. troops were deployed to the Persian Gulf in Operations Desert Shield and Storm. The air assault was initiated on January 16, 1991. On February 24, 1991, the ground assault was launched, and after 100 hours, combat operations were concluded. Approximately 697,000 U.S. military service members served in Operations Desert Shield or Desert Storm. The Gulf War was the first time since World War II in which reserve and National Guard members were activated and deployed to a combat zone. For many of the 106,000 who were mobilized to Southwest Asia, this was a life-changing event.

After their military service, Gulf War veterans reported a wide variety of chronic illnesses and disabilities. Many Gulf War veterans have been diagnosed with chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, and gastrointestinal problems. The multisyptom condition or constellation of symptoms has often been referred to as Gulf War syndrome, Gulf War illness, or Gulf War veterans' illnesses; however, no single unique illness has been definitely identified that explains the complaints of all veterans who fit this description. According to the VA's most recent study, 25 to 30 percent of Gulf War veterans suffer from chronic multisymptom illness above the rate in other veterans of the same era. This confirms five earlier studies showing similar rates. Thus, 18 years after the war approximately 175,000 to 200,000 veterans who served remain seriously ill.

Both the Department of Defense (DOD) and VA have invested in conducting research and providing health care and benefits to address the concerns of Gulf War veterans and their families. These efforts have flagged in the past months as other veterans' issues have captured the attention of Congress and the federal agencies. However, because many Gulf War veterans remain ill, *The Independent Budget* veterans service organizations (IBVSOs) stand firm and urge the DOD and VA not to abandon their search for answers to Gulf War veterans' unique health problems and exposure concerns.

Building a Base of Evidence

Since the Gulf War, federal agencies have sponsored numerous research projects related to Gulf War illnesses. A July 26, 2007, hearing before the House Committee on Veterans' Affairs Subcommittee on Health, reported that VA and the DOD had together spent $260 million on Gulf War illness research. Combined with the Department of Health and Human Services, more than 340 research projects related to Gulf War illnesses have been conducted, totaling more than $340 million. However, Gulf War illness research is handled exclusively by VA and the DOD, and very little money has been invested in treatment research.

As troops in Southwest Asia continue to fight in the same areas as Gulf War veterans, VA's response to this unique situation was to open the Gulf War Registry to Operations Enduring and Iraqi Freedom (OEF/OIF) veterans,[106] and broaden the scope of Gulf War illness research to include "deployment-related health research." The Research Advisory Committee on Gulf War Veterans' Illnesses (RAC-GWVI) appointed by the VA Secretary in 2002 was directed to evaluate the effectiveness of government research in addressing central questions on the nature, causes, and treatments of Gulf War–related illnesses. In reviewing VA-funded research on Gulf War illnesses, the RAC-GWVI has raised questions on the nature of some VA-funded research as to whether these research projects will directly benefit veterans suffering from Gulf War illnesses by answering questions most relevant to their illnesses and injuries. Heightening this concern is a critical need for a comprehensive and well-planned program to actually solve the problems disabled Gulf War veterans face instead of studying peripheral sections.

The IBVSOs are concerned that changing the direction of Gulf War illness research will dilute its focus and divert attention to the, admittedly, urgent issues faced by veterans of OEF/OIF. While it is unclear whether veterans of the current conflicts should be categorically grouped with veterans of the first Gulf War for purposes of VA research on Gulf War illnesses, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of the other, particularly in light of news reports about an open-air "burn pit" at the largest U.S. base in Balad, Iraq, which has been described as an acute health hazard and may have exposed thousands of service members to cancer-causing dioxins; poisons; and hazardous medical waste.[107] Accordingly, the IBVSOs believe the federal research budget needs to prioritize and coordinate investigations in a progressive manner of both postdeployment groups.

The Need for Effective Treatment

The Independent Budget position is that all combat environments are hostile and traumatic; consequently, some Gulf War veterans have suffered the consequences of combat and environmental exposures, and their bravery in dealing with the aftermath of service should be neither discounted nor stigmatized. A holistic, comprehensive investigation into the causes and the most effective treatments for all illnesses and injuries suffered by Gulf War veterans is the proper path to restoring the health and well-being of those who served.

It has been eight years since Congress mandated[108] the Department of Veterans Affairs to commission the United States National Academies' Institute of Medicine (IOM), to convene a committee,[109] which issued a report[110] to address the primary concern of whether Gulf War veterans are receiving effective treatments for their health problems. In its most recent report,[111] the RAC-GWVI states, "treatments that are effective in improving the health of veterans with Gulf War illness are urgently needed." The DOD's Office of Congressionally Directed Medical Research Programs has a program aimed at identifying diagnostic tests and treatments for Gulf War illness. As mentioned in *The Independent Budget for FY 2009,* the program funded a limited number of new treatment studies in 2007 and has invited proposals for additional studies to be funded in 2009. A similar effort, sponsored by VA, is under way at a center of excellence for Gulf War research at the University of Texas Southwestern. In light of a decline since 2001 in the overall federal funding for Gulf War illness research, the IBVSOs believe Congress, VA, and the DOD should meet this need with a renewed federal research commitment and that adequate funding be allocated to achieve the critical objectives of improving the health and lives of Gulf War veterans.

The RAC-GWVI report outlines studies that consistently indicate Gulf War illness is not significantly associated with serving in combat or other psychological stressors, further citing that Gulf War veterans have lower rates of post-traumatic stress disorder than veterans of other wars. However, pyridostigmine bromide pills and pesticides have been consistently identified as significant risk factors for Gulf War illness. Moreover, limited research on other deployment-related exposures[112] currently exists, and its association with Gulf War illness cannot therefore be ruled out. Other concerns have also been raised regarding the rates of birth defects in the children of Gulf War veterans. While no studies have provided comprehensive information on the health of Gulf War veterans' children, Phase III

of VA's large U.S. National Survey of Gulf War Era Veterans and Their Families included clinical evaluations of veterans' children for which findings have not been reported.

Effectiveness of Existing Benefits

Similar to diluting the focus of Gulf War illness research by broadening its scope, the IBVSOs are also concerned about VBA's standing practice of including OEF/OIF veterans with Gulf War veterans in the Gulf War Veterans Information System (GWVIS). The GWVIS report monitors, in part, the service members' use of VA health care and disability benefits.

While the VBA indicates that GWVIS provides the best available current data identifying the 6.5 million Gulf War service member population, it has rebuffed strong criticism to delineate OEF/OIF veterans from Gulf War veterans to provide a more meaningful and timely report. For example, the reports are distributed each quarter during the following months: March, June, September, and December; however, as of this writing, only the March 2008 report has been released. In addition, lumping compensation and pension statistics undermines any reasonable effort to analyze the effects of current regulations for compensating veterans suffering from specific Gulf War illnesses. Moreover, the report lacks any practical information on health-care utilization of Gulf War veterans particularly when compared to the report on the "Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans." Issued by the VHA Office of Public Health and Environmental Hazards, this report is provided on a fairly regular basis and provides a revealing description of the trends in health-care utilization and workload of OEF/OIF veterans, diagnostic data, and where they reside in respect to the VA health-care system they seek. Such monitoring allows VA to tailor its health-care and disability programs to meet the needs of this newest generation of OEF/OIF war veterans.

Despite the GWVIS report's lack of granularity, what can be interpreted based on the February 2008 GWVIS report is that 33 percent of Gulf War veterans have been granted service-connected disability compensation. As of January 31, 2008, just 2 percent of Gulf War veterans had filed disability claims for "undiagnosed illness" and only 0.5 percent had been service-connected for "undiagnosed illness," which suggests that these claims are difficult to prosecute and possibly to adjudicate under current regulations.

Under the direction of Congress, VA has a standing responsibility to commission the IOM to assist the Secretary in making decisions as to whether there is sufficient scientific evidence to warrant a presumption of service connection for the occurrence of a specified condition in Gulf War veterans. On October 16, 2006, the IOM issued a fifth volume of its Gulf War and health series on infectious diseases. Consequently, VA informed[113] Congress of its intent to add nine new presumptive conditions based on service in Persian Gulf War: brucellosis, campylobacter jejuni, Q fever, malaria, mycobacterium tuberculosis, nontyphoid salmonella, shigella, visceral leishmaniasis, and West Nile fever. The VA Task Force charged with reviewing this committee report to determine if new presumptive service connections are warranted has submitted its recommendations to the Office of Management and Budget. To date, no regulations have been proposed for inclusion on the current list of presumptive conditions for Gulf War veterans.

The RAC-GWVI's most recent report outlined some issues regarding the IOM's Gulf War and Health reports. The report states, "IOM's Gulf War and Health series of reports have been skewed and limited by a restrictive approach to the scientific tasks mandated by Congress, an approach directed by VA in commissioning the reports. These limitations are most notably reflected in the selective types of information reviewed and the lack of in-depth analysis of the research literature and scientific questions associated with the health of Gulf War veterans. There is a fundamental disconnect between the Congressional directive to VA and VA's charge to IOM for reviewing evidence on Gulf War exposures and their association with illnesses affecting Gulf War veterans. The reports have particularly fallen short in advancing understanding of associations between Gulf War exposures and Gulf War illness, the most prominent health issue affecting Gulf War veterans." The VA Secretary, and thus veterans suffering from Gulf War illness, depend heavily on the commissioning of the IOM by virtue of Congressional mandate. The IBVSOs believe the concerns raised by the RAC-GWVI should be formally addressed and resolved by Congress to ensure the credibility of established protocols using Gulf War and Health reports to guide VA policy and programs for Gulf War veterans.

While the IBVSOs are hopeful of the work to be done by the newly formed VA Advisory Committee on Gulf War Veterans in its review of the full spectrum of health care and benefits for Gulf War veterans, much work needs to be done to improve the lives of disabled veterans suffering from Gulf War illnesses. While the evidence base to guide policy and programs administered by VA continues to grow, we must remain vigilant to ensure progress is made.

Recommendations:

Congress should ensure that sufficient, dedicated funding is provided for research into the health consequences of Gulf War veterans' service. The unique issues faced by Gulf War veterans should not be lost in the urgency to address other issues related to armed forces personnel currently deployed.

Congress should provide funding to conduct research on effective treatments for veterans suffering from Gulf War illness.

VA should commission the National Academy of Sciences' Institute of Medicine to update the "2001 Gulf War Veterans: Treating Symptoms and Syndromes" report determine whether there are effective treatments for veterans suffering from Gulf War illness and whether these veterans are receiving appropriate care.

Congress must conduct oversight on the concerns raised in the November 2008 report by the Research Advisory Committee on Gulf War Veterans' Illnesses on the IOM's Gulf War and Health reports.

VA should change the current direction of its Gulf War illness research and separate its focus on ill Gulf War veterans and those health concerns from its focus on the health concerns of veterans of Operations Enduring and Iraqi Freedom.

VA should provide a more timely Gulf War Veterans Information System report and should delineate Operations Enduring and Iraqi Freedom veterans from Gulf War veterans.

Congress should make permanent the presumptive period for undiagnosed illnesses, which is due to expire September 30, 2011.

VA should issue regulations to add brucellosis, campylobacter jejuni, Q fever, malaria, mycobacterium tuberculosis, nontyphoid salmonella, shigella, visceral leishmaniasis and West Nile fever as presumptive conditions based on service in the Persian Gulf War.

[106]As of August 2008, more than 106,500 have participated in VA's Gulf War Veterans' Health Registry Examination, of which more than 7,000 veterans are from the current conflicts.
[107]Kelly Kennedy, "Burn Pit Fallout; Military Official: Situation Improving; Troops Report Complications from Asthma to Cancer," *Army Times*, November 7, 2008.
[108]P.L. 105-368 § 105; P.L. 105-277 § 1603.
[109]Committee on Identifying Effective Treatments for Gulf War Veterans' Health Problems, Board on Health Promotion and Disease Prevention.
[110]"Gulf War Veterans: Treating Symptoms and Syndromes," National Academies Press, July 26, 2001.
[111]"Gulf War Illness and the Health of Gulf War Veterans: Scientific Findings and Recommendations," U.S. Government Printing Office, November 17, 2008.
[112]Exhaust from tent heaters and other fuel exposures, fine sand and airborne particulates, solvents, freshly applied chemical agent resistant coating paint, nerve agents, depleted uranium, vaccinations, and petroleum smoke or vapors.
[113]Lawrence Deyton, chief public health and environmental hazards officer, VHA, statement before the Subcommittee on Health, House Committee on Veterans Affairs, July 26, 2007.

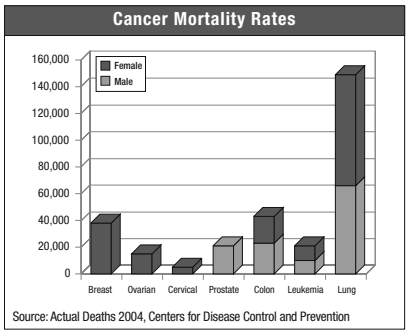
LUNG CANCER SCREENING AND EARLY DISEASE MANAGEMENT PROGRAM:

Lung cancer has a disproportionate impact on veterans, especially those exposed to carcinogens during active duty. A pilot screening program can assess those risks, improve survivability, and provide the Department of Veterans Affairs with vital cost/benefit and survival data on the efficacy of early diagnosis.

Overall Impact

Only heart disease causes more deaths per year than lung cancer. Lung cancer continues to be the number one cancer killer, causing nearly one in every three cancer deaths, more than breast, prostate, colon, kidney, melanoma, and liver cancers combined. More than half of all new cases are being diagnosed in former smokers, many of whom quit decades ago. Another 10 to 15 percent have never smoked. With higher smoking rates than the civilian population, as well as increased exposure to Agent Orange, asbestos, beryllium, nuclear emissions, propellants, and other environmental toxins, veterans, especially those exposed to these carcinogens during active duty, are at higher incidence and mortality risk. As veteran boomers enter their 60s, the decade when most diagnoses are made, the numbers of lung cancer cases will swell. Lung cancer usually re-

mains asymptomatic for 20 years or more. Given the many concerns about conditions during the Gulf War, a pilot screening program should pay particular attention to veterans who served on those battlefields.



High Mortality Rate

Since Congress passed the National Cancer Act of 1971, the five-year survival rates for the three other most common cancers—breast, prostate and colon—have risen to 88 percent, 99 percent, and 65 percent, respectively. These greatly improved survival rates are reflective of the significant federal investment in research and early detection for those cancers and widely promoted screening tests (mammograms, PSA testing, and colonoscopies). By contrast, lung cancer research and early detection has been consistently underfunded and its five-year survival rate is still only 15 percent. Lung cancer is a slow-growing cancer, the symptoms of which rarely become evident until late stage. Only 16 percent of lung cancers are being diagnosed at its earliest and most treatable stage.

Impact on Military and Veteran Populations

The Department of Defense (DOD) routinely distributed free cigarettes and included cigarettes in K-rations until 1976. The 1997 Harris Report to VA documented a higher prevalence of smoking and carcinogenic exposure among the military, with estimated costs to VA and TRICARE of billions of dollars per year. More than 70 percent of Vietnam veterans have smoked, twice the rate of 35 percent for civilians who ever smoked. Asbestos on submarines, Agent Orange, Gulf War battlefield emissions, and other toxins are also carcinogenic factors that add to the overall exposure burden. A 2004 report by the Health Promotion (HPDP) of the Institute of Medicine, titled "Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer," concluded that the presumptive period for lung cancer is 50 years or more. Another HPDP report in 2005, "Gulf War and Health, Volume 3, Fuels, Combustion Products and Propellants," concluded sufficient evidence existed for an association with lung cancer.

Given that lung cancer is an indolent cancer that takes decades to develop, the burden of treatment will fall most heavily on VA. Without screening, more than 70 percent of lung cancer is being diagnosed at late stage and most will die within a year. Late-stage lung cancer is twice as costly to treat as early stage.

The DOD and Cancer Research

In 1991, Congress initiated the Congressionally Directed Medical Research Program (CDMRP). From FY 1992 to FY 2007, appropriations have totaled $4.36 billion, including $2.1 billion for breast cancer research, $810 million for prostate cancer, $111.7 million for ovarian cancer, and $22 million for leukemia. Smaller, miscellaneous amounts have been occasionally earmarked for other cancers. In 2005, lung cancer biomarker research received $1 million in funding.

In the DOD FY 2009 appropriations bill, Congress established a line-item lung cancer research program under the CDMRP and appropriated $20 million for FY 2009. The report notes, "military personnel have heightened exposure to lung cancer carcinogens" and states that for the new program "priority shall be given to the development of the integrated components to identify, treat, and manage early curable lung cancer."

Department of Energy and Lung Cancer

Munitions plant workers have been routinely screened for lung cancer since the Worker Health Protection Program was authorized in the Department of Defense Authorization Act of 1993 and funded through the Office of Environment, Safety and Health of the Department of Energy. Expansion of the program to more plants is being planned for FY 2009.

Justification

On October 26, 2006, the *New England Journal of Medicine* published the results of a 13-year study on

screening for lung cancer with CT scanners of 31,500 asymptomatic people at high risk. The study was carried out by multidisciplinary groups at 40 centers in 26 states and 6 foreign countries. Lung cancer was diagnosed in 484 participants, 85 percent at Stage I (versus 16 percent nationally), and those treated promptly had 10-year survival rates of 92 percent (versus the national 5-year survival rate of 15 percent). The participants in the study, now expanded to 53 sites in the United States and 8 foreign countries, are still being followed to validate the data, and a new study on the diagnosis and interrelationship of chronic obstructive pulmonary disease is now in its second year.

In March 2008, the National Comprehensive Cancer Network, which sets gold standard diagnostic and treatment guidelines, interceded in the screening debate and stated that those at high risk should enter a screening research program based on the International Early Lung Cancer Action Project (I-ELCAP) protocol. Collaborating with I-ELCAP would save VA the cost of "reinventing the wheel," receive training for its staff in the established protocols, and would have access to I-ELCAP's 50,000 scan data base to make the VA pilot study more robust.

2007 Legislative History

On August 2, 2007, the Senate passed S. Res. 87, expressing the sense of the Senate that the President should declare lung cancer a public health priority and implement a comprehensive interagency task force to reduce the mortality rate for lung cancer by 50 percent by 2015. The resolution specifically cited the serious problems of tobacco addiction and exposure among military personnel and veterans, and called for the DOD and VA to develop a lung cancer screening and disease management program.

On November 13, 2007, the House of Representatives passed H. Res. 335, which also cited concerns about lung cancer risk among the military and supported the development of a screening program for the military and veterans.

In addition, Senate Report 110-85 on FY 2008 Appropriations for Military Construction and Veterans Affairs and Related Agencies included the following language:

> Lung Cancer Screening—The Committee encourages the Secretary of Veterans Affairs to institute a pilot program for lung cancer screening, early diagnosis and treatment among high-risk veteran populations to be coordinated and partnered with the International Early Lung Cancer Action Program and its member institutions and with the designated sites of the National Cancer Institute's Lung Cancer Specialized Programs of Research Excellence. The Department shall report back to the Committee on Appropriations within 90 days of enactment of this act, on the viability and plans to institute a program of this nature.

2008 Legislative History

On June 28, Sens. Dianne Feinstein and Chuck Hagel introduced S. 3187, authorizing the priority status called for in the House and Senate resolutions, setting a goal of a 50 percent mortality reduction by 2015 and requiring the Secretaries of Health and Human Services, the DOD, and VA to collaborate on a comprehensive plan of coordinated action to achieve that goal. Specifically, VA was directed to implement, with the DOD, an early detection and disease management program for veterans whose smoking history and exposure to carcinogens during active duty have increased their risk for lung cancer.

On September 30, 2008, the President signed into law (P.L. 110-329) the FY 2009 DOD appropriations bill contained in H.R. 2638, which established in law a new Lung Cancer Research Program with a $20 million appropriation for FY 2009 with report language citing the higher exposure of the military to carcinogens and specific instructions that priority be given to "the development of the integrated components to identify, treat and manage early curable lung cancer."

Recommendation:

VA should request and Congress should appropriate at least $3 million in FY 2010 to conduct a pilot screening program for veterans at high risk of developing lung cancer based on collaboration with the International Early Lung Cancer Action Program and should explore the most effective way to partner with the Department of Defense on its early detection program.

Women Veterans Health and Health-Care programs:

The number of women veterans coming to the Department of Veterans Affairs for health-care services is expected to double within two to four years. VA must reevaluate its programs and services for women veterans to ensure that consistent comprehensive, quality women's health services are delivered across the continuum of care at all VA facilities.

Women have played a vital part in the military service since the birth of our nation. In the past 50 years their roles, responsibilities, and numbers have significantly increased. Current estimates indicate that there are 1.8 million women veterans comprising nearly 8 percent of the United States veteran population.[114] According to the Department of Defense (DOD), women service members represent 15 percent of active duty forces, 10 percent of deployed forces, and 20 percent of new recruits. Thus women are a very rapidly expanding segment of the veteran population.[115]

Historically, women have represented a small numerical minority of veterans who receive health care at VA facilities. However, if women veterans from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) continue to enroll at the current rate of 42.5 percent, it is estimated that the number of women using VA health-care services will likely double within two to four years.[116] Because women will still remain a numerical minority in VA, the overall effect of these increases will be small—but the impact on the gender-specific programs and staff who serve the unique needs of women will be very heavy. Absent significant reforms, women veterans will be unable to maintain their current level of access. VA's women veterans program managers (WVPMs) are a key component to addressing the specialized needs of women veterans in the VA health-care system. *The Independent Budget* veterans service organizations (IBVSOs) were very pleased when VA announced in July 2008 that it would provide a *full-time* women veterans program manager at every VA medical center by December 1, 2008. We believe, however, that a full-time WVPM should also be present at every large multispecialty community-based outpatient clinic (CBOC) and an alternate WVPM position formally assigned to cover responsibilities when the WVPM is unavailable to ensure continuity of services and care. We urge Congress to monitor the quarterly progress reports regarding the implementation of full-time WVPM positions throughout the system.

As noted, women who served in the global war on terrorism make up an important and growing segment of the veteran population. During the past five years, 42.5 percent of women veterans who served in OEF/OIF and separated from military service have used VA health-care services, and of that group 45.6 have visited 2–10 times.[117] The top three diagnostic categories that brought these veterans to VA care were diseases of the musculoskeletal system and connective tissue; mental disorders; and signs, symptoms, and ill-defined conditions.[118] The IBVSOs are pleased that VA is attempting to address the needs of women returning from combat theaters. However, the health consequences of service by women in a combat theater are still largely unknown because no long-term women's health studies have been conducted that focus on these unique issues. Rare events, such as cancers and birth defects, cannot be investigated without a dedicated, longitudinal women's health study that has adequate sample size and a representative population. The current deployments provide a unique opportunity to address these important questions, and we strongly urge that VA and Congress oversee and ensure that these research studies are completed and appropriately translated into VA policy and programs.

Women veterans who use VA health care are younger than men, averaging 49.5 years as compared to 61 years, respectively.[119] Additionally, more than 85 percent of women who served in OEF/OIF are under the age of 40.[120] According to VA researchers women veterans are three times more likely to use fee-basis care, are more likely to have substantial mental health comorbidity, have a greater overall disease burden, and use outpatient services more heavily than men, especially middle-aged women and those with comorbid mental health conditions. In addition, women are much more likely to have experienced sexual trauma while serving in the military, which has been shown to have significant long-term effects on burden of illness and health-care utilization.[121] These demographic changes and patterns of utilization along with the dramatic increases in women veterans' enrollment in VA health care will challenge VA resources and service delivery systems.

Despite the increasing number of women coming to VA for health care, historically, women veterans have been underserved. VA indicates that market penetration for men has remained steady at 22 percent with market penetration for women now at nearly 15 percent nationally

(up from 11 percent).[122] VA accounts for the recent rise in women veteran market penetration rates from 11 percent to 15 percent as an effect of the increasing numbers of women veterans from the OEF/OIF population who are seeking care at VA.[123] Although the IBVSOs are pleased that more women are choosing VA as their preferred health-care provider, we would like to see higher market penetration rates for women equal to that of their male counterparts. VA should begin with targeted outreach to women veterans who are receiving VA disability compensation benefits but who are not enrolled in the VA health-care system. Research has shown that women who do not utilize VA health care experience a number of barriers to accessing VA care, the most significant ones being lack of knowledge about eligibility and benefits and the perception that VA's health-care system is not "welcoming" to them. The IBVSOs agree with VA researchers that these results warrant further study to better understand women's reasons for seeking care elsewhere and urge VA to increase efforts to increase overall market penetration for women veterans.

The VA system was designed to provide health care to the predominantly male population it has traditionally served. Despite concerted efforts by the Department, privacy and safety issues have not been fully resolved to date. In 2003, VA issued Handbook 1330, and mandated minimum levels of women's health services to be provided by each VA facility, independent clinic, and CBOC: Unfortunately, a loophole exists in this policy that states that these services shall be provided "where feasible." However, quality of care measures for both cervical cancer screening and breast cancer screening ensured that at least some gender-specific care is provided to women veterans at each Veterans Health Administration (VHA) facility. Today, women are receiving services in a variety of clinic settings, including physically separate, specialized comprehensive women's centers, partially integrated gender-neutral primary care settings, and gender-specific care as separate clinic stops. The IBVSOs urge VA to also explore "virtual" women's clinics to help reduce barriers to care. Many younger women coming to VA work and are primary caretakers of children and parents and often find it difficult to maintain their health. Many new technologies are now available that can help reduce travel times to appointments for established patients to continue maintenance of their health.

The availability and the quality of this care vary widely across the VA health system, creating inequities in quality and service levels. Today's reality is that women veterans cannot be assured that their needs will be consistently met. In FY 2006, VHA survey results indicated that facilities were using the following models for provision of care to women veterans:

- Separate women's health centers providing comprehensive, multidisciplinary care that includes primary care, gender-specific care, mental health services, and surgical services (i.e., breast clinic or gynecology/colposcopy clinic) within a designated space (14 percent);
- Separate women's health centers providing primary care and gender-specific care within a designated space (19 percent);
- Separate gender-specific and/or gynecology clinics, with primary care provided in a designated women's primary care team within the facility (8 percent).
- Separate gender-specific and/or gynecology clinics, with primary care provided in mixed-gender primary care teams within the facility (43 percent); and
- Integrated gender-specific and primary care provided in mixed-gender primary care teams within the facility (16 percent).

Women's health care in the private sector is also somewhat fragmented; however, the IBVSOs believe VA should create a national model for delivery of comprehensive women's health care through complete women's health-care, education, and research programs, just as it took the lead in developing the best geriatric health-care delivery system for older veterans using VA services. VA women's health researchers have also examined which models of care deliver better quality care and patient satisfaction. Results clearly indicate that women veterans are significantly more satisfied with women's health providers, especially when care is provided by a gender-specific clinic, than they are with care in mixed-gender primary care clinics. When examining the question of provider gender as a factor in satisfaction with care, women prefer a provider who has expertise in women's health over a nonexpert, female provider. However, the highest satisfaction ratings are obtained when providers combine the characteristics of primary care/women's health expertise and female gender. Given these findings, the IBVSOs strongly support VA's initiative to provide training to VA clinical staff to increase their expertise in women's health care. VA also needs to increase its efforts to identify, recruit, retain, and educate clinicians who are proficient and interested in treating women veterans. VA should have at least one provider with women's health-care expertise at every VA medical facility. One way to accomplish this goal would be to establish Women Veterans Research, Education, and Clinical Centers.

The 2008 Congressionally directed "report card" for VA looked at measurements of quality, safety, timeliness, efficiency, and "patient-centeredness" within the VA health-care system. Although the overall report gave the Department high marks, the IBVSOs were distressed to learn that VA performance data revealed that women veterans lag behind their male counterparts in some quality measures and that there are disparities in treatment and satisfaction based on gender or ethnic background. Significant gender differences in provision of clinical prevention measures and mental health screenings were identified.[124] VA has indicated that it is currently working to address the identified health-care disparities faced by women veterans and will devote additional resources and attention to this problem until it is resolved.[125] However, to give the IBVSOs, veterans, and other stakeholders' confidence that health-care quality and access issues are being addressed, VA should begin to provide Veterans Integrated Service Network (VISN) and facility-level quarterly performance reports that are stratified by gender and report them in an easily accessible, public, and transparent manner. VA has been lauded for the overall quality of its health-care services. All veterans should be active and engaged partners in their health care. Veterans should be able to compare the quality of their VHA health-care services with the care of other public and private health-care providers. In order to ensure the highest quality of care, veterans and other stakeholders must have easy access to publically reported performance measurement data.

The women veteran population is predominantly pre-retirement and of child-bearing age; therefore, birth defects and potential exposure to teratogenic agents (which cause developmental deformities) must be addressed as a critical health-care quality and safety issue for women veterans. VA health-care providers should routinely question women about sexual function and reproductive issues and be knowledgeable about health promotion, disease prevention, and current issues related to women's health and treatment regimes. VA health-care providers should make every effort to reduce unnecessary exposure to radiation and pharmaceutical teratogens. VA should facilitate providers' ability to identify compounds associated with an increased risk of birth defects (teratogens) and immediately revise the pharmacy package to provide alerts for potential teratogens prescribed to women veterans under 50 years old. The IBVSOs strongly believe that VA must immediately add functionality to its electronic health record pharmacy package so that providers receive alerts concerning potential teratogenicity of pharmaceuticals being provided, and alternative choices can be offered to women. Equally critical is that every VA facility should have the ability to obtain an urgent beta-HCG pregnancy test so that health-care decisions can be made swiftly without endangering the veteran or fetus. In addition, women veterans should be offered a sexual function and safe-sex-practices screen annually.

Women veterans are often the primary caregivers in their families and extended families. Therefore, VA health-care providers need to be sensitized to the significant health-care access barriers women face as often unmarried employed heads of households, parents, and caregivers. The IBVSOs recommend that VA develop a pilot program to provide child care services for veterans who are the primary caregivers of children, while they receive intensive health-care services for post-traumatic stress disorder (PTSD), mental health, and other therapeutic programs requiring privacy and confidentiality.

Given the increasing role of women in combat theaters and the percentage of OEF/OIF women veterans coming to VA for health care, access to quality mental health services is critical.[126] These issues are especially important for women who deployed to a combat theater or those who suffered sexual trauma during military service. According to VA, in FY 2007, 22.2 percent of women and 1.3 percent of men reported military sexual trauma (MST) when screened. However, the IBVSOs note that the size of each clinical population (men/women) that reports MST is actually similar: 45,570 women and 47,764 men, respectively.[127] VHA staff needs to be sensitive and knowledgeable and recognize the importance of environment of care delivery when evaluating veterans for their physical and mental health conditions. We encourage the VHA to develop na MST provider certification program, guarantee at least 50 percent protected time for MST coordinators to devote to position responsibilities, provide separate/secure women's subunits for inpatient mental health and residential services, and improve coordination with the DOD on transition of women veterans, especially those with complex behavioral health needs.

In 2007, VA's National Center for PTSD published the first-ever randomized controlled trial to assess PTSD treatment for active duty and veteran women. In the study the women who received prolonged exposure therapy had a greater reduction of PTSD symptoms than women who received present-centered therapy. Additionally, the prolonged exposure group was more likely than the present-centered therapy group to no longer meet the criteria for a diagnosis of PTSD and achieve total

remission. However, mental health experts report that these case-intensive treatments are not universally available at VA medical centers (VAMCs) nationwide. This study documented the importance of spreading this evidence-based practice throughout VA's system. The IBVSOs are pleased that VA has developed a program to train its mental health providers to provide the most effective treatment for PTSD due to sexual trauma and combat trauma and is examining how best to address complex combat and MST issues.[128] However, further expansion of these training programs is still needed.

The IBVSOs also urge VA to concentrate on improving services for women with serious physical disabilities, such as spinal cord injury, amputations, and blindness. The physical space, size of examination rooms, the need for specialized equipment, overall setting, and safety issues should be evaluated throughout the VA health-care system. Additionally, all VA's specialized services, including those for polytrauma rehabilitation and transitional centers, substance-use disorders, homelessness, domestic violence, and postdeployment readjustment counseling, should be evaluated to ensure women have equal access.

The IBVSOs remain concerned about the fragmentation of care and disparities in care that exist for women using the VA health-care system. According to VA, 51 percent of women veteran VA who use the VA system split their care across VA and non-VA systems of care.[129] Additionally, a substantial number of women veterans receive care in the community via fee-basis and contract care, and little is known about the quality of that care.[130] For these reasons, we believe studies are needed that evaluate the quality of care delivered and that VA should improve its case management and care coordination programs for women veterans, especially for those with comorbid mental health conditions. VA should also assess care and develop a plan to enhance the provision of integrated primary care, specialty care, and readjustment and mental health services for women veterans. Finally, collaborative care models incorporating mental health providers should be piloted in the ambulatory care clinics where women receive their care.

Summary

As the population of women veterans undergoes exponential growth in the next decade, VA must act now to prepare to meet the specialized needs of women who have served. Overall, the culture of VA needs to be transformed to be more inclusive of women veterans and must adapt to the changing demographics of its women veteran users—taking into account their unique characteristics as young working women with child care and elder care responsibilities. VA needs to ensure that women veterans' health programs are enhanced so that access, quality, safety, and satisfaction with care are equal for women and men. We see the need for VA to reevaluate its programs and services for women veterans and to increase attention to a more comprehensive view of women's health beyond reproductive health needs to include examining cardiac care, breast cancer, osteoporosis, and colorectal cancer in women. A plan should be established that addresses the increased overall demands on ambulatory care, hospital and long-term care, gender-specific services, and mental health programs recognizing the unique and often complex health needs of women veterans. Mental health integration into primary care is also essential for provision of comprehensive women's health care.

Implementation of full-time WVPMs in every VAMC and large multispecialty CBOC, training to increase staff knowledge of the state-of-the-art in women's health, and mental health care and treatment should be fully realized this year. Women should have access to comprehensive primary care services from competent providers, including gender-specific care, at every VA facility. The IBVSOs also recommend that VA focus on improving services for women with serious physical disabilities and focus its women's health research agenda on a longitudinal health study of women who served in Afghanistan and Iraq. Such a study could prove invaluable as a source of information to help VA address a growing burden in the care of women who serve. In order to become a leader in women's health care and ensure that these goals are reached, VA should establish a new program of Women Veterans Research, Education, and Clinical Centers of Excellence.

Recommendations:

VA should conduct a comprehensive assessment of its women veterans' health programs and report the findings to Congress, along with an action plan to improve quality and reduce disparities in health-care services for women receiving VA care. The Government Accountability Office should review and report to Congress on the results of VA's assessment.

VA should redesign its women veterans care-delivery model and establish an integrated system of health-care delivery that covers a comprehensive continuum of care and serves as a best practice in the field.

VA should adopt a policy of transparent information sharing and initiate quarterly public reporting of all quality, access, and patient satisfaction data, including a report on quality and performance data stratified by gender.

VA should ensure that women veterans have access to comprehensive primary care services (including gender-specific care) at every VA facility. Collaborative care models incorporating mental health providers into women veterans' primary care teams should become the norm rather than the exception.

VA should implement and support at least one full-time women veterans program manager in women's health at every VA medical center and large multispecialty community-based outpatient clinic.

VA should fund a prospective, longitudinal long-term research study of the health consequences of women veterans' service in Afghanistan and Iraq. The research should include both telephone surveys and periodic health examinations of deployed and nondeployed women veterans.

VA should complete and report to Congress its comprehensive study of the barriers to health care experienced by recently discharged women veterans. The study should explore the perceptions and experiences of women who have tried to access health-care services at VA facilities.

VA health-care providers should make every effort to reduce women's unnecessary exposure to radiation and pharmaceutical teratogens. VA should facilitate providers' ability to identify compounds associated with an increased risk of birth defects and immediately revise the pharmacy package to provide alerts for potential teratogens to prescribe to women veterans less than 50 years of age. Women veterans should be offered a sexual function and safe-sex-practices screen annually.

VA's sexual trauma programs should be enhanced by requiring consistent training and certification of health-care personnel across all medical and mental health disciplines on techniques for screening women at risk for military sexual trauma, effective care and treatment options, and evidence-based clinical practice guidelines for sexual trauma survivors.

VA should develop a pilot program to provide child care services for veterans who are the primary caregivers of children, while they receive intensive health-care services for post-traumatic stress disorder, mental health, and other therapeutic programs requiring privacy and confidentiality.

VA should assess and develop a plan to enhance the provision of integrated readjustment and related mental health-care services for women veterans at VA's facilities, including Vet Centers.

VA should concentrate on improving services for women with serious physical disabilities and evaluate all VA's specialized services to ensure women have equal access to these programs.

VA's Women Veterans Advisory and Minority Veterans Advisory Committees should include veterans who served in Afghanistan or Iraq.

VA should expand its continuing and graduate medical education programs for women's health.

VA should establish a new program of Women Veterans Research, Education, and Clinical Centers modeled after the Geriatric Research, Education, and Clinical Centers.

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ENDING HOMELESSNESS AMONG VETERANS:

The Department of Veterans Affairs must expand and enhance its homeless veteran assistance programs, including preventative services, to help end and prevent homelessness among America's veterans.

Veterans are at a greater risk of becoming homeless because of many factors, including health problems, extremely low or no livable income due to unemployment or nontransferable skills, and a shortage of safe, affordable housing. Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with post-traumatic stress disorder (PTSD) or have addictions acquired during or worsened by their military service. At least 45 percent of homeless veterans suffer from mental illness, and more than 50 percent have substance-abuse problems. Many are dually diagnosed, which especially challenges existing service-delivery systems.

While most veterans currently homeless served during prior conflicts or in peacetime, the newest generation of combat veterans of Operation Enduring Freedom and Iraqi Freedom (OEF/OIF), both men and women, are returning home and suffering from postdeployment readjustment issues and other war-related conditions, including traumatic brain injury, which may put them at risk for homelessness. The evolving gender mix of the military—women representing 15 percent of the military population—will pose new challenges for the nation's support system for returning veterans and their families. Some women veterans are reporting serious trauma histories related to combat exposure and/or episodes of physical harassment and/or sexual assault while serving in the military. VA and homeless veteran service providers are also seeing increased numbers of veterans with children seeking their assistance.

Mental and physical health problems in addition to the absence of transferable work skills can interrupt veterans' ability to keep a job, find a home, establish savings, and, in some cases, maintain family stability. Veterans' family, social, and professional networks may have been broken as a result of extensive mobility while in military service or lengthy periods away from their hometowns and their civilian jobs. Oftentimes these problems are directly traceable to their experience in military service or to their return to civilian society without appropriate transitional support.

Most Americans believe our nation's veterans are well supported, but, in fact, many go without the services they require and are eligible to receive. According to a Congressional staff analysis of 2000 U.S. Census data conducted in 2005, 1.5 million veterans—nearly 6.3 percent of the nation's veteran population—have incomes that fall below the federal poverty level, including 634,000 with incomes below 50 percent of poverty level. Neither VA nor its state and county equivalents are adequately funded to fully respond to these veterans' health, housing, and supportive services needs. Moreover, community-based and faith-based service providers also lack sufficient resources.

VA estimates 300,000 veterans will experience homelessness at some point during the year. The VA's Health Care for Homeless Veterans program serves about one-third of this population. Community-based organizations serve approximately one-third of those in need. The remaining one-third of the homeless veteran population fails to receive the help they need to transition out of homelessness and reenter society as productive citizens. Likewise, other federal, state, and local public agencies—notably housing agencies and health departments—are not adequately responding to the housing, health-care, and supportive services needs of these vulnerable veterans. Indeed, it appears veterans fail to register as a target group for these agencies in many communities.

VA reports nearly 3,000 OEF/OIF homeless veterans were treated at VA medical centers over the past four years, and, of that number, 11 percent were women. Most likely, increasing numbers of this new generation of war veterans will be coming to VA and community-based homeless veteran service provider organizations to seek services, such as health care, substance abuse prevention, disability compensation, vocational rehabilitation, affordable housing, employment training, and job placement assistance. Poverty, lack of support from family and friends, and unstable living conditions in overcrowded or substandard housing may be factors contributing to these veterans' need for assistance.

With greater numbers of women serving in combat operations, along with increased identification of and a greater emphasis on care for victims of sexual assault and trauma, new and more comprehensive services, housing, and child care services are needed. Furthermore, in the

next 10 years, significant increases in services over current levels will be needed to serve aging Vietnam veterans suffering from chronic mental health problems.

According to the VA 2007 Community Homelessness Assessment, Local Education and Networking Groups report, there were an estimated 154,000 veterans who were homeless on any given night. This estimate of homeless veterans is down 21 percent from the 2006 estimate and represents a 40 percent reduction since 2001. VA stated the decrease was due in part to its partnership with community-based homeless veteran service providers and provides evidence that its programs to help homeless veterans are effective.

The Department of Housing and Urban Development reported in its 2007 *Annual Homelessness Assessment Report to Congress* that there had been a 30 percent reduction in chronic homelessness over the past two years. Among the 1.6 million people who were homeless and found shelter during 2007, 13 percent were veterans. The authors of the report attributed the reduction in homelessness to the effectiveness of supportive housing.

If the trend toward reducing the number of homeless veterans is to continue, more funding is needed for supportive services and housing options to ensure veterans who served prior to the conflicts in Afghanistan and Iraq will continue to take control of their lives and live as productive, self-sufficient citizens. Additionally, increased appropriations to VA homeless veteran assistance programs will help prevent homelessness among the newest generation of combat veterans from Operations Enduring and Iraqi Freedom. With the help of Congress, VA will be able to develop a coordinated approach to reduce, eliminate, and ultimately prevent homelessness among all of America's veterans.

Recommendations:

Congress should increase appropriations for the VA Medical Services Account to strengthen the capacity of the VA Health Care for Homeless Veterans programs; enable VA to increase its mental health and addiction service capacity; and enable VA to increase vision and dental care services to homeless veterans as required by law.

VA should improve its outreach efforts to help ensure homeless veterans gain access to VA health and benefits programs.

Congress should authorize and appropriate funds for competitive grants to community-based, faith-based, and public organizations to provide health and supportive services to formerly homeless veterans placed in permanent housing.

Congress should increase appropriations for the Homeless Veterans Reintegration Program *to the authorized level of $50 million.* Funded by the U.S. Department of Labor Veterans Employment and Training Service, HVRP is the only federal program wholly dedicated to providing employment assistance to homeless veterans and provides competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans.

Congress should increase appropriations for the Veterans Workforce Investment Program. Funded by the DOL, VWIP provides competitive grants to states geared toward training and employment opportunities for veterans with service-connected disabilities, those with significant barriers to employment (such as homelessness), and recently separated veterans.

Congress should establish a Veterans Work Opportunity Tax Credit program. The program would incentivize the hiring of homeless veterans by providing employers a tax credit equal to a percentage of the wage paid to the homeless or other low-income veterans.

Congress should increase the authorization level of and appropriations for the VA Homeless Provider Grant and Per Diem (GPD) program to *$200 million* to meet the need for additional transitional housing and service center programs assistance. GPD provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans. Special needs grant funding under this program should increase for women veterans, frail and elderly veterans, veterans with chronic mental illness, and those who are terminally ill.

Congress should revise the GPD payment program to allow payments to be related to service costs rather than a capped rate. Grantees should be allowed to use GPD funds, both in capital development projects and operating per diem payments, as a match to any other federal grant source. Grantees should also be allowed to use other available sources of income besides the GPD program to furnish services to homeless veterans.

Congress should establish additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers when such services are not available within VA.

Congress should provide and appropriate funding *for an additional 20,000 Section 8 vouchers* for the HUD-Veterans Affairs Supportive Housing Program, which provides permanent housing subsidies and case management services to homeless veterans with mental and addictive disorders, by appropriating additional funds for additional housing vouchers targeted to homeless veterans.

Congress should require applicants for Department of Housing and Urban Development McKinney-Vento homeless assistance funds to develop specific plans for housing and services to homeless veterans. Organizations receiving these assistance funds should screen all participants for military service and make referrals as appropriate to VA and homeless veteran service providers. Congress should authorize and appropriate funds for a targeted permanent housing assistance program to prevent homelessness among low-income and formerly homeless veterans.

Congress should assess all service members separating from the armed forces to determine their risk of homelessness and provide life skills training to help them avoid homelessness.

Congress should ensure VA facilities—in addition to correctional, residential health care, and other custodial facilities receiving federal funds (including Medicare and Medicaid reimbursement)—develop and implement policies and procedures to ensure the discharge of persons from such facilities into stable transitional or permanent housing and appropriate supportive services. Discharge planning protocols should include providing information about VA resources and assisting persons in applying for income security and health security benefits (such as Supplemental Security Income, Social Security Disability Insurance, VA disability compensation and pension, and Medicaid) prior to release.

LONG-TERM-CARE ISSUES

VA Long-Term-Care Issues

The VA Office of Geriatrics and Extended Care is responsible for meeting the diverse long-term-care (LTC) needs of America's aging veteran population. To fulfill this responsibility, the Department of Veterans Affairs must follow Congressional mandates and be responsive to organizations that represent veterans.

The Aging of America's Veterans

Changes in age composition of the veteran population will affect the needs and demand for VA health care. Further, medical care needs are not evenly divided among age groups in the population such that the projected long-term-care cost tends to rise sharply with age.

VA estimates there are 23,442,000[131] veterans living in the United States today, with more than half (12.6 million) 60 years and older. Prior estimates indicated veterans age 85 years and older would peak at 1.3 million by 2012. Notably, the segment of the veteran population age "85 or older" is projected to increase 110 percent between 2000 and 2020.[132] However, some current estimates indicate that this wave of 1.3 million of the eldest segment of the veteran population has already arrived. Historically, only a subset of the total veteran population has enrolled for VA medical care benefits and census statistics show a steady decline of the total veteran population over the next 20 years. However, the subset of veterans enrolling to use the VA health-care system is growing.

Based on a 2007 national survey[133] conducted by the Veterans Health Administration (VHA) on its enrolled

veteran population, the median age of enrollees was 63. Though 46 percent of the total enrolled veterans were 65 years and older, their numbers have steadily increased from 1.6 million in 1999 to 3.3 million in 2007. Furthermore, while there is an expected increase in the number of enrolled veterans aged 65 or older in the next decade, nearly 60 percent of the increase is projected to be among veterans aged 85 or older. Most striking is that the enrollment of all veterans aged 85 and older is projected to grow from 20 percent to 51 percent by 2013.

Historical trends show only about two-thirds of all enrolled veterans actually seek care from VA. Those who do not seek care do so for a variety of reasons such as having other private or public health-care coverage. In addition to age, another key driver for the demand for VA medical care is the reliance and dependence of enrolled veterans on the VA health-care system. Over the past few years, the rate of the total number of unique veteran patients who have sought care from VA has slowed, but is projected to peak in 2012. Furthermore, the increasing reliance on VA care of the aging World War II and Korean War veteran, median ages 83 and 76, respectively, as well as the increased use of pharmaceuticals to manage chronic conditions, is changing the demand for VA health-care services.[134] Interestingly, the largest cohort of the VA enrollee population is Vietnam-era veterans with a median age of 60. Findings based on the 2001 National Survey of Veterans published in *Military Medicine*,[135] indicate veterans under age 60 who served in Vietnam had worse self-reported health and higher rates of stroke than those who served elsewhere during that time. Vietnam veterans 60 years and older had poor self-rated health and a higher risk for cancer than their peers. Many facilities are now beginning to see Vietnam veterans in need of long-term-care (LTC) services.

VA's long-standing goal has been to provide a full spectrum of LTC services to eligible veterans. This oldest segment of the veteran population has had, and will continue to have, an increasing demand for VA health-care services, particularly those services focused on long-term care. With the influx of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans with severely disabling conditions such as traumatic brain injury, VA is challenged to meet their LTC needs, particularly in the area of residential rehabilitation care. Moreover, OEF/OIF veterans place a high value on their independence, are physically strong, and are part of a generation that was socialized differently than their older counterparts were. Although there are generational differences that pose unique challenge in the institutional and LTC environment, there is a shared preference to receive long-term care in noninstitutional settings, so they can stay connected with their community and loved ones. However, the success of such long-term care is critically dependent on the availability of local services and ability of veterans' family and friends to assist in their care. Caregiver burden is common and frequently limits the ability of family and friends to provide that assistance. Caregiving can also have significant negative consequences on the health and well-being of caregivers. *The Independent Budget* veterans service organizations (IBVSOs) believe programmatic changes can be applied, such as our recommendations from the "Family and Caregiver Support Issues Affecting Severely Injured Veterans" section of this *Independent Budget*. VA must move quickly to develop a comprehensive strategic plan, as required by Congress, to address the LTC needs of America's veterans.

Continuing Concerns on VA's Inadequate Planning for Long-Term Care

In 2003, 2004, 2005, and 2006, the Government Accountability Office (GAO) examined various aspects of VA's long-term-care programs at the direction of both the House and Senate Committees on Veterans' Affairs. The reports, which continued to find limitations with VA long-term-care program data for planning and oversight, remain a cause for great concern. In addition, the reports also describe access to a complete continuum of VA LTC services remains markedly variable from network to network.

In its November 2004 report,[136] the GAO pointed out several problems that prevent VA from having a clear understanding of its program's effectiveness. In a follow-up report[137] issued January 2006, the GAO reiterated the need for VA to estimate who will seek VA nursing home care and what their needs will be, to include estimating the number of veterans that will be eligible for nursing home care, based on law and VA policy, and the extent to which these veterans will be seeking care for long and short stays.

To help ensure that VA can conduct adequate program monitoring and planning for nursing home care and to improve the completeness of data needed for Congressional oversight, the GAO recommended that VA collect data for community and state veterans' nursing homes that is comparable to data collected on VA Community Living Centers (formerly Nursing Home Care

Units), including short-stay post-acute needs or long-stay chronic. The GAO also recommended that VA collect data on the number of veterans in these homes that VA is required to serve based on the requirements of the Veterans Millennium Health Care and Benefits Act, P.L. 106-117. VA's position is that data other than eligibility and length of stay, such as age and disability, are "most crucial" for its long-term-care strategic planning and program oversight. To best serve the veteran patient population, the IBVSOs believe Congressional oversight is equally important to VA's need to manage and plan for its long-term-care benefits package, particularly in light of shifting patient workload with 65 percent now being met by community and state veterans homes.

VA has expanded its noninstitutional long-term-care programs, such as home-based primary care, but it has not changed its reporting conventions such that it associates a day of care in a community-based or home-based program with that of a day of care in a nursing home or other institutional setting. This type of data collection and reporting is not conducive to proper oversight and may produce a distortion of activity or workload when in fact none may be present. VA's response to the GAO's 2004 report[138] that VA's workload measurement for home-based primary care does not accurately reflect the amount of care received by veterans specifies a combination of workload measures for home-based primary care and other long-term-care programs beginning in FY 2005, including days enrolled in the program, the number of patients treated, and the number of visits veterans receive.

Congress has shown its concern about VA's long-term-care planning, as evidenced by its rejection of VA's proposals to halt construction and reduce per diem funding to state veterans homes and to repeal the nursing home capacity mandate under P.L. 106-117. Most recently, Congress expanded the authorities for state veterans homes in passing the Veterans Benefits, Health Care, and Information Technology Act of 2006.[139] The law requires VA to reimburse state veterans homes for the full cost of care for a veteran with a 70 percent or greater service-connected disability rating and in need of care for service-connected conditions. It also ensures that veterans with a 50 percent or greater service-connected disability receive, at no cost, medications they need through VA. Moreover, not later than 180 days after its enactment, VA was required to publish a strategic plan for long-term care.

In light of VA's inability to meet mandated capacity requirements, coupled with its commitment to invest in alternative extended-care services, the IBVSOs are concerned about the delicate balance VA must achieve between institutional and noninstitutional long-term-care services to provide for veterans' health-care needs. We believe that the information to be collected and reported be those that are necessary to support strategic planning and program management as well as policy decisions and budget formulation.

Enrollee demand for long-term-care services, modeled by the VHA, lacks reliability, which led to a glaring gap in the Capital Asset Realignment for Enhanced Services (CARES) plan. Also, the limitation of this model was evidenced by VA's request in 2005 outside the regular appropriations process for an additional $1.997 billion, of which $600 million was to be used to correct for the estimated cost of long-term care. One of the most important underlying assumptions needed for VA's long-term-care planning model relates to understanding which enrollees choose to use VA extended-care services and why they make those choices. Until the necessary programmatic and patient population information is collected, validated, and analyzed, the IBVSOs believe VA will continue to struggle to effectively plan and provide for the immediate and future long-term-care needs of America's veterans. While VA can only advise Congress about the program requirements necessary to meet these needs, it is its duty to do so to the extent Congress is able to conduct proper oversight. VA should be the advocate for veterans' long-term-care needs, not just the provider.

VA's Long-Term-Care Programs

VA provides an array of noninstitutional (home and community-based) LTC programs designed to support veterans in their own communities while living in their own homes. Additionally, VA provides institutional (nursing home) care in three venues to eligible veterans and others as resources permit. VA provides nursing home care in VA-operated nursing homes (now termed Community Living Centers (CLCs)), under contract with private community providers, and in state veterans homes.

The long-term-care philosophy adopted by VA is to provide services in the "least restrictive setting." According to the VHA,[140] the aging veteran patient population will result in a 20–25 percent increase in use for both nursing home and home- and community-based services

through 2012. The VHA currently concentrates just over 90 percent of its long-term-care resources on nursing home care. However, among those veterans who receive long-term care from all sources, 56 percent receive care in the community. VHA's experience with providing mandatory nursing home care in its CLCs to service-connected veterans rated 70 percent or higher suggests that only 60–65 percent will choose VHA-provided care primarily due to geographical considerations and cost. These findings support the increased projected use for long-term care through home- and community-based services.

VA's current policy to increase noninstitutional services is supported by veterans, their families, and by organizations that represent them. However, the reality is that VA's own data forecast that demand for long-term-care services will increase over the next decade. Inevitably, thousands of veterans who are currently living in community settings, with the support of VA's noninstitutional services today, will need institutional services tomorrow. The IBVSOs believe the demand for VA nursing home care is increasing, not just because of the growing cohort of veterans 85 and older but also because of the complications related to the secondary conditions associated with military service that often present later in life. Accordingly, the IBVSOs are greatly concerned about VA's inability to maintain its CLC capacity at the 1998 level of 13,391 average daily census (ADC) as mandated by P.L. 106-117. In particular, the decrease in VA's CLC capacity year after year makes it more difficult to reactivate VA nursing home beds to serve veterans in need of such care.

Other equally disturbing issues exist that are aggravated by the continued decrease in CLC capacity along with the shift to provide institutional long-term care to community nursing homes (CNH) and state veterans homes. For example, VA "partnership" with the State Veterans Home program is in essence two-fold: VA's on-site inspections to ensure quality of care in state veterans homes and per diem payment to the states as they care for their veterans' long-term-care burdens. While provisions in P.L. 109-461 have enhanced this relationship, the majority of VA facilities continue to deny access to enrollment and to specialized VA care for residents of state veterans homes on the basis that the homes are responsible for comprehensive care, not VA. Moreover, most VA medical centers do not refer enrolled veterans to state veterans homes even when one is located close to the veteran's community, family, and friends. The lack of a true partnership between VA and state veterans homes affects the ability for veterans to receive patient-centric long-term care.

In addition, VA has become highly efficient at converting veterans it has placed in CNH to Medicaid status for payment purposes without establishing a formal tie to the Centers for Medicare and Medicaid Services (CMS) or with the states to oversee that unwritten policy. Clearly, much work remains to be done in VA's long-term-care program; however, Congress should conduct oversight and VA must maintain a safe margin of CLC capacity that will meet the needs of elderly veterans who can be expected to transition from VA's noninstitutional care programs to VA nursing home care in the near future.

VA Institutional Long-Term-Care Services

VA's Community Living Center
(formerly nursing home care units)

VA owns and operates 133 CLCs from Puerto Rico to Hawaii, which range in size from 20 to 240 beds. As mentioned previously, VA's nursing home ADC has again dropped below that of the previous year. The projected VA nursing home ADC for 2008 is 10,538. This number continues to reflect a steady downward trend in CLC capacity despite increased need for such services (see table below).

VA's national recognition as a leader in providing quality nursing home care is being challenged by its own emphasis on post-acute care at the expense of maintaining CLC capacity. The IBVSOs believe this approach is short-sighted considering the increasing number of veterans most likely to need long-term care. Further, Congress has mandated that VA must maintain its CLC capacity at the 1998 ADC level of 13,391, but VA has not done so despite testifying in 2007 that it expects to sustain existing capacity in its own CLC.[141] The IBVSOs are concerned that the decrease in the number of long-

LTC-ADC VA's Community Living Center (Nursing Home) Care Program	
2008	10,538
2007	10,926
2006	11,434
2005	11,548
2004	12,354
1998 (PL 106-117 Mandate)	13,391
ADC Decrease from PL 106-117 Mandate: (2,853)	

stay patients and the increase in the number of short-stay patients VA treats in CLCs will continue to drain needed capacity. However, VA has chosen to ignore the Congressional mandate without adequate justification, and, to date, Congress has chosen to look the other way.

VA's Community Nursing Home Care Program

VA has contracts with more than 2,500 private CNHs located throughout the nation. In 2005, the ADC for VA's CNH program represented 13 percent of VA's total nursing home workload. VA's CNH program often brings care closer to where the veteran actually lives, closer to his or her family and personal friends. Since 1965, VA has provided nursing home care under contracts or purchase orders. The CNH Program has maintained two cornerstones: some level of veteran choice in choosing a nursing home and a unique approach to local oversight of CNHs.

The IBVSOs have ongoing concerns about the quality of contract community nursing home care in VA[142] and the abrogative relationship VA has with the veterans it places in CNHs. VA must do more to ensure that the quality of care in these facilities meets the highest standards and that VA remain the responsible party to facilitate medical information transfer and coordination of other VA benefits and services. Veterans and their families must be assured that all aspects of care meet the individual veteran's needs. For example, veterans with catastrophic disabilities, such as SCI, blindness, PTSD, and other forms of mental illness, must receive care from trained staff. Their unique medical care needs require access to physicians, nurses, and social workers who are knowledgeable about the specialized care needs of these veteran groups.

VHA Handbook 1143.2 provides instructions for initial and annual reviews of CNH and for ongoing monitoring and follow-up services for veterans placed in these facilities. First introduced in 2002, the handbook updates new approaches to CNH oversight, drawing on the latest research and data systems advances. At the same time, the VHA maintains monitoring of vulnerable veteran residents while enhancing the structure of its annual CNH review process.

LTC-ADC VA's Community Nursing Home Program	
2008	4,787
2007	4,439
2006	4,395
2005	4,254
2004	4,302
ADC Increase over 2007: 248	

VA Nursing Home Care Provided in State Veterans Homes

The VA State Veterans Home Program currently encompasses 137 nursing homes in 50 states and Puerto Rico, with more than 28,000 nursing home and domiciliary beds for veterans and their dependents. State veterans homes provide the bulk of institutional long-term care to the nation's veterans. The GAO has reported that state homes provide 52 percent of VA's overall patient workload in nursing homes, while consuming just 12 percent of VA's long-term-care budget. VA's authorized ADC for state veterans homes was 18,349 for FY 2007 (see table below).

LTC-ADC State Veterans Homes	
2008	19,208
2007	18,349
2006	17,747
2005	17,794
2004	17,328
2008 ADC Increase over 2007: 859	

VA holds state homes to the same standards applied to the nursing home care units it operates. State homes are inspected annually by teams of VA examiners, and VA's Office of Inspector General (OIG) also audits and inspects them when determined necessary. State homes that are authorized to receive Medicaid and Medicare payments also are subject to unannounced inspections by the CMS and announced and unannounced inspections by the OIG of the Department of Health and Human Services.

VA pays a small per diem payment for each veteran residing in a state home, less than one-third of the average cost of that veteran's care. The remaining two-thirds is made up from a mix of funding, including state support, Medicaid, Medicare, and other public and private sources. In P.L. 109-461, Congress authorized VA to reimburse state homes the full cost of care for seriously disabled service-connected veterans (rated at least 70 percent disabled or more), and for veterans who receive state home care primarily for a service-connected disability at any VA rating.

Service-connected veterans should be the top priority for admission to state veterans homes, but traditionally they

have not considered state homes an option for nursing home services because of lack of VA financial support. To remedy this disincentive, Congress provided authority for full VA payment. Although regulations were not proposed until recently,[143] VA has been slow to implement this new mandate, which took effect in March 2007.

In addition to per diem support, VA helps cover the cost of construction, rehabilitation, and repair of state veterans homes, providing up to 65 percent of the cost, with the state providing at least 35 percent. Unfortunately, in FY 2007 the construction grant program was funded at only $85 million, the same amount Congress had provided in FY 2006. Based on a current backlog of nearly $1 billion in grant proposals (including $242 million in life and safety projects) and with thousands of veterans on waiting lists for state beds, *The Independent Budget for FY 2008* recommended no less than $150 million for this program. The IBVSOs are grateful Congress responded and provided $165 million for FY 2008 in the recently enacted omnibus appropriations act. For FY 2009, the *IB* recommended $200 million for the state veterans home construction grant program, and Congress provided $175 million.

For FY 2010, *The Independent Budget* recommends the construction grant program be funded at $250 million.

VA Noninstitutional Long-Term-Care Services

VA offers a wide spectrum of noninstitutional long-term-care (LTC) services to veterans enrolled in its health-care system. From 1998 to 2002, VA's ADC in home- and community-based care increased from 11,706 to 17,465. In FY 2003, 50 percent of VA's total long-term-care patient population received care in noninstitutional care settings. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, home respite care, home hospice care, and community residential care.

In recent years VA has been increasing its noninstitutional (home- and community-based) budget and services through the use of key performance measures for an annual percentage increase of noninstitutional long-term-care average daily census, using 2006 as the baseline of 43,325 ADC. As mentioned previously, simply using the percentage increase[144] is based on the ADC of veterans enrolled in home- and community-based care programs (e.g., community residential care, home-based primary care, contract home health care, adult day health care (VA and contract), homemaker/home health aide services, and care coordination/home telehealth) does not adequately capture the workload for strategic planning, program management, policy decisions, budget formulation, and oversight.

VA must also take action to ensure that these programs, mandated by P.L.106-117, are readily available in each VA network. In May of 2003, the GAO reported: "VA service gaps and facility restrictions limit veterans' access to VA noninstitutional care."[145] The report stated that of the 139 VA facilities reviewed, 126 do not offer all of the six services mandated by P.L. 106-117. In order to eliminate these service gaps, VA must survey each VA network to determine that all of its noninstitutional serv-

Table 4. LTC-ADC for VA Noninstitutional Care Programs

Programs	2004	2005	2006	2007	2008	I/D Over 2006
HHBPC	9,825	11,594	12,641	13,222	16,523	3,301
PSHC	2,606	3,075	2,490	2,656	3,319	663
HHHA	5,580	6,584	5,867	6,631	9,321	2,690
VA ADHC				15	335	320
C ADHC	1,493	1,762	1,304	1,884	2,019	135
Hospice	164	194	427	553	858	305
Respite	84	99	118	254	418	164
SCI					598	598
CRC	5,771	6,810	3,692	5,069	4,248	(821)
Total	**19,752**	**23,308**	**22,847**	**25,215**	**37,639**	**12,424**

Note: NOTE: I/D Change = Increase or (Decrease) Noninstitutional Program ADC over 2007: 12,424

ices are operational and readily available. Despite this information, VA's LTC Strategic Plan neglects to provide a clear and specific VA Action Directive to ensure systemwide compliance with P.L. 106-117.

The success of noninstitutional long-term care is critically dependent on the availability of local services and ability of veterans' family and friends to assist in their care. Family caregivers play an important role in health care, but need regular breaks to maintain their own health and well-being. VA respite care is one of the few services available with a primary focus on supporting family caregivers. Caregiver burden is common and frequently limits the ability of family and friends to provide that assistance. Caregiving can also have significant negative consequences on the health and well-being of caregivers. The IBVSOs applaud Congress for authorizing VA to conduct a pilot program on improvement of caregiver assistance services,[146] and look forward to the lessons learned to enhance caregiver services. Moreover, we believe programmatic changes can be applied, such as recommended in "Family and Caregiver Support Issues Affecting Severely Injured Veterans" in this *Independent Budget*.

The IBVSOs support the expansion of VA's noninstitutional long-term-care services and the adoption of innovative approaches to expand this type of care. Noninstitutional long-term-care programs can sometimes obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost effective and extremely popular. However, the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

Future Directions for VA Long-Term Care

The face of long-term care is changing, and VA continues to work within resource limitations to provide variations in programming that meet veterans' needs and preferences. The IBVSOs expect VA to modify existing programs and develop new alternatives as financial resources allow. New horizons for VA long-term care include the items discussed in the following subsections.

Culture Change in VA's Community Living Centers

Concerned by the perceived devaluation of the elderly and those who care for them, formal and informal meetings of a small group of health-care providers and administrators led to the creation of a national movement within the VHA. This movement aims to engage staff and veterans across the country in transforming the culture of long-term care to a resident-centered model providing compassionate and comprehensive care to veterans in a home-like environment. The culture transformation movement is also expected to ensure increased satisfaction for both nursing home residents and staff at all 134 VA CLCs across the United States. The IBVSOs believe VA should continue the "culture change" transformation; ensure VA medical center executive staff and the CLC nurse manager and staff are involved and committed to this initiative; and issue a report measuring the expected increased satisfaction in VA CLCs.

Hospice and Palliative Care

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings for people in the last phases of incurable disease so they may live as fully and as comfortably as possible. The program emphasizes the management of pain and other physical symptoms, the management of the psychosocial problems, and the spiritual comfort of the patient and the patient's family or significant other. Services are provided by a medically directed interdisciplinary team of health-care providers and volunteers. Bereavement care is also available to the family following the death of the patient. Hospice services are available 24 hours a day, seven days a week and is provided across multiple settings, including hospital, extended-care facility, outpatient clinic, and private residence.

While hospice and palliative care is part of VA's medical benefits package, it was in recent years that this service was made into a formally structured program. Expansion and outreach was greatly assisted through the Hospice-Veteran Partnership, a local coalition of VA facilities, community hospices, veterans service organizations, and volunteers. Community agencies have been made aware of this VA benefit through the Hospice-Veteran Partnership and are actively identifying veterans within the population they serve who were not previously identified.

VA is now providing hospice and palliative care to a growing number of veterans throughout the country. Nearly 9,000 veterans were treated in designated hospice beds at VA facilities in 2007, and thousands of other veterans were referred to community hospices to receive care in their homes. The number of veterans treated in VA's inpatient hospice beds increased by 21 percent in 2007. In addition, the average daily number of veterans

receiving hospice care in their homes paid for by VA increased by 30 percent this past year.

We applaud VA for its commitment to make this service available to all veterans who require such compassionate care. Nearly half of all veterans who died in VA facilities received care from a palliative care team prior to their deaths, although such services are provided at only about one-fourth of all American hospitals. Because of the large number of World War II and Korean War era veterans and a tripling of the number of veterans over the age of 85, the increase in the need for hospice care and palliative care is expected to continue. Furthermore, the IBVSOs applaud Congress's recent efforts to improve access to VA hospice and palliative care services by prohibiting VA from collecting copayments for hospice care provided to enrolled veterans in all settings.[147]

However, some gaps remain that are a cause for concern. Through the use of palliative care consultation services at each of its medical centers and inpatient hospice care in many of its nursing homes, VA is providing hospice and palliative care to a growing number of veterans throughout the country. While VA hospice and palliative care is to be available by direct provision or by purchase in the community, VA must ensure all its medical centers have a Palliative Care Consultation Team consisting of, at a minimum, a physician, nurse, social worker, chaplain, and administrator.[148] Moreover, when a veteran who is dually eligible for VA hospice and Medicare/Medicaid hospice and is referred to a community hospice agency, the veteran is given a choice as to which will pay for hospice care.

Although the IBVSOs believe a veteran's preference should be honored, we are concerned that the choice of payer can affect the types of services provided, the quality of care, and financial expenses the veteran and dependents may incur. VA's hospice care benefit is a greater benefit as it is part of a VA's comprehensive medical care benefits package designed to be patient-centric and treat the whole patient. For example, when a veteran chooses Medicare as the payer of hospice care, Medicare will not pay for any treatment or medications not directly related to the hospice diagnosis. The community hospice would need to inform the veterans and their dependent which treatment or medications are or are not covered. Further, under the Medicare hospice benefit, all care that veterans receive for their illness must be given by the community hospice. Therefore, the veteran must be discharged out of Medicare hospice before any other treatments or medications can be given to ensure the veteran's comfort and quality of life. Finally, the IBVSOs believe both the community hospice agency and VA must ensure that when the veteran dies his or her dependents are made aware of all ancillary VA benefits to which they may be entitled.

Respite Care

According to VA, respite care is a program in which brief periods of care are provided to veterans in order to give veterans' regular caregivers a period of respite. Respite care services are primarily a resource for veterans whose caregivers are neither provided respite services through, nor compensated by, a formal care system (i.e., Community Residential Care (CRC) program agreements, Medicaid waiver programs, hospice programs, and others for which the veteran is dually eligible). The National Family Caregiver Support Program,[149] along with Aged/Disabled (A/D) Medicaid Home and Community-Based (HCBS) waivers and state-funded respite care and family caregiver support programs that provide the bulk of public financing to support family caregiving, including respite care, defines respite care as a service to provide temporary relief for caregivers from their care responsibilities.

Respite care is considered the dominant service strategy to support and strengthen family caregivers under the A/D Medicaid HCBS waiver program. In a survey conducted on A/D Medicaid waiver programs that asked respondents to choose from a list of 20 items the services their program provides specifically to family caregivers, respite care received a 92 percent response, followed by information and assistance, homemaker/chore/personal care, and care management/family consultation at 48 percent each.[150]

Even the Department of Defense (DOD) provides respite services to injured active duty service members, including National Guard/Reserve members injured in the line of duty. TRICARE now offers primary caregivers of active duty service members rest, relief, and reprieve, authorized by section 1633 of the National Defense Authorization Act for Fiscal Year 2008 (NDAA). This respite benefit helps homebound active duty service members who need frequent help from their primary caregiver. If the injured service member's treatment plan requires a caregiver to intervene more than twice in an eight-hour period, the caregiver can receive respite services for a maximum of eight hours of respite per day, five days a week. Active duty service members or their legal representatives can submit receipts for reimbursement of respite care services beginning January 1, 2008, by a TRICARE-authorized home health agency. This benefit serves to mirror other supplementary TRICARE benefits

that provide respite services to active duty family members under TRICARE Extended Care Health Option (ECHO)[151] and TRICARE ECHO Home Health Care, which are created to better align DOD's existing unlimited home health agency and skilled nursing facility benefits to mirror the benefits and payment methodology used by Medicare.

VHA Handbook 1140.02, released on November 10, 2008, seeks to address concerns about the availability of this service in both institutional and noninstitutional settings; however, additional limitations remain. While the VA policy allows respite care services to be provided in excess of 30 days, it requires unforeseen difficulties and the approval of the medical center director. Moreover, long-term-care copayments apply to respite care regardless of the setting or service that provides such care. The IBVSOs believe VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veterans primary treating physician to approve respite care in excess of 30 days, making more flexible the number of hours/days of respite care provided to veterans and their caregivers, and eliminating applicable copayments.

Special Long-Term-Care Innovations to Serve Younger Combat Veterans

VA must move forward in the development of institutional and noninstitutional care programming for young OEF/OIF veterans whose combat injuries are so severe that they are forced to depend on VA for long-term-care services.

An important factor to consider is that extraordinarily disabled veterans are coming home from Afghanistan and Iraq with levels of injury and disability unheard of in past wars. Our incredible military medical triage and its applied technology has saved them, and many of them are now in VA polytrauma centers or other acute care and rehabilitation facilities, but they present a medical and social challenge the likes of which VA has not seen before. It is fortunate that the numbers of these "polytraumatic" injured are relatively small, but we must be cognizant that some of them will need extraordinary care and shelter for the remainder of their lives. Neither VA nor these veterans' families are fully prepared today to deal with their longer-term needs, an issue we have addressed in other sections of this *Independent Budget*. In addition to establishing internal residential treatment and care capacity, the existing partnership between the states and VA may be the basis for state veterans homes to play a small but vital role in aiding some of these catastrophically injured veterans by providing them a home-like atmosphere, a caring environment, and the level of clinical services they are going to need for the remainder of their lives. Also, state veterans homes greatly increase access for services and can offer a less intensive alternative to VA medical facilities in serving as a source of respite for families of these severely injured.

VA's current nursing home capacity is designed to serve elderly veterans, not younger ones. VA must make every effort to create an environment for these veterans that recognizes they have different needs. VA leadership and VA planners must work to bring a new type of long-term-care program forward to meet these needs. To facilitate the integration of young combat injured veterans into appropriately suited VA long-term therapeutic residential care programs, VA should capitalize on the use of state veterans homes that have the capacity of providing respite services to families and other caregivers of severely injured OEF/OIF veterans.

In March 2008, VA testified before the Senate Committee on Veterans' Affairs regarding an initiative to be implemented nationally that includes the Medical Foster Home program. This program identifies families in the area who are willing to open their homes and care for veterans who need daily assistance and are no longer able to remain safely in their own home, but do not want to move into a nursing home. It is provided as an adult foster home arrangement on a permanent basis, supported by VA's Home-Based Primary Care interdisciplinary home care team providing oversight and making regular visits.

VA considers this is a long-term commitment between the veteran and the caregiver. The veteran may live for the remainder of his or her life, and the partnership between VA's Foster Care Program and Home Based Primary Care is a safeguard against abuse. The first foster home program was started in Little Rock, Arkansas, in 1999, followed by sites in Tampa and San Juan. Using New Clinical Initiative Funding in 2000, VA developed medical care foster homes and provided funding at $95,000 for two years. In 2002 VA had 35 foster homes and 45 patients. Currently, the VHA has 38 facilities in 14 Veterans Integrated Service Networks (VISNs) with medical foster home programs, and in 2008, Congress granted funds for 33 additional sites.

Medical foster homes can be owned or rented by the caregiver, and the home is limited to three or fewer res-

idents (veterans and nonveterans) receiving care. The range of fee payments to medical foster home caregivers has increased from $1,000 to $1,800 per month in 2002 to $1,500 to $2,500 based upon the level of care needed by the veteran—for example, a cost of $1,500 for someone with mild cognitive impairment who is independent in activities of daily living but requires supervision, to $2,500 for someone who is incontinent, bed-bound, and needs to be turned every four hours. This payment is made by the veteran directly to the caregiver monthly, which includes room and board, 24-hour supervision, assistance with medications, and whatever personal care is needed.

VA believes Medical Foster Homes are cost-effective alternatives to nursing home placement because veterans must pay for their medical foster care using Social Security, private pensions, and VA pensions, or service-connected disability compensation. Although under current law a veteran having neither a spouse nor a child is covered by Medicaid for nursing facility services, no pension payments exceeding $90 per month after the month of admission are to be paid to the veteran or for him or her to the facility.[152] This does not apply to veterans receiving service-connected disability benefits, however. The IBVSOs are greatly concerned that veterans living in the medical foster home are required to pay for their stay in the home using personal funds, such as their VA compensation.

The newest generation of veterans, from the Gulf War until today, exhibits different expectations than their counterparts of the past. In general, they are computer literate, well educated, want more involvement in their own care, and want to control their own destinies. As these veterans age into later life and begin to need long-term-care services, this will make VA's and our jobs much more challenging. Younger veterans with catastrophic injuries must be surrounded by forward-thinking administrators and staff who can adapt to youthful needs and interests. The entire environment must be changed for these individuals, not just marginally modified. For example, therapy programs, surroundings, meals, recreation, and policy must be changed to adapt to a younger, more vibrant resident. Unfortunately, VA's Strategic LTC Plan does not explain how VA will adjust services to care for younger OEF/OIF veterans.

MyHealtheVet

VA's Office of Geriatrics and Extended Care should aggressively promote VA's MyHealtheVet program. This VA online program can greatly enhance an aging veteran's quality of life and help ensure the quality of medical care he or she receives from VA. MyHealtheVet is a veteran-centered proactive website that encourages veterans to be involved in their own health and the care they receive from VA.

VA's Care Coordination Program

VA's intent is to provide care in the least restrictive setting that is appropriate for the veteran's medical condition and personal circumstances. Further collaboration between programs within Geriatrics and Extended Care and those of the Office of Care Coordination/Home Telehealth can continue to produce positive results by providing services that are tailored to meet individual veterans' needs.

VA has been investing in a national care coordination program for the past three years. The program applies care and case management principles to the delivery of health-care services with the intent of providing veterans the right care in the right place at the right time. Veteran patients with chronic diseases, such as diabetes, heart failure, PTSD, and chronic pulmonary disease, are now being monitored at home using telehealth technologies.

Care coordination takes place in three ways: in veterans homes, using home telehealth technologies; between hospitals and clinics, using videoconferencing technologies; and by sharing digital images among VA sites through data networks. Care coordination programs are targeted at the 2 percent to 3 percent of patients who are frequent clinic users and require urgent hospital admissions. Each patient in the program is supported by a care coordinator who is usually a nurse practitioner, a registered nurse, or a social worker, but other practitioners can provide the support necessary. There are also physicians who coordinate care for complex patients.

As veterans age and need treatment for chronic diseases VA's care coordination program has the ability to monitor a veteran's condition on a daily basis and provide early intervention when necessary. This early medical treatment can frequently reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

As America's veteran population grows older, care coordination will be a useful tool in VA's long-term-care arsenal that can enable aging veterans to remain at home or close to home as long as possible. Congress must assist VA in expanding this valuable program across the entire VA health-care system.

VA Long-Term Care for Veterans with Spinal Cord Injury/Disease (SCI/D)

Both institutional and noninstitutional VA long-term-care services designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D. Older veterans with SCI/D are especially vulnerable and require a high degree of long-term and acute care coordination. A major issue of concern is the fact that a recent VA survey indicated that in FY 2003 there were 990 veterans with SCI/D residing in non-SCI/D designated VA nursing homes. However, VA has not identified the exact locations of these veterans in its LTC Strategic Plan. The special needs of these veterans often go unnoticed and are only discovered when the patient requires admission to a VA medical center for treatment.

VA's LTC Strategic Plan does not provide adequate and specific information to identify the location and facility of service for these veterans. The plan provides a VISN-by-VISN roll-up but does not allow for quality-of-care tracking of individual catastrophically injured veterans. VA must develop a program to locate and identify veterans with SCI/D who are receiving care in non-SCI/D designated LTC facilities and ensure that their unique needs are met. In addition, these veterans must be followed by the nearest VA SCI center to ensure they receive the specialized medical care they require. Veterans with SCI/D who receive VA institutional long-term care services require specialized care from specifically trained professional LTC providers in an environment that meets their accessibility needs.

Currently, VA operates only four designated LTC facilities for patients with SCI/D, and none of these facilities is located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility, Chicago (28 staffed beds); and Castle Point, New York (16 staffed beds). Unfortunately, these limited staffed (121 total) beds are usually filled, and there are waiting lists for admission. These four VA SCI/D long-term-care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

Although the VA CARES initiative has called for the creation of additional long-term care beds in four new locations (30 in Tampa, 20 in Cleveland, 20 in Memphis, and 30 in Long Beach, California), these additional services are not yet available and would provide only 30 beds west of the Mississippi River. These new CARES long-term-care beds present an opportunity for VA to refine the paradigm for SCI/D LTC design and to develop a new SCI/D LTC staff training program.

Assisted Living

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with activities of daily living (ADLs) or the instrumental activities of daily living. Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, VA forwarded a report to Congress concerning the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by P.L. 106-117. The Assisted Living Pilot Program (ALPP) was carried out in VA's VISN 20. VISN 20 includes Alaska, Washington, Oregon, and the western part of Idaho. It was implemented in seven medical centers in four states: Anchorage; Boise; Portland; Roseburg, Oregon; White City, Oregon; Spokane; and Puget Sound Health Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

The VA report on the overall assessment of the ALPP stated: "The ALPP could fill an important niche in the continuum of long-term-care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."

Some of the main findings of the ALPP report include:

- ALPP veterans showed very little change in health status over the 12 months postenrollment. As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that the ALPP may have helped maintain veterans' health over time.
- The mean cost per day for the first 515 veterans discharged from the ALPP was $74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.
- The mean cost to VA for a veteran's stay in an ALPP facility was $5,030 per veteran. The additional cost of case management during this time was $3,793 per ALPP veteran.

- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.
- The average ALPP veteran was a 70-year-old unmarried white male who was not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.
- ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment: 22 percent received assistance with between four and six ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with one to three ADLs; while 35 percent received no assistance.
- Case managers helped ALPP veterans apply for VA Aid and Attendance and other benefits to help cover some of the costs of staying in an ALPP facility at the end of the VA payment period.
- Veterans were very satisfied with ALPP care. The highest overall scores were given to VA case managers (mean: 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82).
- Veterans are quite satisfied with their participation in ALPP with a mean score of almost 8 (of 10).
- Case managers were very satisfied with ALPP. (Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall in between the cracks.")

VA's transmittal letter that conveyed the ALPP report to Congress stated that VA was not seeking authority to provide assisted living services, believing this is primarily a housing function. The IBVSOs disagree and believe that housing is only one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is just part of the mix. VA already provides housing in its domiciliary and nursing home programs, and an assisted living benefit should not be prohibited by VA on the basis of its housing component.

CARES and Assisted Living

VA's final CARES decision document and the VA's CARES Commission recommended utilizing VA's enhanced-use leasing authority as a tool to attract assisted living providers. The enhanced-use lease program can be leveraged to make sites available for community organizations to provide assisted living in close proximity to VA medical resources. The Fort Howard, Maryland, project is a good example of a partnership between a private developer and VA.

The IBVSOs concur with this CARES recommendation and the application of VA's enhanced-use lease program in this area. However, the IBVSOs believe that any type of VA enhanced-use lease agreement for assisted living, or any other projects, must be accompanied with the understanding that veterans have first priority for care or other use.

The IBVSOs acknowledge and appreciate that Congress recently authorized a new VA assisted living pilot project in Section 1705 of Title XVII of the NDAA. We are hopeful that VA and the Department of Defense will expedite the establishment of this program, understanding that its intent is aimed at providing alternative therapeutic residential facilities to severely injured OEF/OIF veterans. However, this new program also provides an important new opportunity to further study the feasibility and worth of assisted living as an alternative to traditional institutional services for elderly veterans.

Recommendations:

VA must develop a more robust Long-Term Care Planning Model to ensure that strategic planning, program management, policy decisions, budget formulation, and oversight are able to meet the growing need of veterans of all ages for long-term care.

Congress must hold appropriate long-term care hearings to learn the specific issues of concern for aging veterans. The information gleaned from these hearings must be used by VA as it moves forward in the development of a comprehensive strategic plan for long-term care.

VA must develop a more detailed comprehensive strategic plan for long-term care that includes milestones for oversight purposes and such a plan must ensure that it meets the current and future needs of America's veterans.

Congress must provide the financial resources for VA to implement its long-term-care strategic plan.

Congress must enforce and VA must abide by P.L. 106-117 regarding VA's nursing home average daily census capacity mandate.

VA and Congress must continue to provide the construction grant and per diem funding necessary to support state veterans homes. Even though Congress has approved full long-term-care funding for certain service-connected veterans in State Veterans Homes under P.L. 109-461, it must continue to provide resources to support other veteran residents in these facilities and to maintain the infrastructure. To that end, Congress should provide state veterans homes $250 million in construction grant funds for FY 2010.

Congress must conduct oversight on VA's relationship and use of community nursing homes to provide long-term care to disabled veterans, and VA must do a better job of tracking the quality of care provided in VA contract CNHs. Unscheduled quality-of-care visits are a good first step but accreditation requirements are a better approach.

Given the evident growth in demand and to protect traditional VA institutional programs, Congress must provide additional resources and VA must increase its capacity for noninstitutional, home, and community-based care.

The Veterans Health Administration must update its noninstitutional extended care directive and information letter to ensure that each noninstitutional long-term-care program mandated by P.L. 106-117 is operational and available across the entire VA health-care system.

VA should continue the "culture change" transformation; ensure that VA medical center executive staff and the community living center nurse manager and staff are involved and committed to this initiative; and issue a report measuring the expected increased satisfaction in VA community living centers.

VA should ensure all veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be provided, at a minimum, all services within the VA medical benefits package regardless of the payer of services.

VA should ensure all dependents of veterans in receipt of hospice care, whether referred by VA or identified by the community hospice agency, be made aware of all ancillary VA benefits to which they may be entitled.

VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating physician to approve respite care in excess of 30 days, making more flexible the number of hours/days of respite care provided to veterans and their caregivers, and eliminating applicable copayments.

VA should expand the care coordination program to reduce the incidence of acute medical episodes and, in some cases, prevent or delay the need for institutional or long-term nursing home care.

VA should not require veterans to use personal funds, such as their service-connected disability benefits, to avail themselves of the type of noninstitutional long-term care provided by the medical foster homes program.

VA's Office of Geriatrics and Extended Care should encourage veterans to use VA's MyHealtheVet website.

Serious geographical gaps exist in specialized long-term-care services (nursing home care) for veterans with spinal cord injury or spinal cord disease. As VA develops its construction plan for nursing home construction, it must provide a minimum of 15 percent bed space to accommodate the specialized spinal cord injury nursing home needs nationally. VA must start by implementing the Capital Asset Realignment for Enhanced Services spinal cord injury/dysfunction long-term-care recommendations. VA must develop a more detailed facility by facility mechanism to locate and identify veterans with SCI/D and other catastrophically injured veterans residing in non-SCI/D long-term-care facilities.

VA should develop a VA nursing home care staff training program for all VA long-term-care employees who treat veterans with SCI/D and other catastrophic disabilities.

While assisted living is not currently a benefit that is available to veterans (outside the two pilot programs discussed above), *The Independent Budget* veterans service organizations (IBVSOs) believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care.

VA's 2004 Assisted Living Pilot Program report seems most favorable and assisted living appears to be an unqualified success. However, to gain further under-

standing of how the ALPP can benefit veterans, it should be replicated in at least three Veterans Integrated Service Networks with a high percentage of elderly veterans. The IBVSOs hope the new pilot program authorized by the National Defense Authorization Act for Fiscal Year 2008 can be a means of evaluating assisted living as an innovative option for meeting long-term-care needs of elderly veterans.

[131](www1.va.gov/vetdata/docs/4X6_fall08_sharepoint.pdf).
[132]*FY 2006–2011 Strategic Plan*, Office of the Secretary of Veterans Affairs, October 2002 (www.va.gov).
[133]2007 *Survey of Veteran Enrollees' Health and Reliance Upon VA* Veterans Health Administration, May 2008 (www.va.gov/vhaeorg).
[134]VA Congressional budget submission for FY 2009.
[135]Matthew S. Brooks, Sarah B. Laditka, and James N. Laditka, "Evidence of Greater Health Care Needs Among Older Veterans of the Vietnam War," *Military Medicine* 173(8) (2008): 715–20.
[136]GAO-05-65.
[137]GAO-06-333T.
[138]GAO 04-913.
[139]P.L. 109-461 § 211.
[140]Bruce Kinosian, Eric Stallard, and Darryl Wieland, "Projected Use of Long-Term Care Services by Enrolled Veterans," *Gerontologist* 47(3) (2007): 356-64.
[141]House Committee on Veterans' Affairs, Subcommittee on Health, "State of the U.S. Department of Veterans Affairs' (VA) Long-Term Care Programs," Hearing. May 9, 2007. 100th Cong., 1st Sess., Washington: Government Printing Office, 2008. Print.
[142]GAO-01-768.
[143]Per Diem for Nursing Home Care of Veterans in State Homes, Proposed Rule. *Federal Register* 73(233) (28 November 2008): 73558–62. Print.
[144]Annual percentage increase from 2006 baseline of 43,325 average daily census of noninstitutional long-term care.
[145]GAO 03-487.
[146]Public Law 109-461, Title II, § 214.
[147]P.L. 110-387, Title IV, § 409.
[148]Additional support may be provided by pharmacists, rehabilitation therapists, recreation therapists, mental health professionals, and other specialists.
[149]Enacted under the *Older Americans Act Amendments of 2000*.
[150]L. Feinberg, L. and S. Newman. "Medicaid and Family Caregiving: Services, Supports, and Strategies Among Aged/Disabled HCBS Waiver Programs in the U.S," (New Brunswick, NJ: Rutgers Center for State Health Policy, May 1, 2005).
[151]Formerly Program for Persons With Disabilities. See *National Defense Authorization Act of 2002*.
[152]38 U.S.C. § 5303.

VA MEDICAL AND PROSTHETIC RESEARCH

VA research is a national asset. The VA Medical and Prosthetic Research program is one of the nation's premier biomedical and behavioral research endeavors. It helps ensure the highest standard of care for veterans enrolled in VA health care, and elevates health-care practices and standards in all of American health care.

Improving Lives through Innovation and Discovery

For more than 60 years, the VA Research and Development program has been improving veterans' lives through innovation and discovery that has led to advances in health care for veterans and all Americans. VA researchers conducted the first large-scale clinical trial that led to effective tuberculosis therapies and played key roles in developing the cardiac pacemaker, the CT scan, radioimmunoassay, and improvements in artificial limbs. The first liver transplant in the world was performed by a VA surgeon-researcher. VA clinical trials established the effectiveness of new treatments for tuberculosis, schizophrenia, high blood pressure, and other heart diseases. The "Seattle Foot" and subsequent improvements in prosthetics developed in VA have allowed people with amputations to run and jump. VA investigators have won three Nobel prizes, six Lasker awards, and numerous other distinctions.

VA investigators are currently doing the following:

- Developing powerful new approaches to assess, manage, and treat chronic pain to help veterans with burns and other injuries.
- Working on ways to ease the physical and psychological pain of returning soldiers.
- Exploring how to deliver low-level, computer-controlled electric currents to weakened or paralyzed muscles to allow people with incomplete spinal cord injury to once again walk and perform other everyday activities.
- Gaining new knowledge of the biological and behavioral roots of post-traumatic stress disorder (PTSD) and developing and evaluating effective PTSD treatments.
- Studying new drug therapies and ways to enhance primary care models of mental health care.
- Identifying genes associated with Alzheimer's disease, diabetes, and other conditions.
- Developing new assistive devices for the visually impaired, including an artificial retina to restore vision.

- Studying ways to prevent, diagnose, and treat hearing loss.
- Pioneering new home dialysis techniques.
- Developing a system that decodes brain waves and translates them into computer commands to allow quadriplegics to perform daily tasks like using email.
- Exploring organization of care, delivery methods, patient outcomes, and treatment effectiveness to further improve access to health care for veterans.

As part of the VA integrated health-care system with a state-of-the-art electronic health record, the VA research program is able to promote prompt translation of research findings into advances in care and medical decision making. By basing its research on patient-centered evidence, VA has become an acclaimed model for conducting superior bench-to-bedside research.

VA research is veteran oriented and focused on prevention, diagnosis, and treatment of conditions prevalent in the veteran population. More than three quarters of VA researchers are clinicians who provide direct patient care to veterans. As a result, the Veterans Health Administration—the largest integrated health-care system in the world—has a unique ability to translate progress in biomedical science directly to improvements in VA clinical practices.

The VA research program is intramural; that is, only VA employees holding at least a five-eighths salaried appointment may apply for VA research awards. Unlike other federal research agencies, such as the National Institutes of Health and Department of Defense, VA does not make grants to external entities. As such, the program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators to the VA health-care system. The resulting environment of health-care excellence and ingenuity benefits every veteran receiving care in the VA health system and, ultimately, all Americans.

The Independent Budget veterans service organizations therefore recommend the funding levels shown in the table below for FY 2010–FY 2012.

Medical and Prosthetic Research (in millions)	
FY 2009	$510
***The Independent Budget* Recommendation**	
FY 2010	$575
FY 2011	$596
FY 2012	$617

Funding for VA Medical and Prosthetic Research:

Funding for VA research must be sufficient, timely, and predictable in size to meet current commitments and allow for innovative scientific growth.

The VA Medical and Prosthetic Research Program leverages the taxpayer's investment via a nationwide array of synergistic partnerships with for-profit industry partners, nonprofit organizations, and academic affiliates. Adding the ability of VA researchers to successfully compete for funding from the National Institutes of Health and other federal agencies to these partnerships, the VA research program has done an extraordinary job leveraging its relatively modest annual appropriation into a $1.8 billion research enterprise that hosts multiple Nobel Laureates and produces an increasing number of scientific papers annually, many of which are published in the most highly regarded journals. The Department of Veterans Affairs has reported that from January 1, 2001, through November 7, 2008, VA investigators and clinicians were coauthors of 65,779 articles in peer-reviewed scientific journals. This highly successful enterprise demonstrates the best in public-private cooperation, but would not be possible without the VA-funded research opportunities. As such, a commitment to steady and sustainable growth in the annual research and development appropriation is necessary for maximum productivity and continued achievement.

Predictable and Sustainable Growth

Funding for VA research has been unpredictable. For example, in FY 2005, VA research was cut by $3.3 million (0.8 percent). In FY 2006, VA research received a less than inflationary $9.7 million (2.4 percent) increase followed by essentially flat funding ($413.7 million) under the FY 2007 joint funding resolution. The FY 2007 emergency supplemental appropriations provided an additional $32.5 million for VA research, thus increasing total research funding in FY 2007 to more than $446 million. In November 2007, the second continuing resolution briefly funded VA health care at a rate equal to that proposed by the President for FY 2008. For FY 2008, the Administration proposed only $411 million for VA research, forcing VA research to temporarily reduce its annualized rate of spending by 7.9 percent. Congress responded by providing VA $480 million, causing VA to reverse course once again. For FY 2009, VA proposed $442 million, another projected and significant cut, while Congress later provided VA research $510 million.

Such a "see-saw" funding history with arbitrary peaks and valleys impedes important VA research on national priorities, including studies on post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), eye and optic nerve injuries, amputations, polytrauma, burns, and other acute and chronic health conditions long prevalent in the veteran population. VA research administrators and investigators are understandably reluctant to expand their research endeavors, since this record of inconsistent and unpredictable funding can quickly devastate plans for growth or cause interruptions and even cancellations of ongoing projects. Furthermore, should availability of research awards decline as a function of budgetary policy, VA risks losing physician-researchers and other clinical investigators who are integral to providing direct care for our nation's veterans and for sustaining high-quality programs for veterans' specialized needs.

VA research awards are typically designed for three-to-five years in duration. However, scientific advancement can demand many more years and requires steady, sustained funding to achieve its optimal potential. To maintain the current level of VA research activity over the next three years, biomedical research and development inflation is assumed at 3.5 percent for FYs 2010 through 2012. Beyond biomedical inflation, additional research funding is needed to (1) take advantage of burgeoning opportunities to improve the quality of life for our nation's veterans through "personalized medicine"; (2) address the critical needs of returning Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and others who were deployed to combat zones in the past; (3) advance health promotion, women veterans' health and long-term care; and (4) raise the VA-imposed cap on investigator-initiated awards.

According to VA, in FY 2007 a total of 192 new projects were funded with supplemental funds provided by Congress that year. For the most part, these projects were research investigations targeting such topics as "Novel Strategies Targeting Gliosis [a process leading to scars in the central nervous system] after Traumatic Brain Injury" and "Feasibility of a Zero-Impingement Socket for Lower Limb Prostheses." In some cases, these projects involved equipment purchases, such as a "Mobile 3.0 Telsa MRI-fMRI Scanner and Mobile Clinical Assessment Center" that supports a collaborative project between Fort Hood and the Central Texas VA Health Care System on TBI and PTSD. These equipment purchases significantly expanded VA's ability to conduct research related to military trauma of OEF/OIF veterans and have leveraged VA's ability to obtain collaboration and funding from other agencies.

With the supplementary funds Congress provided in FY 2008, VA awarded 291 new research investigations, with such titles as "Growth Factor Treatment of Visual Loss in Compressive Optic Nerve Injury" and "Cholinergic Interventions [interventions related to a specific neurotransmitter] to Enhance Rehabilitation from Brain Trauma." VA would not have been able to award these projects without the additional appropriation. In addition, funding was provided to expand the scope of 652 ongoing investigations. Finally, 46 significant equipment purchases were made to improve VA's ability to conduct cutting-edge research directly relevant to veterans' health care.

The Independent Budget veterans service organizations (IBVSOs) expect VA's expansionary research portfolio to grow with the extra funding Congress provided in FY 2009—growth we recommend be sustained in FY 2010, FY 2011, and FY 2012—to support the following:

- VA is uniquely positioned to revamp modern health care and to provide progressive and cutting-edge care for veterans through genomic medicine. VA is the obvious choice to lead advances in genomic medicine. It is the largest integrated health system in the world, employs an industry-leading electronic health record, and has an enrolled treatment population for sustained research. VA combines these

attributes with high ethical standards and standardized practices and policies. Innovations in genomic medicine will allow VA to:

- reduce drug trial failure by identifying genetic disqualifiers and allowable treatment of eligible populations;
- track genetic susceptibility for disease and develop preventative measures;
- predict responses to medications; and
- modify drugs and treatments to match an individual's unique genetic structure.

- Research on strategies for overcoming the devastating injuries suffered by veterans of OEF/OIF needs to be expanded. Improvements in prosthetics and rehabilitation as well as more effective treatments for polytrauma, TBI, injuries to the eye (highly significant in this population), significant body burns, PTSD, and suicide risk are urgently needed. Funding more studies and accelerating ongoing research efforts can deliver results that will make a measurable difference in the quality of life for thousands of our newest generation of war veterans.
- Since 1999, funding limitations in VA research have forced the agency to cap many VA merit-review awards at levels lower than the average award at comparable federal research institutions. VA research awards have been modestly funded since the imposition of a $100,000 cap in 1999. Nearly a decade later, the current $150,000 cap barely keeps pace with biomedical inflation or VA's commitment to scientific innovation.

The cap is a trade-off that VA research leadership makes to continue funding the same number of awards it has historically supported. This is a problem compounded by VA's need to expand its research portfolio to include research on conditions prevalent among veterans of OEF and OIF. The IBVSOs support increasing the number of funded programs to meet these new challenges, but as a secondary objective we also support raising the cap on merit review programs in order to recognize inflation, maximize productivity, foster recruitment, and speed the translation of research from the bench to the bedside.

VA Research Infrastructure Needs

The rising concerns of the IBVSOs about the status of VA's research laboratories and associated facilities are reflected elsewhere in this *Independent Budget*. We urge Congress to begin to address these needs in FY 2010 with a major funding supplement of $142 million available exclusively to VA research infrastructure.

The Uncertain Future

As indicated in the "Critical Health Infrastructure" section of this *Independent Budget* and the *Critical Issues Report* associated with this budget, the IBVSOs are concerned about the future direction of the VA health-care system if VA shifts its focus away from inpatient services and relies primarily on affiliates or contractors to provide those services. If such a shift is being contemplated, in effect "closing" many VA hospital beds, we urge VA and Congress to consider the impact on VA's historic academic and research missions. Although VA research investigators do not necessarily need to rely on hospital inpatients as clinical subjects for their projects, inpatient services and resources are important components of VA's academic and research missions. Moving VA care to external providers raises a number of questions about the viability of both missions.

Concern about Congressionally Directed VA Research

The IBVSOs and Friends of VA Medical Care and Health Research strongly support leaving all decisions about the selection of particular research projects, and their funding, to the VA scientific peer-review process. Funding for any potential Congressionally mandated VA research, therefore, is not included in this *Independent Budget* recommendation. Any such directed research, if so desired by Congress, should be appropriated separately.

Recommendations:

To keep its research funding predictable and stable, VA requires at least $20 million per year to account for rising biomedical research costs. *The Independent Budget* veterans service organizations believe an additional $45 million in FY 2010 is needed for continued support of new research initiatives and to raise the restrictive cap on merit reviews. Thus, the President and Congress should provide an increase of $65 million for VA research in FY 2010, for a total of $575 million.

In keeping with VA's crucial need to have stable, predictable funding so that it can effectively manage critical multiyear proposals, the President and Congress should fund the VA Medical and Prosthetic Research Account at $596 million in FY 2011, and $617 million in FY 2012.

ADMINISTRATIVE ISSUES

RECRUITMENT CHALLENGES FACING THE VETERANS HEALTH ADMINISTRATION:

The Department of Veterans Affairs must strengthen, energize, and expand personnel programs to recruit and retain highly qualified medical and health-care professionals within the Veterans Health Administration (VHA).

Addressing human resource issues within the Department of Veterans Affairs has never been more urgent than now, with the ongoing conflicts in Afghanistan and Iraq and the aging of both the veteran population and the "Baby Boomer" generation. Service members are returning from conflicts abroad and seeking services from VA, and, at the same time, veterans from previous wars, particularly veterans from the Vietnam era, are aging and their need for medical services and other VA benefits is steadily increasing. In this environment, sufficient staffing becomes more essential to ensuring that veterans receive adequate VA care.

The facilities of VA, like many other American health-care providers, are facing a looming and potentially dangerous shortage of available health-care personnel to meet the growing demands of sick and disabled veterans. The current documented national shortage of physicians, nurses, pharmacists, therapists of all disciplines, psychologists, and practitioners in several other professional disciplines is bound to have an impact on the effectiveness of VA's recruitment and retention programs. VA estimates that 163,308 new hires will be needed to handle attrition and maintain the VHA's workforce to 2013. VA must anticipate the effects of the national health-care workforce shortage and work to provide competitive employment packages and a more preferred workplace to ensure veterans continue to receive high quality and effective VA health care in the future.

The dwindling supply of trained and qualified health-care professionals cannot keep pace with the national growth in demand for health care. VA has recognized that the employment market is extremely competitive for some positions and is working to provide innovative professional development opportunities and programs to attract some of the new employees it will need to care for veterans. However, recruitment and retention planning can be fully successful only with sufficient, timely, and predictable funding from Congress for VA's overall health-care mission. After years of reacting to the current erratic funding process, achieving effective health-care budgetary reform can provide VA the confidence it needs to more effectively recruit, develop, and retain its health-care workforce to meet the needs of our nation's veterans.

Registered Nurses

In the area of nursing, the United States is experiencing an unprecedented shortage that is expected to continue well into the future.[153] Two national issues are directly contributing to America's national nursing shortage. First, the number of new nursing students entering nursing education programs is insufficient to meet rising demand. Second, the heightened age and lower numbers of nursing educators has forced nursing schools to restrict or deny applicants into entry-level nursing baccalaureate educational programs. The Health Resources and Services Administration in 2007 projected that the nation's nursing shortage will grow to more than 1 million nurses by the year 2020, and all 50 states will experience a shortage of nurses to varying degrees by the year 2015.

According to projections from the U.S. Bureau of Labor Statistics in the November 2005 *Monthly Labor Review,* 1,203,000 new registered nurses (RNs) will be needed by 2014 to meet job growth and replacement needs. VA must develop a recruitment strategy that attracts and encourages nursing students and new nurse graduates to commit to VA employment by using and increasing educational loan repayment programs and recruiting from local nursing schools. VA must also work to recruit and retain nurses that provide care in VA's specialized service programs, such as spinal cord injury/dysfunction (SCI/D), blind rehabilitation, mental health, and brain injury, using compensatory benefits, such as specialty pay.

According to the July 2006 Aging Workforce Survey conducted by the Nursing Management Organization, 55 percent of surveyed nurses reported the intention to retire between 2011 and 2020.[154] In addition to the

need for 30,211 RNs by 2013, the VHA turnover rate for registered nurses in 2006 was 8.5 percent (full and part-time positions, not including trainees). The American Federation of Government Employees (AFGE) reports that in 2007, 77 percent of all RN resignations within the VA occurred in the first five years of employment, and the average VA-wide cost of turnover is $47 million for nurses. VA simply cannot afford to ignore the concerns of its nurses in the areas of job satisfaction and compensation. VA must also develop and implement innovative personnel programs that allow for nurse representation and input when facility management makes personnel decisions.

The National Commission on VA Nursing report, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce,* cited professional development, work environment, respect and recognition, and fair compensation as a few areas that VA must focus on to become an employer of choice for today's nurse population.[155] The commission also recommended that the VHA provide career development opportunities for nurses that enhance their ability to reach professional goals, develop and implement national staffing standards to properly allocate nursing resources and promote patient safety, and expand recognition of nurse achievements and high performance. *The Independent Budget* veterans service organizations (IBVSOs) support the commission's recommendations and believe that they serve as a sound template for improvements to VA policies and procedures that govern its health-care workforce.

With regard to nurse compensation, VA must ensure that facility managers are using locality pay and financial incentives, such as retention bonuses, to compete with private sector employers. VA must also work to consistently administer locality pay policies that are based on local labor market conditions, as well as overtime and premium pay policies for nurses that are in accordance with VA policy.

Physicians

With respect to VA physicians, the IBVSOs have serious concerns regarding VA's current and future ability to match or exceed private sector physician salaries. In 2004, Congress passed Public Law 108-445, the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004. The act is partially intended to aid VA both in recruiting and retaining VA physicians (including scarce subspecialty practitioners) by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. In the intervening years, VA has implemented the act, but we believe the act may not have provided the Department the optimum tools needed to ensure that veterans will have available the variety and number of physicians needed in their health-care system. For example, a recent review of VA physician position vacancies on usajobs.gov revealed the following: Bay Pines VA Medical Center (VAMC) was recruiting an orthopedic surgeon at a maximum salary of $175,000, while the national average income of orthopedists is $459,000. Indianapolis VAMC was seeking an emergency room physician at a maximum of $175,000, while the national average for this category is $216,000. The Greater Los Angeles VA system was offering a maximum of $270,000 for an anesthesiologist, while the average income for anesthesiologists is $311,000. The IBVSOs urge Congress to provide further oversight and to ascertain whether VA has adequately implemented its intent of P.L. 108-445, or if the Department may need additional tools to ensure full employment for qualified VA physicians as it addresses its future staffing needs.

With regard to physician recruitment, 130 VA medical centers have affiliations in which physicians represent half of approximately 100,000 VA health profession trainees. VA estimates that medical residents equate to approximately one-third of the total VA physician workforce. About 2,500 (16 percent) of VA physicians are currently eligible for voluntary retirement, and it is projected that by 2012, this number will grow to 2,909 (17 percent).[156] Notably, a 2007 survey assessed the impact of VA health profession training on VA physician recruitment. Prior to exposure to training in VA facilities, 21 percent of medical students and 27 percent of medical residents indicated they were "very" or "somewhat" likely to consider post-graduate VA employment. Following training at VA, these positive responses grew to 57 percent of medical students and 49 percent of medical residents. Although current resignation rates among VA physicians remain stable, VA projects the number of voluntary retirements will rise over time. Thus, through its training programs VA is well positioned to take advantage of a ready source of physician recruitment.

Certified Registered Nurse Anesthetists

Over the past few years, the demand for certified registered nurse anesthetists (CRNA) has steadily grown within the private and public nursing sectors. As the need for CRNAs increases, VA becomes more challenged

to recruit and retain these professionals. In a December 2007 report, the U.S. Government Accountability Office (GAO) reported that more than half of VA CRNAs are over 51 years of age, and are seven years closer to retirement eligibility than the average CRNA nationally.[157] The GAO further reported that 54 percent of VA medical facility chief anesthesiologists surveyed reported temporarily closing operating rooms, while 72 percent reported delaying some elective surgeries because no CRNAs were available for the procedures.

The GAO concluded that VA is having difficulty recruiting and retaining CRNAs because it is not providing competitive salaries in comparison to the national labor market. According to the American Association of Nurse Anesthetists, The average turnover and retirement rate for VA CRNAs is approximately 19 percent. VA must vigorously work to retain its current CRNA workforce by providing for professional development opportunities that include developing career paths and internal promotions for CRNAs and individual funding for educational advancements. The GAO reports that many VA facilities are not properly using the VA locality pay system, thus VA CRNAs' salaries have not been adjusted properly and are less competitive with other employers in the health-care industry.[158] It is essential that VA provide adequate oversight to ensure that all facilities are using locality pay correctly and consistently.

Certified registered nurse anesthetists provide the majority of anesthesia services for veterans receiving care in VA medical facilities. Therefore VA must make certain that this vital service of care for veterans is not compromised by VA's inability to succeed in a competitive market for CRNAs. The IBVSOs believe that VA must utilize recruitment bonuses and educational incentives to help offset the differences in salaries between the private sector and VA to recruit new CRNAs. The VA must also work within local nursing schools for CRNA training to recruit nurses receiving a master's degree in anesthesiology and encourage current VA RNs to consider careers as anesthetists.

Mental Health Professionals

According to the American Psychological Association, VA is the largest single employer of psychologists in the nation. The demands placed on VA's mental health service have increased dramatically because of the conflicts in Afghanistan and Iraq. Congress and VA have recognized the need to increase the number of psychologists and have added more than 800 new psychologists since 2005; however, it should be noted that these increased psychology staffing levels are a recent development.

In all, VA's report of hiring several thousand new mental health professionals includes individuals whom VA has identified as having been offered and accepted positions in mental health, but some of these individuals are not yet providing care for veterans. The length of time for a facility to receive allocated funds for staffing, advertise and recruit for a position, and interview and complete credentialing and security clearances is extremely long. VA officials in the field have reported to the IBVSOs that it is common for nine months or more to pass from the beginning to the end of this process. In some instances it has been reported that candidates that have committed to a VA position withdraw their applications because they simply could not wait the number of months to complete the hiring process. New graduates are particularly vulnerable to delay in employment offers. When a candidate withdraws after accepting employment, VA must restart the recruitment process. While we have no national statistics on VA's hiring lag time, we believe that it takes four to five months between VA's tentative offer and an applicant reporting to duty.

The VHA has distributed an unprecedented performance measure to field managers and human resources staffs to improve the hiring process. This measure targets 30 days as the goal to bring new employees on board after they accept employment with the VHA. This 30-day goal is one-third of the current length of time that it takes the VHA to fully hire a new employee. Even if this goal is achieved, VA's average hiring lag will still be expressed in months. This lengthy hiring process deters new applicants and potentially leads to inefficient use of personnel funds.

In 2006, the GAO issued a report critical of VA's hiring practices in mental health.[159] In the report, the GAO concluded that VA lacked proficiency in spending the funds allocated for hiring and paying mental health professionals. The IBVSOs believe that in most instances, VA is not using all of these funds because of the delays in the hiring process. The longer it takes VA to hire and encumber a new employee, the less likely it is that VA will use the full amount of funding provided for that employee's salary in the remainder of the fiscal year. It is essentially impossible for facilities to spend more than a fraction of funds associated with new positions during a new employee's first year. VA must work to speed

up the hiring process for mental health providers, particularly if it intends to refashion its mental health programs with a focus on veteran wellness and recovery. VA must also strive to retain and promote its more experienced mental health practitioners in order to meet new training and supervision requirements for new providers.

VA Human Resources Policies Are Outmoded

VA must work aggressively to eliminate outdated, outmoded VA personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment. It is reported that, on average, from the time a vacancy announcement is posted, appointment of a new employee within the VHA consumes 90 days. In some professional occupations (especially physicians and nurses), many months can pass from the date of a position vacancy until the date a newly VA-credentialed and privileged professional caregiver is on board and providing clinical care to veterans. Its lack of ability to make employment offers and confirm them in a timely manner, especially to new graduates VA has helped train, unquestionably affects VA's success in hiring highly qualified employees, and has the potential to diminish the quality of VA health care. Hiring delays depress current workforce morale and lead to overuse of mandatory overtime for nurses and others, greater workplace stress, and staff burnout. At all levels, the VHA (especially including local facility managements) must be held accountable for improving human resources policies and practices. Congress should require VA to report its efforts to improve recruiting, retention, and environmental/organizational practices to assure veterans that VA will be a preferred health-care provider in the future and will continue to provide veterans an effective health-care system to meet their specialized needs.

Employment Incentives

Existing VA loan repayment and scholarship programs were established by Congress initially to provide individuals interested in VA nursing the financial support they need to enter and stay in the field. Both a recruitment and retention tool, the centrally funded Employee Incentive Scholarship Program (EISP)[160] pays up to $32,000 for health-care-related academic degree programs, with an average of $12,000 paid per scholarship. Since its inception in 1999, through 2007 approximately 7,000 VA employees have received scholarship awards for educational programs related to title 38 and "hybrid" title 5-title 38 VA occupations. About 4,000 employees have graduated from academic programs under these auspices. Scholarship recipients include RNs (93 percent), pharmacists, physical therapists, and other allied health professionals. A five-year VA analysis of program outcomes demonstrates this program's impact on VA employee retention. For example, turnover of nurse scholarship participants is 7.5 percent compared to a nonscholarship nurse turnover rate of 8.5 percent. Also, less than 1 percent of participating nurses left VHA employment during their service-obligation period (from one to three years after completion of degree).[161]

The VA Education Debt Reduction Program (EDRP) provides tax-free reimbursement of existing education debt of recently hired title 38 and hybrid employees. Centrally funded, the EDRP is the title 38 equivalent of the Student Loan Repayment Program administered by the Office of Personnel Management for title 5 employees. More than 5,600 VA health-care professionals have participated in the EDRP. The maximum amount of an EDRP award is limited by statute to $44,000 in exchange for five years of service. As education costs have risen, the average award amount per employee has increased over the years from about $13,500 in FY 2002 to more than $27,000 in FY 2007. While employees from 33 occupations participate in the program, 77 percent are from three mission critical occupations—RN, pharmacist, and physician. The rate of losses from resignation of EDRP recipients is significantly less than that of nonrecipients as determined in a 2005 study. For physicians the study found the resignation rate for EDRP recipients was 15.9 percent compared to 34.8 percent for non-EDRP recipients.[162]

Both the EISP and EDRP initiatives need to be strengthened and expanded to new VA occupations, in particular among the 25 critical occupational categories that will be increasingly competitive as the health manpower shortage worsens. Congress must also consider reinstating the VA Health Professional Education Assistance Scholarship Program. This program would be an excellent medical care student incentive to future VA employment. These programs have proven themselves to be cost-effective recruitment tools and to provide strong incentives for individuals to remain in VA employment rather than to go elsewhere.

Summary

Given the VHA's leadership position as a health system, it is imperative that VA aggressively recruit health-

care professionals and work within established relationships with academic affiliates and community partners to recruit new employees. In order to make gains on these needs, VA must update and streamline its human resource processes and policies to adequately address the needs of new graduates in the health sciences, recruits, and current VA employees. Today's health-care professionals and other staff who work alongside them need improved benefits, such as competitive salaries and incentives, child care, flexible scheduling, and generous educational benefits. VA must actively address the factors known to affect current recruitment and retention, such as fair compensation, professional development and career mobility, benevolent supervision and work environment, respect and recognition, technology, and sound, consistent leadership, to make VA an employer of choice for individuals who are offered many attractive alternatives in other employment settings.

VA's ability to sustain a full complement of highly skilled and motivated personnel will require aggressive and competitive employment hiring strategies that will enable it to successfully compete in the national labor market. VA's employment success within the VHA will require constant attention by the very highest levels of VA leadership. Additionally, Members of Congress must understand the gravity of VA personnel issues and be ready to provide the necessary support and oversight required to ensure VA's success.

Recommendations:

VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment.

VA must implement an energized succession plan in its medical and regional offices that utilizes the experience and expertise of current employees as well as improves existing human resources policies and procedures.

VA facilities must fully utilize recruitment and retention tools, such as relocation and retention bonuses, a locality pay system for VA nurses, and education scholarship and loan payment programs as employment incentives, in both the Veterans Health Administration and the Veterans Benefits Administration.

Congress must provide further oversight to ensure adequate implementation of Public Law 108-445.

Congress should implement a title 38 specialty pay provision for VA nurses providing care in VA's specialized services areas, such as spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury.

VA must provide adequate oversight to ensure that all medical facilities correctly and consistently administer locality pay in accordance with VA policy.

VA must develop a more aggressive recruitment strategy that provides employment incentives that attract and encourage affiliated health professions students, and new graduates in all degree programs of affiliate institutions, to commit to VA employment.

Congress should improve the provisions of VA's Employee Incentive Scholarship Program and Education Debt Reduction Program and make them available more broadly to all VA employees.

VA must become more flexible with its work schedules to meet the needs of today's health-care and benefits professionals and must provide other employment benefits, such as child care, that will make VA employment more attractive.

[153]Peter I. Buerhaus, PhD, RN; Douglas O. Staiger, PhD; David I. Auerbach, MS, "Implications of an Aging Registered Nurse Workforce," *Journal of the American Medical Association.* June 14, 2000, Vol. 283, No.22:2948–2954.
[154](www.nursingmanagement.com).
[155]National Commission on VA Nursing, 2002–2004, final report, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce*, March 2004.
[156]Department of Veterans Affairs Veterans Health Administration, VHA Workforce Succession Strategic Plan, FY 2008–2012 (www1.va.gov/nursing/docs/StratPlanONS_2008–2012FIN_2.pdf); details from Office of Management and Budget (www.whitehouse.gov/omb/circulars/a11/current_year/s200.pdf).
[157]GAO-08-56.
[158]Ibid.
[159]GAO-07-66.
[160]38 U.S.C. §§ 7671–7675; established by P.L. 105-368, Title VIII, *Department of Veterans Affairs Health Care Personnel Incentive Act of 1998*, and amended by P.L. 107-135, *Department of Veterans Affairs Health Care Programs Act of 2001.*
[161]M. Palkuti M., M.Ed., director, Health Care Retention and Recruitment Office, DVA, in testimony before the Senate Committee on Veterans' Affairs, April 9, 2008 (http//veterans.senate.gov/public/index.cfm?pageid=16&release_id=11581&sub_release_id=11633&view=all).
[162]Ibid.

ATTRACTING AND RETAINING A QUALITY VHA NURSING WORKFORCE:

The Veterans Health Administration (VHA) must devote sufficient resources to avert the national shortage of nurses from creeping into and potentially overwhelming VA's critical health-care programs.

As indicated elsewhere in this *Independent Budget,* recruitment and retention of high-caliber health-care professionals is critical to the VHA mission and essential to providing safe, high-quality health-care services to sick and disabled veterans. Given the impact of the nationwide nursing shortage and ongoing reports of difficulty in filling nursing and other key positions within the VHA, this is a continuing challenge for the Department of Veterans Affairs. This section presents concerns specific to VHA's nursing programs.

Addressing the National Nursing Shortage—National Commission on VA Nursing

The environment of the VHA, like America's health-care enterprise in general, is ever-changing and confronted with continuing challenges. Since 2000, VA has been working to address the increasing demand for medical services while coping with the impact of a rising national nursing shortage. In 2001, VHA's Nursing Strategic Healthcare Group released "A Call to Action—VA's Response to the National Nursing Shortage." Since that time, health manpower shortages, and plans to address them, have been dominant themes of numerous conferences, reports by the Government Accountability Office (GAO), other reviewers, and Congressional hearings.

One part of the equation that has remained paramount in the discussion concerns VA's ability to compete in local labor markets, given the barriers that impede nursing recruitment and retention in general. In 2002 the National Commission on VA Nursing (commission) was established by Public Law 107-135 and charged to examine and consider VA programs, and to recommend legislative, organizational, and policy changes to enhance the recruitment and retention of nurses and other nursing personnel, and to address the future of the nursing profession within the VHA. The commission envisioned a desired "future state" for VHA nursing and made recommendations to achieve that vision. In May 2004, the commission published its final report to Congress, "Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce."

Illustrative of the commission's findings and recommendations is this synopsis in its final report:

> Recruiting and retaining nursing personnel are priority issues for every health-care system in America. VHA is no exception. With the aging of the population, including veterans, and the U.S. involvement in military activity around the world, VHA will experience increasing numbers of enrolled veterans. Consequently, as the demand for nursing care increases, the nation will grapple with a shortage of nurses that is likely to worsen as baby boomer nurses retire. VHA must attract and retain nurses who can help assure that VHA continues to deliver the highest quality care to veterans. Further, VHA must envision, develop, and test new roles for nurses and nursing as biotechnologies and innovations change the way health care is delivered.

The Office of Nursing Service in the VA Central Office developed a strategic plan to guide national efforts to advance nursing practice within the VHA, and engage nurses across the system to participate in shaping the future of VA nursing practice. VA's strategic plan embraces six patient-centered goals that encompass and address a number of the recommendations of the commission, including leadership development, technology and system design, care coordination and patient self-management, workforce development, collaboration, and evidence-based nursing practice.

The commission's legislative and organizational recommendations served as a blueprint for the future of VA nursing. The VHA's strategic plan should serve as a foundation for a delivery system that meets the needs of our nation's sick and disabled veterans while supporting those who provide their care. *The Independent Budget* veterans service organizations (IBVSOs), urge Congress to continue to provide appropriations for, and oversight of, VA health care to enable the VHA to carry out an aggressive agenda based on this blueprint, to improve VA's abilities to recruit and retain sufficient nursing manpower while proactively testing new and emerging nursing roles.

Current Workforce-Future Needs

One of VA's greatest challenges is dealing effectively with succession—especially in the health sciences and technical fields that so characterize contemporary American medicine and health-care delivery.

The VHA's Succession Strategic Plan for FY 2008–2012 reports the following:

> VHA faces significant challenges in ensuring it has the appropriate workforce to meet current and future needs, including VHA's role in national and local emergencies. These challenges include continuing to compete for talent as the national economy changes over time, as well as recruiting and retaining health care workers in the face of significant anticipated workforce supply and demand gaps in the health care sector in the near future. These challenges are further exacerbated by an aging federal workforce and an increasing percentage of VHA employees who achieve retirement eligibility each year. With health care being primarily a people-based process, it is essential to ensure the continuous presence of an effective workforce to achieve the VHA mission to provide exceptional health care to America's veterans.

In April 2007, the VHA conducted a national conference titled "VHA Succession Planning and Workforce Development." The conference report indicated the average age of all VHA employees in 2006 to have been 48 years. It estimated that by the end of 2012, approximately 91,700 VHA employees, or 44 percent of current full-time and part-time staff, would be eligible for full civil service retirement, with approximately 46,300 VHA employees projected to retire during that same period. Additionally, a significant number of health-care professionals in leadership positions would also be eligible to retire by the end of 2012. The report concluded that 97 percent of VA nurses in pay band "V" positions would be eligible to retire, and that 56 percent were expected to retire.

VHA's Succession Plan 2008–2012 estimates that 14 percent (5,640) are currently eligible for voluntary retirement, and in 2013, 20.1 percent (8,955) of nurses currently working are projected to be eligible to retire. In its assessment of current and future workforce needs, the VHA identified registered nurses (RNs) as its top occupational challenge, with licensed practical/vocational nurses and nursing assistants also among the top 10 occupations with critical recruitment needs. Currently, VA employs nearly 79,000 nursing and allied personnel, 60 percent of whom are direct care staff.

VA recognizes that in the near term the supply of qualified nurses in the nation will be inadequate to meet increasing demand for services. According to the Health Resources and Services Administration, by 2015 all 50 states will experience a shortage of nurses to varying degrees. According to projections from the U.S. Bureau of Labor Statistics in the November 2005 *Monthly Labor Review,* 1,203,000 new RNs will be needed by 2014 to meet job growth and replacement needs. Registered nurses are projected to create the second-largest number of new jobs among all occupations, growing at 27 percent or more by 2014. Contributing to this shortage is the aging of the nursing workforce. An increasing proportion of RNs are over the age of 50. According to the Health Resources and Services Administration, in 2004, 28 percent of registered nurses were over the age of 50. A recent study by Buerhaus and colleagues published in 2007 reports that the cohort of RNs over the age of 50 has expanded 11 percent annually over the past four years.

In addition, the average age of new nurse graduates has increased considerably over the past two decades. Prior to 1984, the average age of a new nurse graduate was 23.8 years; by 2000–2004, the average age was 29.6 years. Likewise, current enrollments in schools of nursing is not going to meet the projected future demand. The National League for Nursing reports that U.S. nursing schools turned away 147,000 qualified applicants from nursing programs in 2005 primarily due to insufficient number of faculty, clinical sites, and classroom space. The American Association of Colleges of Nursing has reported that three-fourths of the nation's schools of nursing acknowledge faculty shortages along with insufficient clinical practicum sites, lack of classroom space, and budget constraints as reasons for denying admission to qualified applicants. Over the past several years the VHA has been trying to attract younger nurses into VA health care and to create incentives to keep them in the VA system.

In an attempt to attain a more stable nursing corps, VA initiated a "Nursing Academy" pilot program known as "Enhancing Academic Partnerships." VA reports its Nursing Academy will be committed to nursing education and practice and will address the nursing shortages in VA while helping fill the nation's needs for

nurses as well. VA's pilot program for FY 2007–2012 initially partnered with the University of Florida, San Diego State University, the University of Utah, and Connecticut's Fairfield University, with their respective VA affiliates at Gainesville, San Diego, Salt Lake City, and West Haven.

An additional six sites were selected to begin the program in academic year 2008–2009. They included the Medical University of South Carolina, Loyola University of Chicago, Rhode Island College, the University of South Florida, and the University of Oklahoma Health Sciences Center partnering with VA facilities in Charleston, Hines, Providence, and Tampa. The sixth site selected included two institutions, the University of Detroit Mercy and Saginaw Valley State University, partnering with Michigan VA facilities in Detroit, Saginaw, Battle Creek, and Ann Arbor. Additional VA-nursing school partnerships will be selected for 2009, for a total of 14 sites altogether during the five-year pilot program. Similar to VA's long-standing relationships with schools of medicine nationwide, VA nurses with pertinent expertise will be appointed as faculty members at the affiliated schools of nursing. Academy students will be offered VA-funded scholarships in exchange for defined periods of VA employment subsequent to graduation and successful state licensure.

VHA research shows that medical students who perform clinical rotations at a VA facility are more likely to consider VA as an employer. VA is hopeful that the investment made in helping to educate a new generation of nurses, coupled with the requirement that scholarship recipients serve a period of obligated service in VA health care following graduation, will help VA cultivate and retain quality health-care staff, even during a time of nationwide shortage. Continued funding beyond the pilot program is needed to provide this benefit to all VA facilities.

VA Nursing Workplace Issues

The IBVSOs continue to hear concerns from VA nurses about a number of issues they believe have an impact on nursing recruitment and retention. There are reports that VHA staffing levels are frequently so marginal that any loss of staff—even one individual in some cases—can result in a critical staffing shortage and present significant clinical challenges at a medical facility. Some nurses report they have been forced to assume non-nursing duties due to shortages of ward secretaries and other key support personnel. Budget-related "unofficial" hiring freezes and routine delays in recruiting place additional stress on existing nursing personnel and have a negative impact on patient programs. Staffing shortages or hiring freezes can result in the cancellation or delay of elective surgeries and closure of intensive care unit beds. These staff shortages can also cause avoidable referrals of veterans to private facilities—ultimately at greater overall cost to VA. This situation is complicated by the fact that the VHA has downsized inpatient capacity in an effort to provide more services on a primary care basis. The remaining inpatient population is generally more acute, often with comorbid conditions, lengthier inpatient episodes, complicated medical histories, and needing more skilled nursing care and staff-intensive aftercare.

It has also been reported that in some locations, VA is overusing overtime, including "mandatory overtime," reducing flexibility in tours of duty for nurses, and limiting nurse locality pay. The IBVSOs believe the practice of mandatory overtime places an undue burden on nursing staff and compromises the quality of care and safety of veterans in VA health care. Additionally, these actions create a working environment that fosters staff burnout and morale problems. These reports are especially disturbing given that VA has made so much progress in establishing the current national standard of excellence in providing care to its large enrolled population. We believe many of these difficult working conditions continue to exist today for VA's nursing staff, despite the best efforts and intentions of local and central management. Therefore, we suggest Congress provide additional oversight in this area to ensure a safe environment for both patients and staff. Also, we note that many of these workplace issues are driven by short financing and extremely tight local budgets, including the now-routine Continuing Resolution that restricts overall management discretion nationwide.

In October 2007, the House Committee on Veterans' Affairs Subcommittee on Health held a hearing on recruitment and retention of VA health-care professionals. Testimony from the American Federation of Government Employees (AFGE) and the Nurses Organization of Veterans Affairs (NOVA) outlined a number of key issues believed to have an impact on VA's ability to recruit and retain qualified nursing personnel. Issues discussed included flaws in the current credentialing and boarding process for title 38 employees; increasing reliance on contract nurses and its impact on quality of care; impact of the budget on hiring practices; lack of use of authorized pay incentives

by some medical facility managers; reluctance of medical center directors to offer scheduling incentives, such as the popular compressed work schedule; the need to strengthen current overtime policies in all VHA facilities; lack of human resources support; delays in hiring caused by the lengthy process involved for security and background checks; information technology issues; and a number of pay-related issues. The IBVSOs urge Congress to review the aforementioned testimonies by these organizations made up of frontline providers for specific recommendations on how to improve recruitment and retention of VA nursing personnel.

In May 2008, the Senate Committee on Veterans' Affairs held a hearing on the Veterans Medical Personnel Recruitment and Retention Act of 2008. Testimony from AFGE and NOVA identified rationale for support of this legislation to improve retention and recruitment of health-care staff members. Specific issues targeted included waiver of offset from pay for certain reemployed retired annuitants; providing comparable pay for nurse executives and medical center directors and increasing pay limitations and pay caps; providing information and training on locality pay systems; and reestablishing the Health Professions Scholarship Program to increase recruitment of students. Both organizations testified at another hearing in May 2008 of the House Committee on Veterans' Affairs Subcommittee on Health regarding human resources challenges within the VHA. Specific human resource issues identified included retention allowances, special pay rates, streamlining the application process, funds for professional development, converting positions to excepted service, pay flexibilities, succession planning, and review of classification standards.

Like other health-care employers, the VHA must actively address those factors known to affect recruitment and retention of all health-care providers, including nursing staff, and take proactive measures to stem crises before they occur. While the IBVSOs applaud what VA is trying to do in improving its nursing programs, competitive strategies are yet to be fully developed or deployed in VA. We encourage the VHA to continue its quest to deal with shortages of health manpower in ways that keep VHA at the top of the standards of care in the nation.

Recommendations:

Congress must provide sufficient funding through regular appropriations that are provided on time and include resources to support programs to recruit and retain critical nursing staff in VA health care, in particular, to support enlargement of the Nursing Academy.

VA should establish recruitment programs that enable the Veterans Health Administration to remain competitive with private-sector marketing strategies.

Congress should provide adequate funding to reestablish the Health Professions Scholarship Program.

Congress should provide oversight to ensure sufficient nursing staffing levels and to regulate and reduce to a minimum VA's use of mandatory overtime for VA nurses.

VOLUNTEER PROGRAMS:

The Department of Veterans Affairs needs to provide sufficient dedicated staff at each VA medical center to promote volunteerism and coordinate and oversee voluntary services programs and manage donations given to the medical center.

Since its inception in 1946, volunteers have donated in excess of 700.8 million hours of volunteer service to America's veterans in VA health-care facilities and cemeteries through the Veterans Affairs Voluntary Service (VAVS) program. As the largest volunteer program in the federal government, the VAVS program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee, composed of more than 65 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and seven of their subordinate organizations, which report to the VA Under Secretary for Health.

The VHA volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

VAVS volunteers assist veteran patients by augmenting staff in such settings as VA hospital wards, nursing homes, end-of-life care programs, outpatient clinics, community-based volunteer programs, national cemeteries, veterans benefits offices, and veterans outreach centers. With the expansion of VA health care for patients in the community setting, additional volunteers have become involved. During FY 2008, VAVS volunteers contributed a total of 11,479,008 hours to VA health-care facilities. This represents 5,519 full-time employee equivalent (FTEE) positions. These volunteer hours represent more than $224 million if VA had to staff these volunteer positions with FTEEs.

At national cemeteries, VAVS volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on grave sites for Memorial Day and Veterans Day. Hundreds of thousands of hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our nation.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The combined annual contribution made in 2008 to VA is estimated at $82 million. These significant contributions allow VA to assist direct-patient care programs, as well as support services and activities that may not be fiscal priorities from year to year. Monetary estimates aside, it is impossible to calculate the amount of caring and comfort that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers continues to increase dramatically as more demands are placed on VA health-care staff. The way in which health services are provided is changing, providing opportunities for new and less-traditional roles for volunteers. Unfortunately, many core VAVS volunteers are aging and are no longer able to volunteer. Likewise, not all VA medical centers have designated a staff person with management experience to recruit volunteers, develop volunteer assignments, and maintain a program that formally recognizes volunteers for their contributions. It is vital that the VHA keep pace with utilization of this national resource.

Recommendations:

Each Veterans Health Administration medical center should designate sufficient staff with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions. The positions must also include experience in maintaining, accepting, and properly distributing donated funds and donated items for the medical center.

Each VHA medical center should develop nontraditional volunteer assignments, including assignments that are age-appropriate and contemporary.

CONTRACT CARE COORDINATION:

The Veterans Health Administration (VHA) should develop an integrated program of contract care coordination for veterans who receive care from private health-care providers at VA expense, but should maintain vigilance in implementing a new contract care initiative that may have unintended consequences that diminish VA health care.

Current law authorizes the Department of Veterans Affairs to contract for non-VA health care (on a fee or contractual basis) and for scarce medical specialists only when VA facilities are incapable of providing necessary care to veterans, when VA facilities are geographically inaccessible to veterans, and in certain emergency situations. *The Independent Budget* veterans service organizations (IBVSOs) believe contract care should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' maintenance of a full range of specialized inpatient services for veterans who enroll in VA care. We have consistently opposed proposals seeking to expand contracting to non-VA providers on a broader basis than this. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serving larger veteran populations, ultimately only serve to dilute the quality and variety of VA services for new as well as existing patients.

Currently VA spends more than $2 billion annually to purchase private care for eligible veterans. Unfortunately, VA does not track this care, its related costs, outcomes, or veteran satisfaction levels. Therefore, the IBVSOs believe VA should implement a consistent process for veterans receiving contracted-care services to ensure that—

- care is delivered by fully licensed and credentialed providers;
- continuity of care is monitored and that patients are directed back to the VA health-care system for follow-up when appropriate;
- VA records of care are properly annotated with clinical information from contractors; and
- the process is part of a seamless continuum of services for enrolled veterans.

The IBVSOs believe it is critical for VA to implement a program of contract care coordination that includes integrated clinical, record, and claims information for the veterans VA directs to community-based providers. VA's current "Preferred Pricing Program" allows VA medical centers (VAMCs) to save funds when veterans use non-VA medical services by receiving network discounts through a preferred pricing program. However, VA currently has no system in place to direct veteran patients to any participating preferred provider network (PPO) so that it could—

- receive a discounted rate for the outsourced services rendered;
- use a mechanism to direct patients to credentialed and certified providers; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VAMCs, when a veteran inadvertently uses a PPO, not all facilities have taken advantage of the cost savings that are available. Thus, in many cases, VA has paid more for contract health care than is necessary. Nevertheless, the IBVSOs were pleased that VA made participation in its Preferred Pricing Program mandatory for all VAMCs in 2005. We understand that during FY 2008 the Preferred Pricing Program yielded a discount of more than $60 million, although it is not currently being utilized by all VAMCs. However, with full participation of the program, as intended by VA, there is potential to far exceed that amount with the potential of discounted savings of more than $70 million for FY 2009.

While there have been significant savings achieved through the Preferred Pricing Program (more than $172 million in gross discounts to date), through enhancements to preferring pricing, there are several ways to improve cost reduction. The implementation of electronic data interchange across all VAMCs will grow the program and savings for VA exponentially by allowing more claims to be submitted to the Preferred Pricing service-disabled veteran owned (SDVO) contractors. Other enhancements could include—

- scanning all paper claims,
- providing incentives to management and staff to participate, and
- providing additional education and training.

As efficiencies are implemented, and the transaction process is simplified, more claims will be submitted for

repricing and significantly more money will be available to support purchased care programs and the needs of veterans.

Additionally, the recent move by VA to consolidate Preferred Pricing contracts—now administered via 5 regional contracts, rather than the original 21 contracts—should facilitate greater adoption of uniform enhancements and program improvements.

Overall, the IBVSOs believe the national Preferred Pricing Program is a foundation upon which a more proactive managed care program could be established that would not only save significantly more funding when purchasing care, but, more important, could provide the VHA a mechanism to fully integrate contract care into its health-care system. By partnering with an experienced managed-care contractor(s), VA could define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value for the VA.

Currently, many veterans are disengaged from the VA health-care system when receiving health-care services from private physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to health care through coordination of community-based care. The IBVSOs believe it is important for VA to develop an effective care coordination model that achieves both its health-care and financial objectives. Doing so will improve patient care quality, more wisely use VA's increasingly limited resources, and reduce overpayments.

Components of a coordinated care program should include the following:

- Care and case management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical needs, the care coordination contractor could address both appropriateness of care and continuity of care. The result could be a truly integrated seamless health-care delivery system; and
- Provider networks that complement the capabilities and capacities of each VAMC and provide a "surge" capacity in times of increased need. Such contracted networks should address timeliness, access, and cost-effectiveness in both urban and rural environments. Additionally, the care coordination contractor could require private providers to meet specific VA requirements, such as timely communicating clinical information to VA, proper and timely submitting of electronic claims, meeting VA established access standards, and complying with other applicable performance measures.

If properly implemented, a care-coordination system also could improve veteran satisfaction with contract services and optimize workload for VA facilities and their academic affiliates.

VA is currently conducting the pilot project "Project HERO"—Healthcare Effectiveness through Resource Optimization, as directed by the Conference Report[163] on VA's fiscal year 2006 appropriation, Public Law 109-114. Project HERO, according to VA "is aimed at improving the ability of VA's patient-focused healthcare system to care for the Department's 7.7 million enrolled veterans." Under the program, VA asserts it will improve its capacity to care for its veterans at the more than 1,400 sites of care it currently operates and will take steps to ensure that community providers to whom it refers veterans meet VA's quality and service standards. The ultimate goal of Project HERO is to ensure that all care delivered by VA—whether through VA providers or through our community partners—is of the same quality and consistency for veterans, regardless of where care is delivered."[164]

In 2007 VA awarded a contract to Humana Veterans Healthcare Services, a national managed care corporation that is also a major fiscal intermediary and private network manager under the Department of Defense TRICARE program. Under this pilot program, participating Veterans Integrated Service Networks (VISNs) 8, 16, 20, and 23 are to provide primary care and, when circumstances warrant, must authorize referrals to Humana Veterans Healthcare Services for specialized services in the community. These specialty services include medical/surgical, diagnostics, mental health, and dialysis and are made available from private sources through Humana Veterans Healthcare Services. Also, as of January 14, 2008, contract services for dental care have been made available through Delta Dental.

VA asserts that Project HERO will better manage the private health-care services that VA purchases and will ensure that community providers meet the quality standards of VA care in caring for participating veterans. The IBVSOs have been informed that the quality of care provided through Project HERO would be equal

to or better than that provide directly by VA. As part of providing coordinated care, VA has indicated clinical information and patient records pertinent to the specialty care being sought will be shared among participating VA facilities and community providers to ensure quality and continuity of care.

Since this matter first emerged in the FY 2006 Congressional appropriations arena, it has remained a significant concern of the IBVSOs that Project HERO not become a basis to downsize or to privatize VA health care. Our concern remains that this initiative could become a method to contract out VA services beyond the current extent of VA contract care programs. Early in our discussions with the VA, we requested that spending under Project HERO be capped so as not to exceed total contract care costs recorded during the previous year for each network selected to participate. This limitation would have ensured that Project HERO would become an incentive to reduce contract care spending, as originally envisioned. VA chose not to accept our recommendation, and in fact expanded contract maximum spending in some cases upwards of 500 percent; thus, we remain concerned about the intent of this project.

Patient satisfaction for non-VA services provided under this program remains below VA's national average, and timeliness of completed appointments for routine care remains highly variable. In addition, the initial data are a source of concern for the IBVSOs because surveys utilized were provided only to patients that had completed a VA-referred appointment. A bias may confound the results of this survey since Project HERO contract providers are obligated to meet access-to-care standards that include patient scheduling of less than 30 days in order to exercise optional years beyond the current contract. Still, nearly a year since the contract has been awarded the existing network of non-VA providers has failed to meet its own target.

Patient satisfaction does not necessarily equate to quality of care. Of great concern to the IBVSOs is VA's lack of an incentive or measurement to assess that the quality of non-VA care to ensure that it meets or exceeds the clinical quality of VA care such as VA's revolutionary provider self-report on patient safety incidents is of great concern to the IBVSOs. Although our fear remains that under this new pilot project VA will pay significantly more for contract care without the safeguards of VA's high-quality standards—we are encouraged that VA recently contracted with Corrigo Health Care Solutions to evaluate and provide recommendations on the business processes of Project HERO.

The IBVSOs have been assured that VA will provide veterans service organizations (VSOs) with reports on a quarterly and annual basis and that reports will include metrics for cost, quality, safety, vendor performance, and other data relevant to the demonstration. This will help to ensure that Project HERO is meeting the goals and objectives outlined in the report that accompanied P.L. 109-305. While it is true that quarterly updates are being provided to the VSO community, including the organizations that produce this *Independent Budget,* we still await satisfactory reports on "cost, quality, safety, vendor performance, and other data relevant" to the Project HERO demonstration.

Recommendations:

VA should establish a contract care coordination program that incorporates the Preferred Pricing Program discussed herein, based on principles of sound medical management, and tailored to VA and veterans' specific needs. The Preferred Pricing Program should also be enhanced and leveraged to develop pilots to address the needs of rural veteran access issues as well as a formal surge capability.

Veterans who receive private care at VA expense and authorization should be required to participate in the care-coordination program, with limited exceptions.

VA and any care coordinator should jointly develop identifiable measures to assess program results and share results with Congress and stakeholders, including *The Independent Budget* veterans service organizations. Care should be taken to ensure inclusion of important VA academic affiliates in this program.

The components of a care-coordination program should include claims processing, health records management, and centralized appointment scheduling.

VA also should develop a series of tailored pilot programs to provide VA-coordinated care in a selected group of rural communities. As part of these pilots, VA should measure the relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, as compared to similar measurements of a like group of veterans in VA health care. In addition, the national Preferred Pricing Program's network of

providers should be leveraged in this effort. Each pilot also should be closely monitored by the VA's Rural Veterans Advisory Committee. These same pilots can in turn be tailored to create a more formal surge capability addressing future access needs.

VA should establish a mechanism to track contract expenditures within the Project HERO pilot network that include cost comparisons to existing contract costs.

VA should develop a set of quality standards that contract care providers must meet that are equivalent to the quality of care veterans receive within the VA system. Any Project HERO provider should be held to this standard.

VA should provide Congress, and make publicly available, the results of the first year of operations under the Project HERO initiative, including both quality and cost data.

[163]House Report 109-305, 109th Cong., 1st Sess. (2005).
[164]Michael Kussman, principal Under Secretary for Health, VHA, testimony for hearing on "Enhancing Access to Quality Care for Our Nation's Veterans Through Care Coordination Demonstrations—Project HERO" before the House Committee on Veterans' Affairs, March 29, 2006.

NON-VA PURCHASED CARE:

The extent of its decentralized structure, complex legislative authority, and the inadequate funding to local VA facilities for non-VA purchased care continue to erode the effectiveness of this necessary health-care benefit.

The Veterans Health Administration (VHA) is one of the world's largest health-care delivery organizations. As part of an integrated strategy to provide veterans with timely access to quality health-care services, VA health-care facilities are authorized to pay for health-care services acquired from non-VA health-care providers. These services may be provided to eligible veterans from non-VA health-care providers when VA medical facilities are incapable of providing necessary care to a veteran; when VA medical facilities are geographically inaccessible to a veteran for necessary care; when a medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims.

The Non-VA Care Fee Program has historically been called the Fee Program and has included the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Under the Fee Program, veterans who are determined by VHA staff to be eligible and are authorized fee-basis care are allowed to choose their own medical providers. In addition, veterans under the Fee Program are sometimes unable to secure treatment from a community provider because of VA's lower payment, less than full payment, and delayed payment for medical services. *The Independent Budget* veterans service organizations (IBVSOs) are especially concerned that service-connected disabled veterans who are authorized to use non-VA care are at times required by the only provider in their community to pay for the care up front. In these instances, health-care providers frequently charge a higher rate than VA is authorized to pay, resulting in veterans having to pay for the medical care they need and then seek reimbursement from VA. Furthermore, because VA will at times approve only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, veterans who seek reimbursement from VA are paying for part of their care.

Fundamental to a successful non-VA purchased care program (which includes CHAMPVA) is an appropriate information technology (IT) infrastructure. VA manages the authorization, claims processing, and reimbursement for services acquired from non-VA health-care providers through the Purchased Care Program. Due to the program's dated IT infrastructure and cumbersome processes of having multiple and repetitive data entry points and local modifications to suit

local needs resulting in inconsistent claims processing, VA approved funding in October 2002 to replace its IT infrastructure by FY 2009. However, the project subsequently lost its funding in December 2005, eliminating the necessary IT infrastructure to manage the program.

Much effort has been made by VA to address existing variability in processing non-VA medical care claims. By initiating improvements to its business practices, VA has begun to address the timeliness to pay a claim. The IBVSOs applaud the implementation of a national Fee training program for local fee staff as well as certification for authorization and claims processing. Field assistance teams have been deployed to work directly with the field fee offices and facilities to provide standardization in business practices and target specific improvements as requested from the field. Some temporary stand-alone IT systems have been put in place, but they lack the functionality for centralized reporting, recording, and decision support. Clearly, what leadership expects of IT today to manage this program for decision making, policy change, and the like is not being provided by the interim solution. In light of the need for significant changes to the overall infrastructure, the short-term band-aid approach may be adequate, but is not in the best interest of veteran patients or the VA to provide timely access to quality health-care services. The IBVSOs believe VA leadership must continue to provide the support needed to achieve the goals of these initiatives. Moreover, Congress should provide the necessary resources to fulfill the need for an IT infrastructure replacement system for this program.

Recommendations:

When VA preauthorizes non-VA medical care for a veteran, it should coordinate with the chosen health-care provider for both the veteran's care and payment of medical services. Service-connected veterans should not be required to negotiate payment terms with private providers for authorized fee-basis care or pay out-of-pocket for such services.

VA should continue to pursue the regulatory changes needed for its payment methodology to provide equitable payments for the care veterans receive in the community.

VA should provide the necessary support and place a higher priority for a long-term solution to standardize business practice in the non-VA purchased care program to allow efficient and timely processing of claims.

Congress should provide the necessary funds to facilitate development and implementation of an appropriate IT infrastructure for VA's non-VA purchased care program.

CENTRALIZED INFORMATION TECHNOLOGY IMPACT ON VA HEALTH CARE

While still concerned about the impact of centralization of information technology (IT) on the Veterans Health Administration (VHA),* The Independent Budget *veterans service organizations (IBVSOs) are hopeful that a number of issues we have raised in the past will be resolved early in the new Administration.

The VA health-care system has iteratively developed and perfected a unique VA electronic health record (EHR) system over a 30-year period. The most important, impressive, and lasting value of the VHA's EHR system is that it was conceived and developed internally by thousands of VA clinicians, administrators, managers, biomedical and health services researchers, and clinical informatics experts—those same professionals who actually deliver VA health care in VA facilities.

The current version of this EHR system, based on the VHA's self-developed Veterans Health Information Systems and Technology Architecture (VistA) public domain software, sets the standard for EHR systems in the United States and has been publicly touted by the President, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and other federal officials as a model to be emulated by other health-care providers nationwide.[165] In fact, a commercial form of VistA has been installed by public and private sector entities into the patient care systems of a number of U.S. and foreign health-care providers and networks, including state mental health facilities and community health centers in West Virginia; long-term care facilities in Oklahoma; private general hospitals in Texas, New York, California, and Wyoming; and health systems in a number of foreign nations (including Colombia, Finland, Germany, Mexico, and Nigeria), including one nation that is in the process of a trial implementation of VistA as its national EHR system.

VA VistA: World-Class Electronic Health Record

The VHA's unparalleled success in integrating use of its comprehensive EHR system into its day-to-day health-care delivery process has been a critical factor in the VHA's transformation in becoming recognized as a national leader in health-care quality, safety, prevention, and clinical effectiveness. Among health-care and IT industries worldwide, the VistA program is one of the most successful and remarkable Health IT and EHR systems. In recognition of this fact, in 2006 VA's VistA won the prestigious "Innovations in American Government Award." The annual award is sponsored by Harvard University's Ash Institute for Democratic Governance and Innovation at the Kennedy School of Government and administered in partnership with the Council for Excellence in Government, and honors excellence and creativity in the public sector.

The workings of this EHR system constitute one of the fundamental and critical components of the VHA's ability to deliver consistently high-quality and safe health care to 5.8 million of our nation's veterans. In fact, VHA's EHR system has hard-earned the reputation as "world class," and is acknowledged by most observers as the most successful EHR operating in the world today. It is also important to recognize that VHA's EHR is not simply an IT system, but rather is a health-care tool that is just as vital a component of the VHA's successful health-care delivery capability as its cardiac catheterization laboratories or its magnetic resonance imaging scanners. Without its EHR system, the VHA would be unable to deliver 21st century health care. Therefore, VistA should not, and cannot, be viewed as a standard IT system of network servers and operating systems but rather as a medical device. In fact, Food an Drug Administration (FDA) policies do consider the VistA system to be a medical device for regulatory purposes.

Additionally, a number of former VHA leaders who helped bring this remarkable system into being are now major participants in efforts being led by the Department of Health and Human Services (HHS) and the private sector to implement the secure, interoperable, nationwide health IT infrastructure necessary to markedly improve the quality, safety, and efficiency of health care across the United States. As part of this infrastructure to enable the desired transformational improvements, the same pervasive use of EHRs needs to be attained in routine private and other public health-care systems that the VHA has already accomplished with its VistA system, and will be advancing even more with its next-generation EHR system, HealtheVet. For example, in September the Secretary of HHS hosted a

Federal Advisory Committee of the American Health Information Community (AHIC), where, before two cabinet-level secretaries, VA was a showcase model of interoperability, a goal only achieved because the VA's VistA system already has all information available electronically.[166]

The AHIC was the initial public-private forum for setting priorities to achieve nationwide health information interoperability, including the pervasive use of interoperable EHRs in the American public and private health-care sectors-an effort that will save lives and money, improve health outcomes, and, crucially, avoid medical errors. The nation is attempting to emulate many of the lessons learned from VA's successful development of VistA as benchmarks for future development of EHR systems, specifications, and standards.

Under guidance from the AHIC and help from the public-private AHIC Successor (www.ahicsuccessor.org), private and other public health-care systems and facilities are trying to germinate the seeds and promote the incentives for mainstream American health care to achieve what the VHA already has accomplished—but many challenges lie ahead. Currently only about 12 percent of the nation's private hospitals use advanced EHRs with any clinical decision-support capability, but, as mentioned by the presenter at the September AHIC meeting, the number doubles when you include federal hospitals because of the work of VA. Additionally, only about 20 percent claim significant physician use of computerized provider order entry systems—whereas the VHA has a paperless system used universally by students, residents, and VA attending staff.

As previously discussed, the existence of automated records enables the VHA to provide higher quality, and safer, more efficient health care to veterans. VistA empowers VA—uniquely—to avoid medical mistakes routinely being made by other providers in the private and public sectors. The Institute of Medicine in its report titled "To Err Is Human" has estimated that preventable medical mistakes result in an estimated 98,000 or more deaths in the United States annually. VistA saves veterans' lives by reducing unreadable physician orders, issuing alerts for life-threatening drug allergies, and eliminating medication errors. VA estimated that VistA improved 6,000 veterans' lives by raising rates of pneumonia vaccination among veterans with emphysema, cutting pneumonia hospitalizations in half, and reducing VA costs by $40 million per year.

Reducing Medication Errors

A report by the Institute of Medicine of the National Academy of Sciences estimates more than 1.5 million Americans are harmed by drug errors in medical settings each year, and calls for all prescriptions to be written electronically by 2010. The report said, on average, a hospitalized patient is subject to at least one medication error per day, despite recent initiatives to improve the administration of medicines.

More lives are saved through use of VistA's Bar Code Medication Administration (BCMA) to verify a patient's identity and validate that patient's proper dosage and medication—before it is administered. National implementation of this simple process, with a complex VistA applications program underpinning it, has virtually eliminated medication errors in VA inpatient services. The idea for BCMA was originated by a nurse at the Topeka VA medical center (VAMC) who worked with local IT staff to develop a working prototype. The importance of BCMA has received wide recognition, and it has become an industry standard that has sparked numerous commercial products.

In our highly mobile society, portability of health records is a major concern. In 2005, the value and power of portable electronic health records was proven during the Gulf Coast hurricanes. Many private health-care providers and organizations lost their paper medical records. The VHA's EHRs with its critical systems redundancies allowed VA to access backup records and transfer them to the veterans' new VA facility location. While VA shuttered and evacuated its New Orleans and Gulfport medical centers, as well as a number of its community-based outpatient clinics, and moved thousands of patients to higher ground, these veterans' care was uninterrupted, and not a single VA patient health record was lost.

The VHA's health-care quality improvements over more than a decade have been lauded by many independent and outside observers, including the Institute of Medicine of the National Academy of Sciences, JCAHO, the National Quality Forum, and the HHS Agency for Health Care Quality and Research. While its IT accomplishments alone certainly do not account for all of the VHA's success in improving health-care quality, the electronic integration of enrollment, computerized provider order entry, laboratory, radiology, nuclear medicine, pharmacy, surgery, scheduling, human resources, logistics, management, and multiple reporting systems en-

ables VHA to operate, coordinate, and plan health care for veterans across the continuum of care and across the largest integrated health-care system in the United States. These systems function at a level well above the capabilities of other public and private health-care organizations. In order to continue to maximize health-care quality and efficiency in a dynamic and rapidly changing environment, VHA must have the flexibility and management control to address urgent needs throughout the clinical environment of care. The VistA system is a vital health-care tool and an essential component of VA health care, no less crucial than medical devices used in diagnosis and treatment. In the judgment of the IBVSOs, VHA is the essential place where this management and governance responsibility for health IT should lie.

Despite this record of remarkable success, in late 2006 VistA (and its planned successor, HealtheVet) was swept up in a VA management decision to restructure all VA IT systems under a departmental-level chief information officer (CIO), with centralization of governance authority and IT budgets. This action was triggered in the wake of the theft of a VA laptop computer from the home of a VA management analyst. That computer, later recovered intact, contained personal information on an extensive number of living American veterans and serving members of the U.S. armed forces. This was not a VHA laptop, contained no VHA clinical information, and the employee involved was not a VHA employee (he was employed by the Secretary's Office of Policy and Planning). It should also be noted that this was primarily a breach of the employee's office security policy, not IT security policy. The medium by which the offending employee removed the sensitive information from VA was electronic, rather than paper, and this theft event was not a breach of an IT security system.

In the aftermath of the laptop theft, the Secretary of Veterans Affairs acted on VA IT systems as a whole in an effort to both satisfy Congress that VA was taking a serious action to solve a chronic and serious problem in information security, about which many critics had complained for years, and to reassure veterans that VA would use all means at its disposal to protect their personal information.

All VA IT resources have since been gathered under the new Office of Information and Technology, with a Department-wide CIO who reports to the Secretary. Both the positive and negative effects of that centralization have emerged. While the IBVSOs continue to support the idea that sensitive veteran-specific information in the hands of the government needs to be secured, the IBVSOs have expressed our concern that focusing on information security as a problem that can be solved exclusively by IT centralization may retard the creative and crucial organizational elements that might be important in sustaining a culture of organizational vigilance in information protection. VHA and the entire U.S. health-care community are subject to privacy and security regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), an act that comprehensively prescribes the vigilance required to protect health information. HIPAA is legislation that covers health information within VHA, and is used by all VHA employees to guide their privacy activities related to health information on veterans.

Nationally and internationally, private sector and governments (including the U.S. government) have turned to VHA to learn what was unique about its health-care system that would enable it to create and so extensively implement a transformational tool as powerful as VistA has become. Ironically, within VA now, the environment has been changed with the possible result of jeopardizing the unique circumstances in VHA that fostered the successful enhancement, improvement, and evolution of VistA from predecessor health and research IT activities. The future viability and sustainability of these technology advancements, now integrally intertwined with VHA's health-care delivery processes, are threatened. In doing so, VA's IT reorganization may ultimately threaten the lives of the veterans they serve.

VistA has been so successful as an electronic health record system because it was developed by clinicians and for clinicians and was responsive to the directions and priorities of the VHA leadership. Putting together IT development teams composed of clinician users, VA program managers, policy makers, and software programmers facilitated rapid development, improvement, and continued innovation. VHA clinicians are highly motivated toward investigation, research, and teaching, and the IBVSOs encourage those laudable motives because they lead to higher quality, efficiency, and improved outcomes in health care. VHA's former IT development process spurred rapid innovation and creative practical applications to solve difficult, complex problems and facilitate quality clinical care. The VA CIO Office of Enterprise Development (OED) has fallen short of this standard. Impediments to VHA's ability to determine the rate and scope of change in its health IT solutions embedded within the care delivery processes endangers VHA's abil-

ity to deliver the high-quality health care our nation's veterans deserve. As an example, when rapid development of new IT software was needed to address the needs of Operations Enduring and Iraqi Freedom (OEF/OIF) veterans and the recommendations of the President's Commission on Care for America's Returning Wounded Warriors, the CIO Office of Enterprise Development (OED) could not meet the challenge and VHA stepped in to provide the needed clinical expertise and software development. Who will respond in the next 5, 10, or 15 years when this critical knowledge and skills are lost?

The health IT innovation exhibited by VHA cannot be sustained without maintaining the balanced systems and development principles that were responsible for its past success. All IT decisions should not be made in Washington and permission obtained for development, planning, procurement, and other key functions be granted through a centralized bureaucracy that is ignorant of the needs and input from frontline health-care providers. The dampening effects are already evident in VAMCs nationwide. VHA staff are frustrated that systems that functioned smoothly in the past no longer support their routine delivery of good health care. Such impediments delay or prevent VHA from rapidly incorporating advancements derived from its own research activities as well as from the exponentially increasing medical literature, and obstruct VHA from continuing to transform the care delivery processes themselves. Such erosion places veterans' health in jeopardy.

Governance of VA IT Systems

The IBVSOs are concerned that the current governance policy gives the VA CIO and associated offices, with no responsibility or accountability for health-care delivery to our nations veterans, decisional authority affecting VHA IT resource and mission decisions, including its EHR maintenance requirements and priorities. This is considered antithetical to both the Department of Defense health systems and the private health-care enterprise and, we believe, is against all accepted principles of existing best practices. In our opinion, no other contemporary health-care organization exists where the service provider (the CIO) is superior to, and often in a position to override, the decisions and needs of the chief health-care executive.

While the governance decision has caused a number of unintended consequences and critical challenges, some of the more significant ones are the impact on VA's medical centers, their community-based outpatient clinics, and their supervising Veterans Integrated Service Network (VISN) offices. In these locations, managers can no longer purchase needed medical IT equipment, software, or supportive services of any kind independently or even through the approval by direction of the Under Secretary for Health, without further approval by the CIO. In the current governance alignment, the VA CIO has the ability to override any Under Secretary, regional network, or local facility leadership decision to purchase IT-related equipment, software, or services—even those critical to providing direct, safe care to enrolled veterans.

The IBVSOs understand that the VHA is working on a proposal to revise governance to ensure that it regains, to a greater extent, decisional and funding authority for health-care development and ongoing operational activities of VistA. In our view, the optimal model is the VHA as mission "owner" when it comes to its own health IT system. We believe the VHA should set the strategy and agenda for the support of and future improvement to its all-important EHR system. Specifically, the VHA should have the authority commensurate with accountability to set its own priorities, define its plans, manage project resources and implement and redirect resources, if necessary. Essentially, the VHA should own and direct its IT/EHR budget and mission priorities as well. Additionally, the VHA must regain at least some responsibility for ensuring that an application and the underlying system (now VistA, and eventually migrating to HealtheVet) meets known clinical needs for safe and efficient delivery of health care to veterans. It must be understood, however, that this can only be accomplished with the right governance, organizational realignments, and appropriate accountability.

The IBVSOs further believe that the CIO structure and reporting relationships are not aligned today for optimal service delivery to the VHA. Illustrations of the kinds of problems caused by the current organizational alignment include the following:

- VHA health-care facilities are unable to obtain approval or funds to hire needed IT staff, resulting in work-arounds, including use of work-study temporary assignments, contractors, technical career field interns, clinical application coordinators, and other transient methods to meet ongoing, and even routine, workload demands.
- Facilities have limited ability to initiate IT projects to meet new and increasing patient care demands.

We urge the Under Secretary for Health to reiterate to the Secretary of Veterans Affairs our contention that the most effective field governance would be through direct alignment of the CIO field staff to the VHA networks, through permanent reassignments, with interim details until those reassignments can be effected. These staff are crucial to the daily maintenance of VistA. We are informed that the VA General Counsel has determined or opined that such reassignments of field IT staff would require a legislative authorization from Congress, a proposal that we urge be pursued if the Secretary agrees with counsel's interpretation of current law. Pending a decision to go forward with a legislative proposal to effect this change, however, we understand that the CIO has agreed to work with VHA to develop local facility governance principles to give each VISN a greater share of control and flexibility in using onsite IT staff resources. We appreciate that willingness to cooperate.

Central Office Organization Holding Up Progress

The IBVSOs observe that the current CIO OED seems unable to adequately support current and future requirements for VA's flagship EHR next-generation program, particularly the major HealtheVet programs such as pharmacy, laboratory, computerized patient record system reengineering, scheduling, health data repository, blood bank, etc. And in FY 2009, VA's ability to begin exchanging health information through the Nationwide Health Information Network may be at risk. We also have found that OED organizational and contracting issues and hiring delays are significantly exacerbating the problem, moving the previously planned implementation date for the major programs listed above from FY 2012 to FY 2015, and possibly later. We are disturbed by this delay in VA's moving to the next generation of health IT, and assuming centralization continues, we conclude that OED needs to significantly improve its programmatic capability at all levels of the OED organization, and especially at the senior level, to get this key program back on track.

Budget Inflexibility

VA is currently faced with severe restrictions imposed by Congress (and the Administration) on its budgetary management with respect to IT. Within the Medical Services account, VHA is obstructed from moving any funding into VHA IT support or development without explicit approval by Congress. Within the IT appropriation itself, VA must notify Congress and wait a specified period if it intends to move IT funds of $1 million or more from one purpose to another. At the local and network levels, VA is without any funding authority to procure local-use computing equipment, including printers, laptops, etc. These kinds of restrictions essentially paralyze VHA at all levels from being adaptive at a time of great change and great challenge in IT management.

Contracting Difficulty

Because of the IT centralization, the IBVSOs observe a VA-wide problem affecting the use of contracts and contractors in operating and maintaining VHA's EHR system to keep it up to date and running for the benefit of enrolled veterans. Corrections, "patches," and other improvements to numerous VHA critical EHR programs (scheduling, pharmacy, laboratory, radiology, etc.) are stymied due to the length of time required to navigate the unclear legal and procedural contracts-review process, one now completely centralized and under the aegis of the CIO. Given the inherent delays and bureaucratic behaviors we see occurring in procurement and legal reviews brought on by centralization, we believe because of its critical nature and tie to quality of health care, the HealtheVet next-generation development should be provided a dedicated contracting and legal review team to expedite these decisions.

Perennially inadequate, VA's contracting resources and capabilities to address the ever-growing problem in VHA IT are worsening, and a recent VA CIO decision to reduce the dollar threshold for contract legal review will only exacerbate this problem.

Recruitment of IT Workforce Lagging

As indicated elsewhere in this *Independent Budget,* the IBVSOs are concerned about VA's human resources management programs and consequently VA's ability to compete for scarce health, technical, and general professional fields. Nowhere is this more apparent than in VHA's IT field. Numerous IT hiring issues recur across the VA system, marked significantly by the inordinate length of time required to enter and successfully exit the VA hiring process. Also, VA lacks sufficient flexibility in providing attractive compensation packages to recruited IT professionals, and thereby

loses many highly valued candidates to other agencies of government and private employers. In particular, these constrictions obstruct VA from appointing military retirees with strong IT credentials—despite VA's strongly stated goal of hiring veterans. The OED section with responsibility for VA medical care IT programs, including future development of those programs, is particularly unable to timely hire sufficient personnel with critical talents, and key personnel such as major program managers, system architects, program planners, and other crucial staff.

Emerging Hope

The IBVSOs understand that the former Secretary of Veterans Affairs, who was not in VA when the centralization decision was made by his predecessor, and who is a doctor of medicine by profession and personal history, reportedly signaled a level of sympathy with and understanding of the plight of VHA IT in this hardened centralized environment. As a result, we understand that in FY 2008 the VHA was able to gain the Secretary's support for transferring significant funds from the Medical Services account to VHA IT in support of the EHR and its critical infrastructure in the field. A similar proposal for flexibility has been submitted for fiscal year 2009, but is currently pending. Partly because of this more flexible posture as exemplified by the slight shift in funding flexibility, we hold out hope that the VHA may eventually gain more control over the fate of its IT systems in the future.

Given the degree of success evident in the VHA today, not only in its clinical care results but also in its world-renowned biomedical research programs, the authors of *The Independent Budget* see no defensible justification for VA having centralized VHA IT governance and budgetary authority in a non-VHA environment that lacks any health-care expertise or accountability for health-care delivery.

The principal reason we believe VHA IT has been successful and so critically linked to the documented improvements in VA health-care quality is that VA health-care officials, who are accountable for health-care quality, have controlled and managed the VHA IT policy, planning, and budget functions for VHA for 30 years. Thousands of clinical and other VHA personnel who deliver health care to veterans have served as software developers and testers, subject matter experts on technical evaluation panels, and daily users of the IT system that supports the delivery of coordinated clinical care—care that they themselves largely manage and plan. Without this degree of health IT sophistication and integration with health-care delivery itself, we contend that the VHA could not have doubled enrollment since 1995, significantly reduced the cost of care, and improved quality and safety for America's veterans. With continued inflexible centralization, we fear these gains remain in jeopardy.

The IBVSOs believe the VHA can best manage its own IT operations, planning, and budgeting. We feel certain that this will be true with respect to the next generation of VHA software, HealtheVet, a web-enabled system that was already well into development by VHA clinicians but now under control of the OED and the CIO. We acknowledge that centralization of any governmental or business function can be made to save dollars; however, these savings in the case of VHA may come at a cost of eroded quality of care to sick and disabled veterans with an inevitable overlay of bureaucracy that is endemic to centralization. Removing field facility personnel, especially clinical caregivers, investigators, and even local IT technical personnel, from the planning and development aspects of IT, could serve to diminish VA health care.

While the IBVSOs recognize that IT centralization may make sense for many administrative functions in the Veterans Benefits Administration (VBA), various staff offices to the Secretary in the VA Central Office and functions of the National Cemetery Administration (NCA), the IBVSOs oppose absolute centralization of IT in the VHA. Those offices' functions that are candidates for centralization can be compared favorably to many other federal activities that rely on automated server systems and laptop or desktop applications such as those offered by Microsoft, Computer Associates, Oracle, and other commercial vendors of IT business platforms and database management systems.

The IBVSOs continue to believe turning on its head the VHA's 30-plus year creative authority and forcing VHA to compete with other elements of the VA for IT resources for VistA, and now for HealtheVet, while satisfying external requirements unrelated to health-care delivery, is a potential strategic mistake of major proportions. VHA's IT and its health-care delivery system are one and the same; therefore, we cannot support a policy that assumes VHA's IT needs are not materially different from any other type of administrative application.

Recommendations

The Veterans Health Administration should regain at least partial—if not total—authority over health care-related information technology used within the VA health-care systems clinical, research, and education environment. The VHA should regain its authority for planning, programming, operating, and budgeting information technology matters that directly affect delivery of health care to enrolled veterans, and those directly affecting the conduct of VA's sensitive biomedical research and development programs. In regaining some management responsibility, the VHA should establish policies and procedures that ensure coordination with the VA chief information officer to guarantee compliance with all federally mandated IT security requirements, in a manner congruent with the VHA responsibilities as a direct health-care service provider.

If Congressional action is necessary to enable the VHA to control and supervise IT staff in VA health-care facilities and network offices (more than 1,400 locations), Congress should permit this change. If Congressional action is not required (as the IBVSOs believe to be the case), the Secretary of Veterans Affairs should take administrative action to effect reassignments of field IT staffs to the respective VHA health-care facilities where they currently work.

Any strictures on VA's ability to shift funds in or out of IT financial accounts, whether by appropriations transfers or by reprogramming, should be examined by Congressional appropriations committee staffs to determine if more flexibility is needed within the VA to ensure continuity of operations of VA's IT systems—and particularly those affecting direct VA health care.

Because of its critical nature and tie to quality of health care, the HealtheVet next-generation IT development should be provided a dedicated contracting and legal review team to expedite decisions that move this key project forward.

[163]www.whitehouse.gov/news/releases/2004/04/20040427-5.html, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). (http//www.jointcommission.org/NR/rdonlyres/1C9A7079-7A29-4658-B80D-A7DF8771309B/0/Hospital_Future.pdf).

[164](www.hhs.gov/healthit/community/meetings/m20080923.html).

VHA Physician Assistant Director:

The full-time position of physician assistant advisor to the Under Secretary for Health should be located in the VA Central Office.

The Department of Veterans Affairs is the largest single federal employer of physician assistants (PAs), with approximately 1,800 full-time PA positions, and has utilized PAs since 1969 when the profession started. However, since the Veterans Benefits and Health Care Improvement Act of 2000 directed that the Under Secretary of Health appoint a PA advisor, the Veterans Health Administration (VHA) continued to assign the PA position as a part-time, field based employee until April 2008, with collateral administrative duties in addition to the PA advisor's clinical duties. Although full-time currently, the position is still field-based and often does not receive travel funding until late in the second quarter each year, resulting in missed opportunities to attend VHA meetings.

The Independent Budget veterans service organizations (IBVSOs) have requested for the past seven years that physician assistant be made a full-time position within the VHA. We testified in support of H.R. 2790, a bipartisan bill that would require a full-time PA advisor in the VA Central Office. While this bill passed the House, unfortunately, the Senate did not act.

As structured currently, PAs have been strictly field based. In addition, the PA advisor has had a limited scope of PA-specific clinical or personnel issues; has not been appointed to any of the major health care VA strategic planning committees; has not been included in many aspects of planning on seamless transition, polytrauma centers, traumatic brain injury staffing, or the Office of Rural Health Care; and has not been utilized for emergency disaster planning even though 34 percent of all VA-employed PAs are veterans or currently serve in the military reserves. This critical occupation

could bring vital experiences to new initiatives for improving veteran's health-care access, especially during a time when there is shortage of primary care physicians.

PAs in the VA health-care system are essential primary care providers for millions of veterans annually, with approximately 1,800 PAs now employed by VA. PAs currently work in ambulatory care clinics, emergency medicine, and numerous other medical and surgical subspecialties. The IBVSOs believe that PAs are a critical component of VA health-care delivery and urge that this occupation be included in any recruitment and retention legislation coming when the 111th Congress revisits S. 2969 on Enhancement of Authorities for Retention of Medical Professionals. The five-year average turnover "retention rate" for PAs has been 8.9 percent, and by 2012 it is projected that 28 percent of the PA workforce would be eligible for retirement. Similar to other critical health-care occupations, these needs must be addressed.

A new version of H.R. 2790 should be introduced early in the 111th Congress, by both the Senate and House Veterans Affairs' Committees, to ensure that the chief consultant Physician Assistant Services, within Office of Under Secretary of Health, is finally established by statute to avoid further delays.

Recommendations:

Congress should mandate a full-time chief consultant for Physician Assistant Services within the Office of the Under Secretary for Health. Implementation of this position should be required, with reports back to the chairmen of the Committees on Veterans' Affairs.

Congress should include the PA occupation in any future legislation concerning health-care retention, and education, training, and debt-reduction programs.

FAMILY AND CAREGIVER SUPPORT ISSUES AFFECTING SEVERELY INJURED VETERANS:

Given the prevalence and severity of polytrauma in the newest generation of disabled veterans, VA should establish a series of new programs to provide support and care to immediate family members who are committed to providing these veterans with lifelong personal care and attendance.

In "The Challenge of Caring for Our Newest Generation of War Veterans," *The Independent Budget* veterans service organizations (IBVSOs) describe the nature, prevalence, and degree of injuries that veterans have suffered in Operations Enduring and Iraqi Freedom (OEF/OIF). These veterans often have disabling physical conditions, such as multiple limb amputations, spinal cord injury, internal shrapnel injury, loss of sight, and residuals of severe burns. Blast injuries are common in Afghanistan and Iraq, resulting in traumatic brain injury (TBI) that compromises cognitive functions and memory and often results in an inability to inhibit certain behaviors that are self-harming, such as domestic violence and substance misuse, among other problems and risky behaviors. The violence of an improvised explosive device detonation also results in psychological stress reactions, including post-traumatic stress disorder (PTSD) in many of these severely wounded veterans.

A miraculous number of our veterans are surviving what surely would have been fatal events in earlier periods of warfare, but many are grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal support. Eventually, most of these veterans will be able to return to their families, at least on a part-time basis, or will be moved to an appropriate therapeutic residential care setting—but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them compensate for the dramatic loss of physical, mental, and emotional capacities as a result of their injuries.

Immediate families of severely injured veterans of OEF/OIF face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical[167] and emotional problems[168] of the severely injured veteran plus deal with the complexities

of the systems of care[169] that these veterans must rely on, while struggling with disruption of family life, interruptions of personal professional goals and employment, and dissolution of other "normal" support systems because of the changed circumstances resulting from the veteran's injuries and illness. Research suggests that caregiver support services (e.g., individual and family counseling, respite care, education, and training) can help to reduce the burden, stress, and depression arising from caregiving responsibilities and can improve overall well-being.[170, 171, 172]

Care of the Severely Wounded and Support of Caregivers

As severely injured troops are released from active duty, they are in need of full-time care. The options include institutional care provided by or paid for by VA, or full-time care in the home supported by a VA provided caregiver or by a family member. Were it not for the Caregiver Assistance Pilot Programs,[173] the VA system currently offers little recognition of the caregiver sacrifices being made daily by spouses and families in taking over the care of their wounded loved ones at home. A spouse who becomes the primary caregiver of a severely injured soldier experiences individual challenges, as well as marital stress. The injury, the result of an unexpected event, throws the family unit into a situational crisis, not something that is a part of normal family development. Events like these are likely to be perceived as more stressful than giving care to an elderly family member, simply because it is "off-time"—away from the "normative life cycle."[174]

Caregiver burden is the strain or load borne by an individual caring for an older, chronically ill, or disabled family member or other person. It is a multidimensional response to the physical, psychological, emotional, social, and financial stressors associated with caring for another person. According to a research synthesis on caregiver role strain conducted at the University of Texas, added burden and strain is experienced when the caregiver is living with the recipient; limited resources are available for tangible support; and the care recipient's self-perception of health status is poor.[175] A recent study of female partners of veterans with PTSD found that significant others also suffer from caregiver burden. The partners in this study exhibited high levels of psychological stress with their clinical stress scale scoring above the 90th percentile. In addition to psychological stress, the spouse caregivers fought depression and suicidal ideations. Clearly, mental health care, support group services, and individual counseling for family members are needed beyond VA's Polytrauma Rehabilitation Centers.

The spouse of a severely injured veteran is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. They are also more likely to be dependent on state programs and Medicaid, with great variability from state to state.[176] Complicating matters is the fact that an increasing number of the severely injured are from reserve components (primarily Army and Marine) and National Guard units. It is likely that the families of these troops have never lived on military bases and do not have access to the vibrant social support services and networks connected with active duty military life. Spouses of the injured often must give up their own employment (or withdraw from school in many cases) to care for, attend to, and advocate for their injured veterans. They often fall victim to bureaucratic mishaps in the shifting responsibility of conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation). Also, they rely on this much-needed subsistence in the absence of other personal income.

In November 2008, an account was published in the *New York Time*s documenting these very circumstances. A young staff sergeant suffered a wound to the neck, severing his spinal cord. His wife had to quit her job to take care of him. They tried to hire help provided by the government but the people they found to help were incompetent. And even a good caregiver did not allow the veteran to live the life that he wanted to live. Because of their lack of education about such a situation, the veteran and his wife were led to believe that government regulations prohibit caregivers from taking disabled veterans for whom they are caring out of the house. This sergeant did not want to live like a shut-in. So his wife had to quit her job—forcing them to get by only on his disability compensation—in order to provide him with full-time quality care.[177] This couple and many like them support legislation that would provide family caregivers compensation or a salary for keeping their loved one at home—legislation the VA has opposed.

To address the need for financial support to family caregivers of severely disabled veterans, VA testified before Congress stating, "VA currently contracts with more than 4,000 home health agencies that are approved by the Centers for Medicare and Medicaid Services (CMS) and/or are state licensed. Many of these agencies have

expertise in training and certifying home health aides, including family members. Many operate in rural communities. VA refers interested family members to these agencies and, after their training, these family caregivers become paid employees of the agencies. VA provides remuneration pursuant to agreements with the home health agencies, thus compensating family caregivers indirectly. Importantly, VA also ensures that these home health agencies meet and maintain training and certification requirements specific to caregivers of traumatic brain injured (TBI) patients."[178]

According to the Department of Labor,[179] unlike personal and home care aides, who provide mainly housekeeping and routine personal care services, home health aides help elderly, convalescent, or disabled persons live in their own homes instead of health-care facilities. Under the direction of nursing or medical staff, they provide health-related services, such as administering oral medications. Experienced home health aides, with training, also may assist with medical equipment, such as ventilators, to help patients breathe.

VA's agreements with home health agencies fall under federal guidelines for home health aides whose employers receive reimbursement from Medicare. Federal law requires home health aides to pass a competency test covering a wide range of areas; however, states may have additional licensure requirements adding to the variability, and thus complexity, of VA's program, which requires family caregivers to complete a 75-hour course of instruction and 16 hours of supervised practical training in addition to annual training. Moreover, median hourly earnings of home health aides were $9.34 in May 2006; they receive slight pay increases with experience and added responsibility. Median hourly earnings of psychiatric aides were $11.49 in May 2006.[180]

If VA were to purchase home health services, it would use a maximum payment rate that is locally calculated and specific to one of six disciplines. The Medicare low utilization payment adjustment (LUPA) rates[181] are used by VA as the maximum cap for home health aide services.[182] The LUPA rate in and of itself is used by Medicare for episodes with four or fewer visits within a 60-day period, and VA then uses it based on two hours of care per visit. In states that reimburse separately for homemaker services, VA's rate will not exceed 110 percent of the established state rate for that home care agency or geographic area. VA uses LUPA home care rates without regard to the number of visits or the length of the home care episode.[183] Unfortunately, while family members are allowed to train with the companies under contract to provide home health aides, only certain veterans are allowed to go through those companies to hire family members, and for only four hours a day. VA does not keep data on how many families use this program. Families who think the program does not go far enough object to giving a third party a cut of the money, and say that four hours is insignificant when they often spend 24 hours a day in the job. It also limits compensation to time spent on medical needs like bladder assistance and feeding, leaving out other tasks, such as chauffeuring and paperwork.[184]

For many younger, unmarried veterans, finding appropriate community-based care is even more complicated. Their primary caregivers are their parents, who have limited eligibility for military assistance, often are on limited incomes, and have no current eligibility for VA benefits or services of any kind. They, too, face the same or worse dilemmas as spouses of severely injured veterans because of their advancing age and life circumstances. The support systems they need are limited or restricted, often informal, and clearly inadequate for the long term. Under current law, the spouse of an enrolled veteran is eligible for limited VA mental health services and counseling only as a so-called "collateral" of the veteran; such services are spotty to nonexistent across the VA system. The IBVSOs have been informed by some local VA officials that they are providing a significant amount of training, instruction, counseling, and health care to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the absence of legal authority to provide these services without recognition within VA's resource allocation system and that scarce resources that are needed elsewhere are being diverted to those needs, without recognition within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are financially penalizing themselves in doing so, but they clearly have recognized the urgency of this need.

The IBVSOs have also been informed by other local providers about barriers to accessing caregiver support services that have been identified by their patients and families: education about the availability of services generally not being provided, lack of flexibility of existing services, lack of local availability of services, varied quality of services received and trust and privacy issues of VA and non-VA staff. The most commonly used example is the low utilization of VA's home respite care program. This is of great concern to the IBVSOs because

this is the only significant supportive service that addresses family caregivers of severely disabled veterans.

VA's home respite care program provides supportive care to veterans on a short-term basis to give the caregiver a planned period of relief or respite from the physical and emotional burdens associated with furnishing daily care to chronically ill and severely disabled persons. Respite care may be provided in a home or other noninstitutional setting. It also supports the veteran's desire to delay, or prevent, nursing home placement. According to VA policy,[185] a useful characteristic of respite care is the opportunity for development of a plan for respite care in advance of acute need on the caregiver's part. In this way, respite care is a key component of, rather than incidental to the provision of, routine necessary care. Although the purpose is to be a preventive scheduled benefit, herein lies the inflexibility of the program. An acute need is not a scheduled event and arises throughout the lifetime, not on a short-term basis. Moreover, VA policies indicate that respite care may be provided in a home or other noninstitutional settings or in community nursing homes, but is limited to no more than 30 days per year.

Caregivers of severely injured service members need the flexibility to access shorter respite care periods, such as in two-, four-, or even six-hour increments, as well as availability of services overnight and weekends. In addition, the lack of available beds persists for institutional respite care, and these inpatient settings are more often not an age-appropriate setting for a young generation of injured veterans. The IBVSOs believe VA should enhance this service to reduce the variability across a veteran's continuum of care by, at a minimum, allowing the veteran's primary treating team or physician to approve respite care in excess of 30 days, making more flexible the number of hours/days available for use, providing overnight and weekend respite care to veterans and their caregivers, and eliminating applicable long-term-care copayments.

Another concern the IBVSOs have is on the availability of transportation. If a veteran meets VA's eligibility criteria for beneficiary travel reimbursement,[186] he or she may be eligible for special mode transportation to and from medical appointments. Caregivers may ride with the veteran if there is a designated need for an attendant, which is determined by a VA provider. Since the definition of "medically indicated" is not explicitly defined, the use of this benefit varies considerably. In general, the definition refers to veterans requiring ambulance, ambulette, air ambulance, wheelchair transportation, or transportation specially designed to transport disabled persons. Beneficiary travel regulations specifically indicate that normal modes of transport, such as bus, subway, taxi, train, or airplane, are not included.

The IBVSOs believe Congress should formally authorize, and VA should provide, a full range of psychological and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum, this benefit should include relationship and marriage counseling, family counseling, and related assistance for the family coping with the stress and continuous psychological burden of caring for a severely injured and permanently disabled veteran. VA should develop plans to deploy such services in every location in which VA treats OEF/OIF veterans, and at a minimum should provide such services at every Veterans Health Administration (VHA) access point, including all medical centers and substantial community-based outpatient clinics. When warranted by circumstances, these services should be made available through other means, including the use of telemental health technology and the Internet. When necessary because of scarcity or rural access challenges, VA's local adaptations should include consideration of the use of competent community providers on a fee or contract basis to address the needs of these families.

Additionally, families of severely disabled veterans need practice before they are saturated with responsibilities in caring for their extraordinary veterans. To this end, VA should establish a pilot program immediately for providing severely disabled veterans and family members residential rehabilitation services, to furnish training in the skills necessary to facilitate optimal recovery, particularly for younger, severely injured veterans. Recognizing the tremendous disruption to their lives, the pilot program should focus on helping the veteran and other family members restarting, or "rebooting," their lives after surviving a devastating injury. An integral part of this program should include family counseling and family peer groups so they can share solutions to common problems.

Today, VA's system for providing respite care for severely injured veterans—and to provide needed rest for a family caregiver—is fragmented and unpredictable, and governed by local VA nursing home care unit (NHCU) and adult day health-care (ADHC) policies. Understandably, these programs are targeted to older veterans with chronic illnesses, whereas veterans who survived horrific injuries in Afghanistan and Iraq are still in the early parts of their lives. Thus, VA's NHCU

and ADHC programs remain unattractive to many OEF/OIF veterans. These programs need to be adapted to be more acceptable and attractive to this new generation of disabled veterans.

Policy making and planning to better serve family caregivers of severely injured veterans should depend on statistically representative data that can be used to determine validity, reliability, and statistical significance. The National Long Term Care Survey (NLTCS) is a longitudinal survey designed to study changes in the health and functional status of older Americans (aged 65 and older). It is funded through a Cooperative Agreement[187] between the National Institute on Aging and Duke University. It also tracks health expenditures, Medicare service use, and the availability of personal, family, and community resources for caregiving. The survey began in 1982, and follow-up surveys were conducted in 1984, 1989, 1994, 1999, and 2004. Ancillary surveys to include an Informal Caregiver Survey (ICS) conducted in 1982, 1989, 1999, and 2004 have been added to obtain information on the health and functional status of people who take care of the 65 years and older population in a home environment.

The NLTCS in combination with ICS can be used to examine such things as how many hours of help with activities of daily living (ADLs) and instrumental ADLs chronically disabled elders weekly, and what number and percentage of those hours are provided by informal caregivers. It can also be further broken down by primary and secondary caregivers and by relationship, (e.g., spouse, son, daughter, friend, etc.) as compared to paid workers. This enables policy researchers to measure the time burden of providing informal care on caregivers (especially primary caregivers) in relation to the severity of disability and other care recipient characteristics. The relationship between the weekly time burden of informal care and self-reported indicators of caregiver stress can then be analyzed. Further analyses could be carried out with respect to relationships among time burden of informal care, self-reported caregiver stress, use or non-use of formal services, and funding source for formal services (public/private).

Finally, the NLTCS and ICS contain numerous questions regarding the primary informal caregiver's perception of the need or lack thereof for formal services and the reason why these services are not being used if they are perceived as needed (e.g., lack of affordability, lack of local availability, etc.). This enables policy makers to estimate (using various different criteria) the potential size and characteristics of the target population for public policy interventions to assist caregivers. The IBVSOs believe VA should conduct a standardized baseline and successive national surveys of caregivers of veterans similar to the NTLCS and ICS. Considering the demographics of the VA health-care system's enrolled and user population, it should include a special emphasis on caregivers of OEF/OIF veterans.

Because health outcomes and quality of life of veterans with serious injuries and chronic disability also affect the family, a patient- and family-centered perspective is essential for quality improvement in redesigning long-term care. Policymakers must view family caregivers of severely injured service members as a resource rather than as an unrecognized cost-avoidance tool. In programs where caregivers are assessed, they can be acknowledged and valued by practitioners as part of the health-care team. Caregiver assessment can identify family members most at risk for health and mental health effects and determine if they are eligible for additional support. Effectively supporting caregivers can result in delayed placements of more costly nursing home care.[188]

Assessment is a critical step in determining appropriate support services. Caregiver assessment is a systematic process of gathering information to describe a caregiving situation. It identifies the particular problems, needs, resources, and strengths of the family caregiver and approaches issues from the caregiver's perspective and culture to help the caregiver maintain her or his health and well-being.[189]

The National Consensus Development Conference for Caregiver Assessment brought together widely recognized leaders in health and long-term care, with a variety of perspectives and expertise, to advance policy and practice on behalf of family and informal caregivers. The Family Caregiver Alliance's (FCA) National Center on Caregiving designed and convened this conference, held September 7–9, 2005, in San Francisco. The conference generated a report[190] on the fundamental principles and guidelines to advance caregiver assessment nationally and in each state, and to serve as a catalyst for change at federal, state, and local levels. The IBVSOs believe VA should conduct caregiver assessments that meet the principles outlined in the conference report. Conference participants agreed upon a set of seven basic principles to guide caregiver assessment policy and practices:

1. Because family caregivers are a core part of health care and long-term care, it is important to recognize, respect, assess, and address their needs.
2. Caregiver assessment should embrace a family-centered perspective, inclusive of the needs and preferences of both the care recipient and the family caregiver.
3. Caregiver assessment should result in a plan of care (developed collaboratively with the caregiver) that indicates the provision of services and intended measurable outcomes.
4. Caregiver assessment should be multidimensional in approach and periodically updated.
5. Caregiver assessment should reflect culturally competent practice.
6. Effective caregiver assessment requires assessors to have specialized knowledge and skills. Practitioners' and service providers' education and training should equip them with an understanding of the caregiving process and its impacts, as well as the benefits and elements of an effective caregiver assessment.
7. Government and other third-party payers should recognize and pay for caregiver assessment as a part of care for older people and adults with disabilities.

VA must realize its one-size-fits-all approach to long-term care is not patient-centric, particularly for severely injured OEF/OIF veterans, and current support services for family caregivers are deficient. VA's programs should be designed to meet the needs of younger severely injured or ill veterans who wish to reside at home with their loved ones, in addition to the generally older veteran population now served by VA programs. Where appropriate VHA services are not available because of geographic barriers, the VHA should develop contractual relations with appropriate, qualified private or other public facilities to provide respite services tailored to this population's needs.

While family caregivers may be driven by empathy and love, they're also dealing with guilt over the anger and frustration they feel. The very touchstones that define their lives—careers, love relationships, friendships, even their goals and dreams—are often being sacrificed. Simply, family caregivers who are vital for VA's patient-centric care provided in the least restrictive setting must not remain unpaid, unappreciated, undercounted, untrained, and exhausted. Given the nature of these issues, and the unique situation that confronts our newest generation of severely disabled war veterans, the IBVSOs believe Congress and the Administration need to address a number of observed deficiencies to give needed support and make a family caregiver's tasks and roles more manageable over the long term. This is in the best interests of these families, whose absence as personal caregivers and attendants for these seriously disabled veterans would mean even higher costs to the government to assume total responsibility for their care and would lower the quality of life for the very veterans for whom VA was established as a caring agency.

Recommendations:

The case management system should be seamless for veterans and family caregivers. Case manager advocates must be empowered to assist with medical benefits and family support services, including vocational services, financial services, and child care services.

Congress should formally authorize, and VA should provide, a range of transitional psychological and social support services to family caregivers of veterans with severe service-connected injuries or illnesses.

VA should provide psychological support services to the family caregivers of severely injured and ill veterans. This support must include relationship and marriage counseling, family counseling, and related assistance to the family in coping with the inevitable stress and discouragement of caring for a seriously disabled veteran. These services should be made available at every VA facility that cares for severely disabled veterans of Operations Enduring and Iraqi Freedom.

VA should establish clear policies outlining the expectation that every VA nursing home and adult day health-care program provide appropriate facilities and programs for respite care for severely injured or ill veterans. These facilities should be restructured to be age-appropriate, with strong rehabilitation goals suited to the needs of a younger population, rather than expecting younger veterans to blend with the older generation typically resident in VA nursing home care units and adult day health-care programs. VA must adapt its services to the particular needs of this new generation of disabled veterans and not simply require these veterans to accept what VA chooses to offer.

VA should develop support materials for family caregivers, including the following:

- A "Caregiver Toolkit" available in hard copy and from the Internet—to supplement the recently published "National Resource Directory," which may not be fully responsive to their needs. This should include a concise "recovery road map" to assist families in understanding, and maneuvering through, the complex systems of care and resources available to them.
- Social support and advocacy support for the family caregivers of severely injured veterans, including:
  - Peer support groups, facilitated and assisted by committed VA staff members;
  - Appointment of caregivers to local and VA network patient councils and other advisory bodies within the Veterans Health Administration and Veterans Benefits Administration; and
  - A monitored chat room, interactive discussion groups, or other online tools for the family caregivers of severely disabled OEF/OIF veterans, through My HealtheVet or another appropriate web-based platform.

VA should enhance its respite care services to reduce the variability across a veteran's continuum of care by allowing the veteran's primary treating physician to approve respite care in excess of 30 days; making the benefit more flexible by increasing the number of hours/days, overnight respite, and weekend respite care provided to veterans and their caregivers; and by eliminating applicable copayments.

Clarification is needed regarding the application of the Family and Medical Leave Act to address the special needs of the families of severely injured veterans, including increasing the duration of family leave time that is authorized by that act and adding additional employment protections for parents who are caregivers of severely disabled veterans of OEF/OIF.

Congress should authorize a compensation system for family caregivers of severely disabled veterans, intended to make up for the loss of income resulting from full-time caregiving, and to provide supplemental financial support to maintain their homes.

Congress should require the Government Accountability Office to examine the current Civilian Health and Medical Program of Veterans Affairs to ensure the health coverage available to full-time caregivers is adequate.

To better serve family caregivers of severely injured veterans, VA should conduct a baseline and succeeding national surveys of caregivers of seriously injured veterans that will yield statistically representative data for policy and planning purposes.

VA should conduct caregiver assessments to identify the particular problems, needs, resources, and strengths of family caregivers of severely injured service members and determine appropriate support services and help the caregiver maintain her or his health and well-being.

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[171]S. K. Ostwald, K. W. Hepburn, et al., "Reducing Caregiver Burden: A Randomized Psychoeducational Intervention for Caregivers of Persons with Dementia, *Gerontologist* 39(3): 299–309.
[172]S. H. Zarit, M. A. Stephens, et al., "Stress Reduction for Family Caregivers: Effects of Adult Day Care Use, *Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 53(5) S267–77.
[173]P.L. 109-461, Title II § 214, Pilot Program on Improvement of Caregiver Assistance Services.
[174]Tracey A. Revenson, "Scenes from a Marriage: Examining Support, Coping, and Gender within the Context of Chronic Illness," in J. Suls and K. Wallston, ed., *Social Psychological Foundations of Health and Illness* (pp. 530–559) (Oxford, England: Blackwell Publishing, 2003).
[175]Rebecca G. Judd, *Caregiver Role Strain: A Research Synthesis* (Arlington, Texas: University of Texas, 2006).
[176]United States Agency for Healthcare Research and Quality, 2007 National Healthcare Quality & Disparities Reports, Rockville, MD, 2008. Also, Jim Garamone, U.S. Military Recruiting Demographics," American Forces Press Service, November 23, 2005; David S. Riggs, "Difficulties in Family Reintegration Following Military Deployments," *Healing the Scars of War* (New York: Institute for Disaster Mental Health. 11 Apr. 2008); U.S. Department of Defense, Population Representation in the Military Services. (Washington: Office of the Under Secretary of Defense, Personnel and Readiness, 2006) (www.defenselink.mil/prhome/PopRep_FY06).
[177]Leslie Kauffman, "Veterans' Families Seek Aid for Caregiver Role," *New York Times*, November 11, 2008.
[178]Gerald M. Cross, principal deputy under secretary for health, DVA, statement before the Subcommittee on Health, House Committee on Veterans' Affairs, September 9, 2008.
[179](www.bls.gov/oco/ocos165.htm).
[180]Ibid.
[181]"Medicare Program: Home Health Prospective Payment System Rate Update for Calendar Year 2009," Notice. *Federal Register* 73 (3 November 2008): 65351–65384.
[182]Home health aide, $53.78; skilled nursing, $118.75; medical social services $190.36; occupational therapy $130.71; physical therapy, $129.84; speech-language pathology, $141.09.
[183]DVA, Veterans Health Administration Handbook 1140.3, August 16, 2004.
[184]Leslie Kauffman, "Veterans' Families Seek Aid for Caregiver Role," *New York Times*, November 11, 2008.
[185]DVA, VHA Directive 2002-016, March 19, 2002.
[186]DVA, Beneficiary Travel Handbook1601B.05, July 29, 2008.
[187]Cooperative Agreement Grant 2 U01 AG0007198.
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[189]Lynn Feinberg, "Caregiver Assessment," *Journal of Social Work Education* 44(3) (2008): supplement.
[190]Family Caregiver Alliance, Caregiver Assessment: Principles, Guidelines and Strategies for Change: Report from a National Consensus Development Conference, vol. 1 (San Francisco: Family Caregiver Alliance, 2006) (www.caregiver.org/caregiver/jsp/content/pdfs/v1_consensus.pdf).

Construction Programs

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

CARES—VA's data-driven assessment of its current and future construction needs—gave the Department a long-term road map and has helped guide its capital planning process over the past few fiscal years. CARES showed a large number of significant construction priorities that would be necessary for VA to fulfill its obligation to this nation's veterans, and over the past several fiscal years the Administration and Congress have made significant inroads in funding these priorities. Since FY 2004, $4.9 billion has been allocated for these projects. Of these CARES-identified projects, VA has completed 5, and another 27 are currently under construction. It has been a significant, but necessary, undertaking and VA has made slow, but steady, progress on these critical projects.

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

VA's most recent Asset Management Plan[191] provides an update of the state of CARES projects—including those only in the planning or acquisition process. Appendix E of the plan shows a need for future appropriations of $2.195 billion to complete these projects.

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

The $2.195 billion represents only the backlog of current approved construction projects. It also does not reflect the additional $401 million Congress gave VA as part of the FY 2009 appropriation, which did not earmark specific construction projects.

Meanwhile, VA continues to identify and reprioritize potential major construction projects. These priorities, which are assessed using the rigorous methodology that guided the CARES decisions, are released in the VA's annual "5-Year Capital Plan," which is included in the Department's budget submission. The most recent one was included in Volume IV and is available on the VA website.[192] Pages 7–12 of that document show the priority scoring of projects. Last year's budget request sought funding for only three of the top-scored projects. No funding was requested for any other new project, including those in Seattle, Dallas, Louisville, or Roseburg, Oregon. In addition to the already-identified needs from that table, pages 7–86 show long list of potential major construction projects the Department plans to evaluate from now through FY 2013. These 122 potential projects demonstrate the continued need for VA to upgrade and repair its aging infrastructure and that continuous funding is necessary for not only the backlog of projects, but also to keep VA viable for today's and future veterans.

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

It is clear that VA needs a significant funding for its construction priorities; its own words and studies show this.

Major Construction Account Recommendations	
Category	**Recommendation ($ in Thousands)**
Major Medical Facility Construction	$900,000
NCA Construction	$80,000
Advance Planning	$45,000
Master Planning	$20,000
Historic Preservation	$20,000
Miscellaneous Accounts	$58,000
TOTAL	**$1,123,000**

Major Construction Account recommendations shown in the table are as follows:

- Veterans Health Administration (VHA) Facility Construction—this amount would allow VA to continue addressing the $2 billion backlog of partially funded construction projects. Depending on the stages and ability to complete portions of the projects, any additional money could be used to fund new projects identified by VA as part of its prioritization methodology in its 5-Year Capital Plan.
- National Cemetery Administration (NCA) Construction—pages 7–143 of the 5-Year Capital Plan detail numerous potential major construction projects for the National Cemetery Administration throughout the country. This level of funding would allow VA to begin construction on at least three of its scored priority projects.
- Advance Planning—this amount helps develop the scope of the major medical facility construction projects as well as identify proper requirements for their construction. It allows VA to conduct necessary studies and research similar to planning processes in the private sector.
- Master Planning—a description of *The Independent Budget* (*IB*) request follows later in the text.
- Historic Preservation—a description of the *IB* request follows later in the text.
- Medical Research Infrastructure—a description of the *IB* request follows later in the text.
- Miscellaneous Accounts—these include the individual line items for such accounts as asbestos abatement, the judgment fund, and hazardous waste disposal. The *IB* recommendation is based upon the historic level for each of these accounts.

Minor Construction Account Recommendations	
Category	**Funding ($ in Thousands)**
Veterans Health Administration	$550,000
Medical Research Infrastructure	$142,000
National Cemetery Administration	$100,000
Veterans Benefits Administration	$20,000
Staff Offices	$15,000
TOTAL	**$827,000**

Minor Construction Account recommendations are:

- VHA—pages 7–95 of VA's capital plan reveal hundreds of already-identified minor construction projects that update and modernize VA's aging physical plant, ensuring the health and safety of veterans and VA employees. Additionally, a great number of minor construction projects address maintenance deficiencies identified in the facility condition assessment, the backlog of which was nearly $5 billion at the start of FY 2008 (page 7–64).
- Medical Research Infrastructure—a description of the *IB* request follows later in the text.
- NCA—pages 7–145 of the capital plan identify numerous minor construction projects throughout the country, including the construction of several columbaria, installation of crypts, and landscaping and maintenance improvements. Some of these projects could be combined with VA's new NCA nonrecurring maintenance efforts.
- Veterans Benefits Administration—pages 7–126 of the capital plan lists several minor construction projects in addition to the leasing requirements VBA needs. This funding also includes $2 million transferred yearly for the security requirements of its Manila office.
- Staff Offices—Pages 7–166 list numerous potential minor construction projects related to staff offices, including increased space and numerous renovations for the VA Office of Inspector General.

[193]www.va.gov/oaem/docs/FY08AssetManagementPlan.pdf.
[192]www.va.gov/budget/summary/2009/index.htm.

CONSTRUCTION ISSUES

Inadequate Funding and Declining Capital Asset Value

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

The past decade of delayed and underfunded construction budgets has meant that VA has not adequately recapitalized its facilities. Recapitalization is necessary to protect the value of VA's capital assets through the renewal of the physical infrastructure. This ensures safe and fully functional facilities long into the future. VA's facilities have an average age of more than 55 years, and it is essential that funding be increased to renovate, repair, and replace these aging structures and physical systems.

As in past years, *The Independent Budget* veterans service organizations (IBVSOs) cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). It found that from 1996–2001, VA's recapitalization rate was just 0.64 percent. At this rate, VA's structures would have an assumed life of 155 years.

The PTF cited a PricewaterhouseCoopers' study[193] of VA's facilities management programs that found that to keep up with industry standards in the private sector and to maintain patient and employee safety and optimal heath-care delivery, VA should annually spend a minimum of 5 percent to 8 percent of plant replacement value (PRV) on its total capital budget.

The FY 2008 VA Asset Management Plan[194] provides the most recent estimate of VA's PRV. Using the guidance of the federal government's Federal Real Property Council, VA's PRV is just over $85 billion.

Accordingly, using that 5 percent to 8 percent standard, VA's capital budget should be between $4.25 and $6.8 billion per year in order to maintain its infrastructure. VA's capital budget request for FY 2009—which includes major and minor construction, maintenance, leases, and equipment—was just $3.6 billion. The IBVSOs greatly appreciate that Congress increased funding above that level with an increase over the Administration request of $750 million in Major and Minor Construction alone. That increased amount brought the total capital budget in line with industry standards, and we strongly urge that these targets continue to be met and we would hope that future VA requests use these guidelines as a starting point without requiring Congress to push them past the target.

Recommendation:

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

[193]Final Report, Independent Review of Office of Facility Management, PriceWaterhouse, June 17, 1998.
[194]www.va.gov/oaem/docs/FY08AssetManagementPlan.pdf., p. 26.

INCREASED SPENDING ON NONRECURRING MAINTENANCE:

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

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

These projects are vitally important. If left unrepaired, they can exact a significant toll on a facility, leading to more costly repairs in the future and the potential of a need for a minor construction project. Beyond the fiscal aspects, facilities that fall into disrepair can create access difficulties and impair patient and staff health and safety. If the needs develop into a larger construction project because early repairs were not done, it creates an even larger inconvenience for veterans and staff.

The industry standard for medical facilities is for managers to spend from 2 percent to 4 percent of plant replacement value (PRV) on upkeep and maintenance. The 1998 PricewaterhouseCoopers[195] study of VA's facilities management practices argued for this level of funding, and previous versions of VA's own Asset Management Plan have agreed that this level of funding would be adequate.

The most recent estimate of VA's PRV is from the FY 2008 Asset Management Plan.[196] Using the standards of the federal government's Federal Real Property Council (FRPC), VA's PRV is just over $85 billion. Accordingly, to fully maintain its facilities, VA needs an NRM budget of at least $1.7 billion. This number would represent a doubling of VA's budget request from FY 2009, but it is in line with the total NRM budget when factoring in the increases Congress gave in the appropriations bill and the targeted funding included in the supplemental appropriations bills.

Increased funding is required not just to fill current maintenance needs and levels, but also to reduce the extensive backlog of maintenance requirements VA has identified. VA monitors the condition of its structures and systems through the Facility Condition Assessment (FCA) reports. VA surveys each medical center periodically, giving each building a thorough assessment of all essential systems. Systems are assigned a letter grade based upon the age and condition of various systems, and VA gives each component a cost for repair or replacement.

Most of these repairs and replacements are managed through the NRM program, although the large increases

in minor construction over the last few years have helped VA to address some of these deficiencies. VA's 2009 5-Year Capital Plan discusses FCAs and acknowledges the significant backlog, noting that in FY 2007, the number of high-priority deficiencies—those with ratings of D or F—had replacement and repair costs greater than $5 billion. Even with the increased funding of the past few years, VA estimates that the cost for repairing or replacing the high-priority deficiencies is more than $4 billion. VA uses the FCA reports as part of its FRPC metrics. It calculates a facility condition index, which is the ratio of the cost of FCA repairs to the cost of replacement. According to the FY 2008 Asset Management Plan, this metric has gone backward from 82 percent in 2006 to just 68 percent in 2008. VA's strategic goal is 87 percent, and for it to meet that, it would require a sizable investment in NRM and minor construction.

Given the low level of funding the NRM account has historically received, the IBVSOs are not surprised at the metrics or the dollar cost of the FCA deficiencies. The 2007 "National Roll-Up of Environment of Care Report,"[197] which was conducted in light of the shameful maintenance deficiencies found at the Department of Defense's Walter Reed Army Medical Center, further proves the need for increased spending on this account. Maintenance has been neglected for far too long, and for VA to provide safe, high-quality health care in its aging facilities, it is essential that more funding be allocated for this account.

The IBVSOs also have concerns with how NRM funding is actually apportioned. Because it falls under the Medical Care account, NRM funding has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This model works when distributing health-care dollars, targeting funding to those areas with the greatest demand for health care. When dealing with maintenance needs, however, this same formula may actually intensify the problem, moving money away from older hospitals, such as in the Northeast, to newer facilities where patient demand is greater, even if the maintenance needs are not as high. We were happy to see that the conference reports to the VA appropriations bills required NRM funding to be apportioned outside the VERA formula, and we would hope that this continues into the future.

Another issue related to apportionment of funding came to light in a May 2007 Government Accountability Office (GAO) report that found that the bulk of NRM funding is not actually apportioned until September, the final month of the fiscal year.[198] In September 2006, the GAO found that VA allocated 60 percent of that year's NRM funding. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and because NRM funding is year-to-year, this practice could lead to wasteful or unnecessary spending as managers attempt to hastily spend their apportionment before forfeiting it. We cannot expect VA to perform a year's worth of maintenance in a month. It is clearly poor policy and not in the best interest of veterans. The IBVSOs believe that Congress should consider allowing some NRM money to be carried over from one fiscal year to another. Whereas we would hope that this would not resort to medical centers hoarding funding, it could result in more efficient spending and better planning than the current situation in which hospital managers sometimes have to spend a large portion of maintenance funding before losing it at the end of the fiscal year.

Recommendations:

VA must dramatically increase funding for nonrecurring maintenance in line with the 2 percent to 4 percent total that is the industry standard so as to maintain clean, safe, and efficient facilities. VA also requires additional maintenance funding to allow the department to begin addressing the substantial maintenance backlog of facility condition assessment–identified projects.

Portions of the nonrecurring maintenance account should be continued to be funded outside of the Veterans Equitable Resource Allocation formula so that funding is allocated to the facilities that actually have the greatest maintenance needs.

Congress should consider the strengths of allowing VA to carry over some maintenance funding from one fiscal year to another so as to reduce the temptation some VA hospital managers have of inefficiently spending their NRM money at the end of a fiscal year for fear of losing it.

[195]Final Report, Independent Review of Office of Facility Management, PriceWaterhouse, June 17, 1998.
[196]www.va.gov/oaem/docs/FY08AssetManagementPlan.pdf., p. 26.
[197]www1.va.gov/opa/pressrel/docs/Environment_of_Care_Roll-up.pdf.
[198]www.gao.gov/new.items/d07410r.pdf.

MAINTAIN VA'S CRITICAL HEALTH INFRASTRUCTURE:

The Independent Budget ***veterans service organizations (IBVSOs) are concerned with VA's recent attempts to back away from the capital infrastructure blueprint laid out by the Capital Asset Realignment for Enhanced Services (CARES) plan, and we are worried that its emerging plan to begin widespread leasing and contracting for inpatient services might not meet the needs of veterans.***

The Department of Veterans Affairs acknowledges three main challenges with its capital infrastructure projects: First, they are costly. According to a March 2008 briefing given to veterans service organizations, over the next five years VA would need $2 billion per year for its capital budget. Second, there is a large backlog of partially funded construction projects. That same briefing claimed the difference in major construction requests given to the Office of Management and Budget was $8.6 billion from FY 2003 through FY 2009 and that it has received slightly less than half that total. Additionally, there is a $2 billion funding backlog for projects that are partially but not completely funded. Third, VA is concerned about the timeliness of construction projects, noting that it can take the better part of a decade from the time VA initially proposes a project until the doors actually open for veterans.

Given these challenges, VA has broached the idea of a new model for health-care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF, VA would begin leasing large outpatient clinics in lieu of major construction. These large clinics would provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

On the face of it, this sounds like a good initiative. Leasing has the advantage of being able to be completed quickly, as well as being adaptable, especially when compared to existing major medical facilities. Leasing has been particularly valuable for VA as evidenced by the success of the community-based outpatient clinics and Vet Centers.

The IBVSOs are concerned, however, with VA's plan for inpatient services. VA aims to contract for these essential services with affiliates or community hospitals. This program would privatize many services we believe VA should continue to provide. We lay out our objections to privatization and widespread contracting for care in the "Contract Care Coordination" section of this *Independent Budget.*

Beyond those objections, though, is the example of Grand Island, Nebraska. In 1997 the Grand Island VA Medical Center closed its inpatient facilities, contracting out with a local hospital for those services. Recently the contract between the local facility and VA was canceled, meaning veterans in that area can no longer receive inpatient services locally. They must travel great distances to other VA facilities, such as the Omaha VA Medical Center. In some cases, when Omaha is unable to provide specialized care, VA is flying patients at its expense to faraway VA medical centers, including those in St. Louis and Minneapolis.

Further, with the canceling of that contract, the local hospital no longer provides the same level of emergency services that a full VA medical center would provide. With VA's restrictions on paying for emergency services in non-VA facilities, especially for those who may have some form of private insurance, this amounts to a cut in essential services to veterans. Given the expenses of air travel and medevac services, the current arrangement in Grand Island has likely not resulted in any cost savings for VA. Ferrying sick and disabled veterans great distances for inpatient care also raises patient safety and quality of care concerns.

The HCCF program raises many concerns the IBVSOs believe VA must address. Among these questions, we wonder how VA will handle governance, especially with respect to the large numbers of non-VA employees who would be treating veterans? How will the non-VA facility deal with VA directives and rule changes that govern health-care delivery and that ensure safety and uniformity of the quality of care? Will VA apply its space planning criteria and design guides to non-VA facilities? How will VA's critical research activities, most of which improve the lives of all Americans and not only veterans, be affected if they are being conducted in shared facilities, and not a traditional part of VA's first-class research programs? What will this change mean for VA's electronic health record, which many have rightly lauded as the standard that other health-care systems should aim to achieve? Without the electronic health record, how will

VA maintain its high quality of care standards and continuity for a veteran who moves to another area?

But, most important, CARES required years to complete and consumed thousands of hours of effort and millions of dollars of study. The IBVSOs believe it to be a comprehensive and fully justified road map for VA's infrastructure as well as a model VA can apply periodically to assess and adjust those priorities. Given the strengths of the CARES process and the lessons VA learned and has applied from it, why is the HCCF model, which to our knowledge has not been based on any sort of model or study of the long-term needs of veterans, the superior one? We have yet to see evidence that it is and until we see more convincing evidence that it will truly serve the best interests of veterans, the IBVSOs will have a difficult time supporting it.

Recommendation:

VA must not implement the Health Care Center Facility model without fully addressing the many questions raised in *The Independent Budget*, and VA must explain how the program would meet the needs of veterans, particularly as compared to the road map the Capital Asset Realignment for Enhanced Services laid out.

RESEARCH INFRASTRUCTURE FUNDING:

The Department of Veterans Affairs must have increased funding for its research infrastructure to provide a state-of-the-art research and laboratory environment for its excellent programs, but also to ensure that VA hires and retains the top scientists and researchers.

VA Research Is a National Asset

Research conducted in the Department of Veterans Affairs has led to such innovations and advances as the cardiac pacemaker, nuclear scanning technologies, radioisotope diagnostic techniques, liver and other organ transplantation, the nicotine patch, and vast improvements in a variety of prosthetic and sensory aids. A state-of-the-art physical environment for conducting VA research promotes excellence in health professions education and VA patient care as well as the advancement of biomedical science. Adequate and up-to-date research facilities also help VA recruit and retain the best and brightest clinician scientists to care for enrolled veterans.

VA Research Infrastructure Funding Shortfalls

In recent years, funding for the VA Medical and Prosthetics Research Program has failed to provide the resources needed to maintain, upgrade, and replace VA's aging research facilities. Many VA facilities have exhausted their available research space. Along with space reconfiguration, ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades in VA's academic health centers. In the 2003 Draft National Capital Asset Realignment for Enhanced Services (CARES) plan, VA included $142 million designated for renovation of existing research space and build-out costs for leased researched facilities. However, these capital improvement costs were omitted from the Secretary's final report. Over the past decade, only $50 million has been spent on VA research construction or renovation nationwide, and only 24 of the 97 major VA research sites across the nation have benefited.

In House Report 109-95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee directed VA to conduct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies." In FY 2008, the VA Office of Research and Development initiated a multiyear examination of all VA research infrastructure for physical condition and capacity for current research, as well as program growth and sustainability of the space needed to conduct research.

Lack of a Mechanism to Ensure VA's Research Facilities Remain Competitive

In House Report 109-95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee expressed concern that "equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." A significant cause of research infrastructure's neglect is that there is no direct funding line for research facilities.

The VA Medical and Prosthetic Research appropriation does not include funding for construction, renovation, or maintenance of research facilities. VA researchers must rely on their local facility managements to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with other medical facilities' direct patient care needs—such as medical services infrastructure, capital equipment upgrades and replacements, and other maintenance needs—for funds provided under either the VA Medical Facilities appropriation account or the VA Major or Minor Medical Construction appropriations accounts.

Recommendations:

The Independent Budget veterans service organizations anticipate VA's analysis will find a need for funding significantly greater than VA had identified in the 2004 Capital Asset Realignment for Enhanced Services report. As VA moves forward with its research facilities assessment, the IBVSOs urge Congress to require the VA to submit the resulting report to the House and Senate Committees on Veterans' Affairs no later than October 1, 2009. This report will ensure that the Administration and Congress are well informed of VA's funding needs for research infrastructure so they may be fully considered at each stage of the FY 2011 budget process.

To address the current shortfalls, the IBVSOs recommend an appropriation in FY 2010 of $142 million, dedicated to renovating existing VA research facilities in line with the 2004 CARES findings.

To address the VA research infrastructure's defective funding mechanism, the IBVSOs encourage the Administration and Congress to support a new appropriations account in FY 2010 and thereafter to independently define and separate VA research infrastructure funding needs from those related to direct VA medical care. This division of appropriations accounts will empower VA to address research facility needs without interfering with the renovation and construction of VA direct health-care infrastructure.

PROGRAM FOR ARCHITECTURAL MASTER PLANS:

Each VA medical facility must develop a detailed master plan.

The delivery models for quality health care are in a constant state of change. This is the result of many factors, including advances in research, changing patient demographics, and new technology.

The Department of Veterans Affairs must design health care facilities with a high level of flexibility in order to accommodate these new methods of patient care. VA must be able to plan for change to accommodate new patient care strategies in a logical manner with as little effect as possible on other existing patient care programs and provide for growth in already existing programs.

A facility master plan is a comprehensive tool to look at potential new patient care programs and how they might affect the existing health-care facility. It also provides insight with respect to possible growth, current space deficiencies, and other facility needs for existing programs and how VA might accommodate these in the future.

In some cases in the past, VA has planned construction in a reactive manner. After funding, VA would place projects in the facility in the most expedient manner—often not considering other projects and facility needs.

This would result in shortsighted construction that restricts rather than expands options for the future.

The Independent Budget veterans service organizations believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility. Short- and long-term Capital Asset Realignment for Enhanced Services (CARES) objectives should be the basis of the master plan.

Four critical programs were not included in the CARES initiative. They are long-term care, severe mental illness, domiciliary care, and polytrauma. VA must develop a comprehensive plan addressing these needs and its facility master plans must account for these services. VA has undertaken master planning for several VA facilities, most recently in the Tampa medical center. This is a good start, but VA must ensure that all facilities develop a master plan strategy to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care. Other projects for consideration in developing master plans should include Jackson, Mississippi; San Diego; Long Beach, California; and Memphis.

Recommendations:

Congress must appropriate $20 million to provide funding for each medical facility to develop an architectural master plan.

Each facility master plan should include the areas omitted from the Capital Asset Realignment for Enhanced Services: long-term care, severe mental illness, domiciliary care, and polytrauma programs as they relate to a particular facility.

The VA Central Office must develop a standard format for these master plans to ensure consistency throughout the VA health-care system.

Completed architectural master plans should be considered as VA develops future major medical construction budget requests.

Empty or Underutilized Space:

The Department of Veterans Affairs must not use empty space inappropriately and must continue disposing of unnecessary property where appropriate.

Studies have suggested that the VA medical system has extensive amounts of empty space that the Department can reuse for medical services. Others have suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function and the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. For example, VA cannot use unoccupied rooms on the eighth floor to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a function expands or moves, these demands create a domino effect of everything around it. These secondary impacts greatly increase construction expense, and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, interstitial space, column spacing, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs of different column spacing and perimeter configuration.

Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expense and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary costs, a renovation can end up costing more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but they are rarely economical.

Many older VA medical centers that were rapidly built during and after World War II to treat a wounded veteran population are simply unable to be renovated for contemporary needs. Most of these Bradley-style buildings were designed before the widespread use of air conditioning and the floor-to-floor heights are very low. Accordingly, it is impossible to retrofit them for modern mechanical systems. Many also have long, narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another critical problem with this unused space is its location. Much of it is not located in a prime location; otherwise, VA would have previously renovated or demolished this space for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

Public Law 108-422 incentivized VA's efforts to dispose of excess space by allowing VA to retain the proceeds from the sale, transfer, or exchange of certain properties in the Capital Asset Fund. Further, that law required VA to develop short- and long-term plans for the disposal of excess facilities, which it reports to Congress annually. VA must continue to develop these plans, working in concert with their architectural master plans and the long-range vision for VA medical centers. VA has developed metrics to track its use of underutilized space and actively monitor this as part of the Federal Real Property Council reporting requirements.

Recommendation:

VA must continue to monitor and develop short- and long-term plans with respect to the disposal of unnecessary space in nonhistoric properties that otherwise are not suitable for medical or support functions because of the structure's permanent characteristics or its location.

VA Space Planning Criteria/Design Guides:

The Department of Veterans Affairs must continue to maintain and update its Space Planning Criteria and Design Guides to reflect state-of-the-art methods of health-care delivery.

VA has developed space-planning criteria it uses to allocate space for all VA health-care construction projects. These criteria are organized into 60 chapters: one for each health-care service provided by VA and its associated support services. VA updates these criteria to reflect current methods of health-care delivery.

In addition to updating these criteria, VA has utilized a computer program called VA SEPS (Space and Equipment Planning System) as a tool to develop space and equipment allocation for all VA health-care projects. This tool is operational and VA currently uses it on all projects.

The third component used in the design of VA health-care projects is design guides. Many of the 60 space-planning criteria chapters has an associated design guide. These design guides go beyond the allocation of physical space and outline how this space is organized within each individual function, as well as how the function relates to the entire medical facility.

VA has updated several of the design guides to reflect current patient delivery models. These include guides that cover spinal cord injury/disorders center, imaging, and polytrauma centers, as well as several other services.

Recommendation:

VA must continue to maintain and update the space-planning criteria and the VA Space and Equipment Planning System tool. It also must continue the process of updating the design guides to reflect current delivery models for patient care. VA must regularly review and update all of these space-planning tools as needed, to reflect the highest level of patient care delivery.

DESIGN-BUILD CONSTRUCTION DELIVERY SYSTEM:

The Department of Veterans Affairs must evaluate use of the design-build construction delivery system.

For the past 10 years, VA has embraced the design-build construction delivery system as a method of project delivery for many health-care projects. Design-build attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to the owner and reduce the project delivery schedule. Design-build, as used by VA, places the contractor as the design builder.

Under the contractor-led design-build process, VA gives the contractor a great deal of control over how he or she designs and completes the project. In this method, the contractor hires the architect and design professionals. With the architect as a subordinate, a contractor may sacrifice the quality of material and systems in order to gain profits at the expense of the owner.

Use of design-build has several inherent problems. A shortcut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents may not provide adequate scope for the project, leaving out important details regarding the workmanship or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, which often compromises VA's design standards.

Design-build forces the owner to rely on the contractor to properly design a facility that meets the owner's needs. In the event that the finished project is not satisfactory to the owner, the owner may have no means to insist on correction of work done improperly unless the contractor agrees with the owner's assessment. This may force the owner to go to some form of formal dispute resolution, such as litigation or arbitration.

Recommendations:

VA must evaluate the use of design-build as a method of construction delivery to determine if design-build is an appropriate method of project delivery for VA health-care projects.

VA must institute a program of "lessons learned." This would involve revisiting past projects and determining what worked, what could be improved, and what did not work. VA should compile and use this information as a guide to future projects. VA must regularly update this document to include projects as they are completed.

PRESERVATION OF VA'S HISTORIC STRUCTURES:

The Department of Veterans Affairs must further develop a comprehensive program to preserve and protect its inventory of historic properties.

VA has an extensive inventory of historic structures that highlight and memorialize America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great nation. Of the approximately 2,000 historic structures in VA's inventory, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected, and preserved because they are an integral part our nation's history.

Most of these historic facilities are not suitable for modern patient care. As a result, a preservation strategy was not included in the Capital Asset Realignment for Enhanced Services process. For the past six years, *The Independent Budget* veterans service organizations (IBVSOs) have recommended that VA conduct a formal inventory of these properties, classifying their physical condition and their potential for adaptive reuse. VA has been moving in that direction and historic properties are identified on its website. VA has placed many of these buildings in an "Oldest and Most Historic" list, and these buildings require immediate attention.

At least one project has received funding. VA has invested more than $100,000 in the past year to address structural issues at a unique round structure in Hampton, VA. Built in 1860, it was originally a latrine and the funding is allowing VA to convert it into office space.

The cost for saving some of these buildings is not very high considering that they represent a part of history that enriches the texture of our landscape that once gone cannot be recaptured. For example, VA can restore the Greek revival mansion in Perry Point, Maryland, which was built in the 1750s, to use as a training space for about $1.2 million. VA could restore the 1881 Milwaukee Ward Memorial Theater for use as a multipurpose facility at a cost of $6 million. This is much less than the cost of a new facility.

As part of its adaptive reuse program, VA must ensure that the facilities that it leases or sells are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds.

The IBVSOs encourage the use of P.L. 108-422, the Veterans Health Programs Improvement Act, which authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property.

Recommendation:

VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

Career and Occupational Assistance

Employment policy is vital to veterans and veterans with disabilities in today's environment, in which work is critical to independence and self-sufficiency. People with disabilities, including veterans, often encounter barriers to entry or reentry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties, in turn, contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels, entitlement programs cannot keep pace with the current and future demand for benefits.

The Department of Defense indicates that each year approximately 25,000 active duty service members are found "not fit for duty" due to medical conditions that may qualify for VA disability ratings and eligibility to Vocational Rehabilitation and Employment (VR&E) services. In response to criticism of the VR&E Service, a VR&E task force was formed to conduct an "unvarnished top-to-bottom independent examination, evaluation, and analysis" of the program and recommend "effective, efficient, up-to-date methods, materials, and metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment (Congressional Research Service Report for Congress RL34627). In March 2004, the task force released its report with 110 recommendations for VR&E improvements. By the end of fiscal year 2007, only 89 had been implemented.

Citing several studies of VR&E within the past decade, the Veterans' Disability Benefits Commission (VDBC) in 2007 identified a host of ongoing problems with the program, including:

- the need for more aggressive and proactive approaches to serving veterans with serious employment barriers;
- a limited number of VR&E counselors and case managers to handle a growing caseload;
- inadequate and ineffective tracking and reporting on participants;
- employment outcomes that are measured no further than 60 days after hiring; and
- the possibility that the current 12-year limit for veterans to take advantage of VR&E may be unrealistic.

The Independent Budget continues to support the recommendations of the VR&E task force and the VDBC:

- expanding access to all medically separated service members;
- making all disabled veterans eligible for vocational rehabilitation counseling services;
- screening through VR&E counselors all applicants for individual unemployability ratings;
- increasing VR&E staffing and resources, tracking employment success beyond 60 days, and implementing satisfaction surveys of participants and employers; and
- creating incentives to encourage disabled veterans to complete their rehabilitation plan.

The Independent Budget veterans service organizations look forward to monitoring the continued implementation of these recommendations and future program changes.

Career and Occupational Assistance Programs

VOCATIONAL REHABILITATION AND EMPLOYMENT

VOCATIONAL REHABILITATION AND EMPLOYMENT FUNDING:

Congressional funding for the VA Vocational Rehabilitation and Employment (VR&E) Service must keep pace with veteran demand for VR&E services.

The VR&E program is authorized by Congress under title 38, United States Code and is better known as chapter 31 benefits. The program provides services and counseling necessary to enable service disabled veterans to overcome employment barriers and allow them to prepare for, find, and maintain gainful employment in their communities. The program also provides independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their reentry back to private life. The program further offers educational and vocational counseling to service-disabled veterans recently separated from active duty and helps to expedite their reentry into the labor force. These services are also available to dependents of veterans who meet certain eligibility requirements.

The Office of Management and Budget (OMB) estimates the average cost of placing a service-disabled veteran in employment at $8,385 as calculated by dividing VR&E program obligations by the number of veterans rehabilitated. However, OMB calculations do not include a provision for inflation, increased student tuition costs, and the numbers of veterans who drop out of the VR&E program or enter interrupt status of their rehabilitation plan. Comparisons to other vocational programs are not appropriate since nonfederal dollars are excluded when calculating their cost to place an individual in employment status.

Many veterans are facing significant challenges as they return home from the global war on terrorism. These large numbers of regular military, National Guard, and Reserves are creating tens of thousands of new veterans, many of whom are eligible for VR&E programs. As indicated earlier, present funding levels for VR&E programs cannot keep pace with the current and future demands for VR&E benefits.

The Independent Budget veterans service organizations are concerned that service members, National Guard, and Reservists involved in the global war on terrorism who are being discharged from military service with service-connected disabilities will not receive effective vocational rehabilitation services in a timely manner due to a lack of available resources.

Recommendation:

Congress must provide the funding level to meet the increasing veteran demand for VA Vocational Rehabilitation and Employment program services.

VOCATIONAL REHABILITATION AND EMPLOYMENT PRODUCTIVITY:

Staffing levels of the VA Vocational Rehabilitation & Employment (VR&E) Service are not sufficient to meet the needs of our nation's veterans in a timely manner.

The VR&E Service is charged with the responsibility to prepare service-disabled veterans for suitable employment and provide independent living services to those veterans with severe disabilities and who are unlikely to secure suitable employment at the time of their entry into the program. VR&E must begin to strengthen its program due to the increasing number of service members returning from Afghanistan and Iraq with serious disabilities. These veterans require both vocational rehabilitation and employment services. There is no VA mission more important during or after a time of war than to enable injured military personnel to have a seamless transition from military service to a productive life after serving their country.

Success in the transition of disabled veterans to meaningful employment relies heavily upon VA's ability to provide vocational rehabilitation and employment services in a timely and effective manner. Unfortunately, the demands and expectations being placed on the VR&E Service are exceeding the organization's current capacity to effectively deliver a full continuum of comprehensive programs. The service had been experiencing a shortage of staff nationwide because of insufficient funding, which, as a result, has caused delays in providing VR&E services to disabled veterans, thus reducing the veteran's opportunity to achieve successful rehabilitation.

To increase emphasis on employment, the service has begun an initiative titled "Coming Home to Work" as an early outreach effort to provide VR&E services to eligible service members pending medical separation from active duty at military treatment facilities. This and other new programs will require additional staff to maintain efforts nationwide. We must stress the point again, that VA must increase VR&E staffing levels to meet the increasing demand our nation's veterans have for services.

The number of veterans in the various phases of VR&E programs is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Even though the focus of the VR&E program has drastically changed to career development and employment, it is not clear, despite VR&E's addition of 83 employment coordinators, whether VA is able to meet the current and future demand for employment services. It is just not good enough to say the program's focus is on employment when the data demonstrate that only 9,000 veterans were placed in employment out of 90,000 active cases.

In addition, there is no specific data to demonstrate how long beyond 60 days that a newly employed veteran remains in the workforce. Once the veteran is placed, there is minimal follow-up by VR&E with the employer.

For many years, *The Independent Budget* veterans service organizations have criticized VR&E Service programs and complained that veterans were not receiving suitable vocational rehabilitation and employment services in a timely manner. Many of these criticisms remain a concern, including the following:

- inconsistent case management with lack of accountability for poor decision making;
- delays in processing initial applications due to staff shortages and large caseloads;
- declaring veterans rehabilitated before suitable employment is retained for at least six months;
- inconsistent tracking of electronic case management information system; and
- failure to follow up with veterans, employers, and referral agencies beyond 60 days to ensure employment placement is appropriate for the veteran.

Recommendations:

VA needs to strengthen its Vocational Rehabilitation and Employment program to meet the demands of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq, by providing a more timely and effective transition into the workforce and providing placement follow-up with employers for at least six months.

The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.

The VR&E Service must place higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

VOCATIONAL REHABILITATION AND EMPLOYMENT NATIONAL SURVEY AND PERFORMANCE DATA:

The Department of Veterans Affairs should report accurate performance data that include all veterans who participate in the Vocational Rehabilitation & Employment (VR&E) program and initiate a national survey to determine why veterans drop out prior to rehabilitation.

Performance reporting for the VR&E, chapter 31 benefits program, which is used by VA and Congress to authorize funding and staffing needs, must be improved. For example, in FY 2006, VA reported a rehabilitation rate of 73 percent in its Performance and Accountability Report and Budget Submission. However, VA excluded veterans who discontinued participating in the program without implementing a written rehabilitation plan, even though these veterans represent a majority of veterans served by the program. When calculating the rehabilitation rate including all participants, the VR&E success rate would be 18 percent. As a result, decision makers and Congress are not totally aware of the overall performance rate when making decisions on needed resources.

Recommendations:

The Independent Budget veterans service organizations recommend that the Vocational Rehabilitation & Employment Service initiate a nationwide study to reveal the reasons why veterans discontinue participation in the VR&E program and use the information to design interventions to reduce the probability of veterans dropping out of the program.

The VR&E Service needs to report the true number of veterans participating in the program and accurate performance data for budgetary and other resource decisions.

VOCATIONAL REHABILITATION AND EMPLOYMENT ELIGIBILITY:

Congress needs to change the eligibility requirements for the VA Vocational Rehabilitation and Employment (VR&E) program.

The period of eligibility for VR&E benefits is 12 years from the date of separation from the military or the date the veteran was first notified by VA of a service-connected disability rating. Unfortunately, many veterans are not informed of their eligibility to VR&E services or do not understand the benefits of the program. In addition, veterans who later in life may become so disabled that their disabilities create an employment barrier would benefit from VR&E services well beyond the 12-year delimiting date.

Many veterans who served this country honorably and returned from service uninjured acquire nonservice-connected disabilities post-discharge and, if these disabilities are severe enough, they will be eligible for Social Security Disability Insurance. Under current law, they will not be eligible for the VR&E program but must rely on vocational and employment help from state vocational rehabilitation programs, Social Security work incentives, Department of Labor veterans programs, and other private sector options available to most people with disabilities. In addition to forcing veterans with nonservice-connected disabilities to seek vocational services outside the VA, this adds to increasing demands placed on non-VA vocational rehabilitation programs, which are also underfunded.

Recommendations:

Congress needs to change the eligibility delimiting date for VA Vocational Rehabilitation and Employment services by eliminating the 12-year eligibility period for chapter 31 benefits and allow all veterans with employment impediments or problems with independent living to qualify for VR&E services.

The VR&E Service must develop an aggressive outreach program to inform veterans of the benefit of participating in the VR&E program.

VA needs to streamline eligibility and entitlement to VR&E programs to provide earlier intervention and assistance to disabled veterans.

VOCATIONAL REHABILITATION AND EMPLOYMENT INDEPENDENT LIVING PROGRAM ANNUAL CAP:

Congress needs to eliminate the Vocational Rehabilitation & Employment (VR&E) Independent Living annual participation cap.

The VR&E Independent Living (IL) program was established by Congress in 1980 to serve severely disabled veterans who were determined by VA to be unable to obtain and retain suitable employment due to their disabilities. The IL program provides these disabled veterans services to enable them to achieve maximum independence in daily living. However, Chapter 31, title 38, United States Code, limits the maximum length VA can provide services to 30 months and restricts the number of disabled veterans who can be placed in the program to 2,500 annually. Therefore, because of this cap, the VR&E Service has instructed VA regional offices to discontinue placing veterans into IL status as they approach the 2,500 participant cap. It is this anticipation of exceeding the cap that has delayed access of eligible veterans into the IL program.

In May of 2007, the VA Secretary stated that "VR&E anticipates a steady increase in demand for IL services over the next 10 years based on historical data and the increased need for IL services by OEF and OIF veterans."[199] VA estimates a program growth of 10 percent in FY 2009 and future years.

The Independent Budget veterans service organizations believe that the ever-growing number of seriously disabled veterans returning from the conflicts in Iraq and Afghanistan could result in significant demand for IL services and low-cost transitional housing. VA should not be constrained from providing these services by an arbitrary cap on new cases or limit the amount of time they may provide services. Many of the newly injured veterans have multiple complex disabilities that will require long-term management and programs to include IL services.

Recommendation:

Congress should eliminate the 30-month maximum requirement for providing Independent Living services and the statutory cap of 2,500 new Vocational Rehabilitation and Employment Independent Living program participants because the effect of the cap and the increasing veteran demand for services delays providing needed IL programs to severely disabled veterans.

[199] DVA OIG Report 06-00493, December 17, 2007.

FOLLOW-UP ON REFERRALS TO OTHER AGENCIES FOR ENTREPRENEUR OPPORTUNITIES:

VA Vocational Rehabilitation and Employment (VR&E) Service staff should follow up with veterans who are referred to other agencies to ensure the veterans' entrepreneur opportunities have been achieved.

VR&E has expanded its effort toward fostering awareness and opportunities for self-employment by signing memorandums of understanding with the Department of Labor, the Small Business Administration, the Veterans Corporation, and SCORE. They have also implemented the Five Track Employment Process, which places emphasis on self-employment as a potential for gainful employment. VR&E has further included self-employment in standardized operation materials, online employment sources, and information guides. However, VR&E must follow up with veterans who were referred to other agencies for entrepreneur opportunities and reassess their employment needs if they were not successful.

Recommendation:

Vocational Rehabilitation & Employment Service staff must follow up with veterans after being referred to other agencies for self-employment to ensure that veterans' entrepreneur opportunities have been successfully achieved.

VOCATIONAL REHABILITATION AND EMPLOYMENT COUNSELING PARTNERS:

VA needs to improve its coordination with non-VA counselors to ensure that veterans are receiving the full array of Vocational Rehabilitation and Employment (VR&E) programs and services in a timely and compassionate manner.

VA's Strategic Plan for FY 2006–2011 reveals that VA plans to continue the utilization of non-VA providers to supplement and complement services provided by VR&E staff. Numerous nonprofit vocational rehabilitation providers have served veterans with disabilities for many years in partnership with the VA. Unlike state vocational rehabilitation processes, through which qualified providers partner with state agencies to provide vocational rehabilitation services, the VA's national acquisition strategy is viewed as overly cumbersome. As a result, non-VA providers that could address some of the demand by veterans with disabilities for employment assistance are shut out by complicated contracting rules.

At the same time, VR&E must maintain its responsibility to the veterans it serves by monitoring the quality and impact of vocational rehabilitation services delivered by these non-VA agencies.

Recommendations:

The VA Vocational Rehabilitation and Employment Service should improve its national acquisition strategy to make it easier for qualified vocational rehabilitation providers to offer services to veterans with disabilities.

VR&E Service staff must improve the oversight of non-VA counselors to ensure veterans are receiving the full array of services and programs in a timely and effective manner.

The VR&E Service should improve case management techniques and use state-of-the-art information technology to track the progress of veterans served outside VR&E.

The VR&E Service should follow up with rehabilitated veterans for at least six months to ensure that the rehabilitation and employment placement plan has been successful.

BUILDING VOCATIONAL REHABILITATION COUNSELING PARTNERSHIPS:

There are 10 times as many state vocational rehabilitation counselors as there are VA Vocational Rehabilitation and Employment (VR&E) counselors across the nation.

Given these statistics, it is evident that state vocational rehabilitation agencies could amplify the assistance available to veterans with disabilities if appropriate outreach and partnerships are established. Many state vocational rehabilitation agencies have memorandums of understanding with their state departments of veterans services to coordinate services to veterans with disabilities, and some state agencies have identified counselors with military backgrounds to serve as liaisons with the VA and veterans groups. State vocational rehabilitation and VA VR&E programs should offer joint training to their staffs on traumatic brain injury, post traumatic stress disorder, and other veteran specific disability issues to improve cross-agency coordination. VA should also work with the Rehabilitation Services Administration to establish national criteria for state agencies' acceptance of veterans with service-connected disability ratings to avoid inconsistent admission policies and the potential for veterans to be bounced between state vocational rehabilitation and VA VR&E.

Recommendation:

VA needs to utilize more effectively those resources within the nation's workforce development system that focus on obtaining and maintaining gainful employment for veterans. Until such time as the Vocational Rehabilitation & Employment Service's resources can accommodate the full range of services needed by veterans with disabilities, better coordination with state vocational rehabilitation programs, One-Stop Career Centers, and private sector vocational rehabilitation programs can help prepare veterans for interviews, offer assistance creating résumés, and develop proven ways of conducting job searches.

VETERAN ENTREPRENEURSHIP:

Promotion of self-employment continues to be a challenge for the Department of Veterans Affairs.

Increasing attention has been called to the entrepreneurial needs of American veterans, particularly those who have service-connected disabilities. Not since the Vietnam War have American veterans experienced such high rates of disabilities. For many of these veterans, self-employment will be the only alternative to employment and successful reintegration back into society.

More than one-third of both new veteran entrepreneurs and current veteran business owners have gained skills from their military service that are relevant to business ownership. Several government reports indicate that approximately 22 percent of America's war fighters returning from the war on terrorism are purchasing, starting, or considering starting a small business. Unfortunately, there are many obstacles for them to overcome. There are major issues that veterans face, including financing, bonding, and access to federal contracts. These necessary business elements have become so restrictive that it has become impossible for many veterans to establish or maintain their own small business enterprises.

As an effort to resolve these problems, a new VA program entitled the Center for Veterans Enterprise (CVE) was established by the passage of the Veterans Entrepreneurship and Small Business Development Act of 1999.

The CVE is a subdivision of the Office of Small and Disadvantaged Business Utilization that extends entrepreneur services to veterans who own or who want to start a veteran-owned small business. It also helps federal contracting offices to identify veteran-owned small businesses in response to Executive Order 133600 calling for federal contracting and subcontracting oppor-

tunities for Service-Disabled Veteran-Owned Small Businesses. In addition, the CVE works with the Small Business Administration's Veterans Business Outreach Centers nationwide regarding veteran business financing, management, bonding, and providing technical support for veteran entrepreneurs with the goal of increasing the number of veteran- and service-disabled veteran-owned small businesses. Unfortunately, the funding for this program is insufficient to meet the ever-increasing needs of our nation's veterans.

Recommendations:

Congress should provide VA with additional funding for the Center for Veterans Enterprise so it can meet the increasing veteran demand for entrepreneurial services.

VA must help eliminate the barriers that veterans face when trying to establish and/or maintain a veteran- or service-disabled veteran-owned small business.

VA FAILURE TO IMPLEMENT P.L. 109-461 CONTRACTING:

VA has yet to approve any policy or procedures to guide VA contracting officers on how to set aside and/or award sole source contracts for service-disabled veteran-owned small businesses.

Public Law 109-461, the Veterans Benefits, Health Care and Information Technology Act of 2006, was signed into law by President Bush on December, 22, 2006, and required the law to take effect by June 20, 2007. The law allows VA special authority to provide set-aside and sole source contracts to small businesses owned and operated by veterans and service-disabled veterans. This legislation is codified in 38 United States Code sections 8127 and 8128.

Nearly two years have passed, and Acquisition and Material management staff, in conjunction with VA attorneys, have yet to approve any policy or procedures to guide VA contracting officers on how to set aside and/or award sole source contracts for service-disabled veteran-owned small businesses. Without specific guidance and changes to the Federal Acquisition Regulations, existing acquisition policy will continue to apply. VA personnel involved in the acquisition process need to become familiar with the new authorization and their responsibilities under P.L. 109-461. Our service-disabled veterans who own small businesses cannot afford to wait any longer for VA to become compliant with the law.

Recommendation:

VA must expedite the overdue implementation of P.L. 109-461 so veteran entrepreneurs can receive set-aside and sole source contracts. Further delays in approving policy and regulation endanger the success and longevity of recently established service-disabled veteran-owned small businesses.

VETERAN SURETY BONDING:

Surety bonding levels provided by the Small Business Administration (SBA) are inadequate for veteran entrepreneurs to compete in today's construction field.

Surety bonding continues to be a major problem for service-disabled veteran-owned small businesses in the construction field. Surety bonding levels currently guaranteed by SBA at $2 million are grossly inadequate for today's federal construction process. Service-disabled veterans who are small business owners find it difficult to obtain surety bonding required by federal contracting officers to compete for government contracts. Service-disabled veteran small business owners also have difficulties preparing their businesses to withstand the scrutiny of the surety bonding process, especially when working on other construction projects.

Recommendation:

VA needs to establish a shared bonding process in conjunction with the Small Business Administration and provide a process to increase bonding limits upward to $15 million, which is necessary for service-disabled veterans to compete in today's construction market. VA should also develop a program for service-disabled veterans to teach them how to prepare their companies to overcome the obstacles that preclude them from obtaining surety bonding in a timely and efficient manner.

VA VENDOR INFORMATION PAGE DATABASE:

Government agencies need a one-stop access to identify veteran-owned and service-disabled veteran-owned small businesses and verify their veteran status.

At the present time, vendors desiring to do business with the federal government must register in the Central Contractor Registration (CCR) database, and those who indicate they are veterans or service-disabled veterans, self-certify their status without verification. P.L. 109-461 required VA to establish a Vendor Information Page (VIP) database designed to identify businesses that are 51 percent or more owned by veterans or service-disabled veterans. Congress should take appropriate steps to require all agencies to use VIP to certify veteran status and ownership before awarding contracts to companies claiming to be a veteran-owned or service-disabled veteran-owned small business.

Recommendation:

All federal agencies should be required to certify veteran status and ownership through the VA's Vendor Information Page program before awarding contracts to companies claiming to be veteran-owned or service-disabled veteran-owned small businesses.

TRAINING INSTITUTE INADEQUATELY FUNDED:

The National Veterans Training Institute (NVTI) lacks adequate funding to fulfill its mission.

The NVTI was established to train federal and state veterans' employment and training service providers. Primarily, these service providers are Disabled Veterans' Outreach Program (DVOP), Local Veterans' Employment Representative (LVER), and employment coordinators under the VA Vocational Rehabilitation and Employment (VR&E) Service. DVOP/LVER specialists are located throughout the country at various locations, such as state workforce centers. VA employment coordinators are found at VA VR&E Service offices and VA medical centers.

These employment specialists help veterans make the difficult and uncertain transition from military to civilian life. They help provide jobs and job training opportunities for disabled veterans by serving as intermediaries between employers and veterans. They maintain contacts with employers and provide outreach to veterans. They also develop linkages with other agencies to promote maximum employment opportunities for veterans.

The NVTI was established in 1986 and authorized in 1988 by P.L. 100-323. It is administered by the Department of Labor Veterans Employment and Training Service through a contract with the University of Colorado at Denver. The NVTI curriculum covers an array of topics that are essential to DVOP/LVER and VA employment coordinators and provides them with the knowledge and ability to assist veterans in their quest to obtain and maintain meaningful employment. *The Independent Budget* veterans service organizations are concerned because, after several years of level funding, appropriations for the NVTI have decreased. This reduction compromises the ability of the institute to provide quality training to those individuals serving veterans.

Recommendation:

Congress must fund the National Veterans Training Institute at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.

National Cemetery Administration

The Department of Veterans Affairs National Cemetery Administration (NCA) currently maintains more than 2.9 million gravesites at 125 national cemeteries in 39 states and Puerto Rico. Of these cemeteries, 65 will be open to all interments; 20 will accept only cremated remains and family members of those already interred; and 40 will only perform interments of family members in the same gravesite as a previously deceased family member. The NCA also maintains 33 soldiers' lots and monument sites. All told, the NCA manages 17,000 acres, half of which are developed.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the global war on terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from approximately 100,000 in 2007 to 111,000 in 2009. Historically, 12 percent of veterans opt for burial in a state or national cemetery.

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the armed forces. Therefore, the purpose of these cemeteries as national shrines is one of the NCA's top priorities. Many of the individual cemeteries within the system are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of the United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and cherished.

The Independent Budget veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families. We call on the Administration and Congress to provide the resources needed to meet the changing and critical nature of NCA's mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

National Cemetery Administration Accounts

In FY 2008, $195 was million appropriated for the operations and maintenance of the National Cemetery Administration (NCA), $28.2 million more than the Administration's request, with only $220,000 in carryover. The NCA awarded 39 of the 42 minor construction projects that were in the operating plan. The State Cemetery Grants Service awarded $37.3 million of the $39.5 million that was appropriated. This carryover was caused by the cancellation of a contract that the NCA had estimated to be $2 million but the contractor's estimation was considerably higher. Additionally, $25 million was invested in the National Shrine Commitment.

The NCA has done an exceptional job of providing burial options for 88 percent of the 170,000 veterans who fall within a 75-mile radius-threshold model. However, under this model, no new geographical area will become eligible for a national cemetery until 2015. St. Louis, Missouri, will, at that time, meet the threshold due to the closing of Jefferson Barracks National Cemetery in 2017. Analysis shows that the five areas with the highest veteran population will not become eligible for a national cemetery because they will not reach the 170,000 threshold.

The NCA has spent years developing and maintaining a cemetery system based on a growing veteran population. In 2010 our veteran population will begin to decline. Because of this downward trend, a new threshold model must be developed to ensure more of our veterans will have reasonable access to their burial benefits. Reducing the mile radius to 65 miles would reduce the veteran population that is served from 90 percent to 82.4 percent, and reducing the radius to 55 miles would reduce the served population to 74.1 percent. Reducing the radius alone to 55 miles would bring only two geographical areas in to the 170,000 population threshold in 2010, and only a few areas into this revised model by 2030.

Several geographical areas will remain unserved if the population threshold is not reduced. Lowering the population threshold to 100,000 veterans would immediately make several areas eligible for a National Cemetery regardless of any change to the mile radius threshold. A new threshold model must be implemented so more of our veterans will have access to this earned benefit.

The Independent Budget recommends an operations budget of $241.5 million for the NCA for fiscal year 2010 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

The NCA is responsible for five primary missions: (1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application; (3) to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries; (4) to award a presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turfs, and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

Therefore, in accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress establish a five-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the FY 2008 operations budget.

Volume 2 of the Independent Study provides a systemwide, comprehensive review of the conditions at 119 national cemeteries. It identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. These projects include cleaning, realigning, and setting headstones and markers; cleaning, caulking, and grouting the stone surfaces of columbaria; and maintaining the surrounding walkways. Grass, shrubbery, and trees in burial areas and other land must receive regular care as well. Additionally, cemetery infrastructure, i.e., buildings, grounds, walks, and drives must be repaired as needed. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options, and maintenance programs.

The Independent Budget veterans service organizations (IBVSOs) are encouraged that $25 million was set aside for the National Shrine Commitment for FY 2007 and FY 2008. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. By enacting a five-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

In addition to the management of national cemeteries, the NCA is responsible for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries. Public Law 110-157 gives VA authority to provide a medallion to be attached to the headstone or marker of veterans who are buried in a private cemetery. This benefit is available to veterans in lieu of a government furnished headstone or marker.

FY 2010 National Cemetery Administration	
Category	**($ in Thousands)**
FY 2009 Administration Request	$181,000
FY 2009 *IB* Recommendation	$251,975
FY 2009 Enacted	$230,000
FY 2010 *IB* Recommendations:	
Operations and Maintenance	$241,500
Shrine Initiative	$50,000
Total FY 2010 *IB* Recommendation	**$291,500**

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully. We believe Congress should provide NCA with $241.5 million for fiscal year 2010 to offset the costs related to increased workload, additional staff needs, general inflation and wage increases and include as part of the NCA appropriation $50 million for the first stage of a $250 million five-year program to restore and improve the condition and character of existing NCA cemeteries.

The State Cemetery Grants Program:

Adequate funding is needed to ensure that the SCGP can meet the challenge of growing interest from states to provide burial services in areas that are currently underserved.

The SCGP complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials through this program.

The SGGP faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. The intent of the program is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial service to veterans, especially those living in less densely populated areas not currently served by a national cemetery. Currently there are 55 state and tribal government cemetery construction grant preapplications, 34 of which have the required state matching funds necessary, totaling $120.7 million.

The Independent Budget recommends that Congress appropriate $52 million for the State Cemetery Grants Program for FY 2010. This funding level would allow SCGP to establish six new state cemeteries that will provide burial options for 179,000 veterans who live in region that currently have no reasonably accessible state or national cemetery.

Recommendation:

Congress should fund the State Cemetery Grants Program at a level of $52 million.

Veterans' Burial Benefits:

Veterans' families do not receive adequate funeral benefits.

In 1973 NCA established a burial allowance that provided partial reimbursements for eligible funeral and burial costs. The current payment is $2,000 for burial expenses for service-connected (SC) death, $300 for nonservice-connected (NSC) deaths, and $300 for plot allowance. At its inception, the payout covered 72 percent of the funeral cost for a service-connected death, 22 percent for a nonservice-connected death, and 54 percent of the burial plot cost. In 2007 these benefits eroded to 23 percent, 4 percent, and 14 percent, respectively. It is time to bring these benefits back to their original value.

Burial allowance was first introduced in 1917 to prevent veterans from being buried in potters' fields. In 1923 the allowance was modified. The benefit was determined by a means test, and then in 1936 the allowance was changed again, removing the means test. In its early history, the burial allowance was paid to all veterans, regardless of the service-connectivity of their death. In 1973 the allowance was modified to reflect the relationship of their death as service connected or not.

The plot allowance was introduced in 1973 as an attempt to provide a plot benefit for veterans who did not have reasonable access to a national cemetery. Although neither the plot allowance nor the burial allowances were intended to cover the full cost of a civilian burial in a private cemetery, the increase in the benefit's value indicates the intent to provide a meaningful benefit by adjusting for inflation.

The national average cost for a funeral and burial in a private cemetery has reached $8,555, and the cost for a burial plot is $2,133. At the inception of the benefit the average costs were $1,116 and $278, respectively. While the cost of a funeral has increased by nearly seven times the burial benefit has increased only by 2.5 times. To bring both burial allowances and the plot allowance back to their 1973 values, the SC benefit payment will be $6,160, the NSC benefit payment will be $1,918, and the plot allowance will increase to $1,150. Readjusting the value of these benefits, under the current system, will increase the obligations from $70.1 million to $335.1 million per year.

Based on accessibility and the need to provide quality burial benefits, *The Independent Budget* recommends that VA separate burial benefits into two categories: veterans who live inside the VA accessibility threshold model and those who live outside the threshold. For those veterans who live outside the threshold, the service-connected burial benefit should be increased to $6,160; nonservice-connected veteran's burial benefit should be increased to $1,918; and the plot allowance should be increased to $1,150 to match the original value of the benefit. When a veteran lives within reasonable accessibility to a state or national cemetery that is able to accommodate burial needs but the veteran prefers to be buried in a private cemetery, the burial benefit should be adjusted. These veterans' burial benefits will be based on the average cost for VA to conduct a funeral: the benefit for a service-connected burial will be $2,793; the amount provided for a nonservice-connected burial will be $854; and the plot allowance will be $1,150. This will provide a burial benefit at equal percentages, but based on the average cost for a VA funeral and not on the private funeral cost that will be provided for those veterans who do not have access to a state or national cemetery.

The recommendations of past legislation provided an increased benefit for all eligible veterans but it currently fails to reach the intent of the original benefit. *The Independent Budget's* benefit distribution model will cost $211.1 million annually as opposed to the $221.1 million it would cost to implement past legislation. The new model will provide a meaningful benefit to those veterans whose access to a state or national cemetery is restricted as well as provide an improved benefit for eligible veterans who opt for private burial.

Recommendations:

Congress should establish two categories of veterans for the purpose of burial benefits: veterans within the accessibility model and veterans outside the accessibility model.

Congress should increase the plot allowance from $300 to $1,150 for all eligible veterans and expand the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected burial benefit from $2,000 to $6,160 for veterans outside the radius threshold and to $2,793 for veterans inside the radius threshold.

Congress should increase the nonservice-connected burial benefit from $300 to $1,918 for veterans outside the radius threshold and to $854 for veterans inside the radius threshold.

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

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