THE VETERANS HEALTH ADMINISTRATION'S FISCAL YEAR 2011 BUDGET

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

FEBRUARY 23, 2010

Serial No. 111–61

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE

55–229 WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office
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THE VETERANS HEALTH ADMINISTRATION'S FISCAL YEAR 2011 BUDGET

TUESDAY, FEBRUARY 23, 2010

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

The Subcommittee met, pursuant to notice, at 1:05 p.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Snyder, Teague, Donnelly, Halvorson, Brown of South Carolina, Boozman, and Buchanan.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. We may as well get started. Mr. Brown is on the floor giving a 1 minute speech, and I know Mr. Teague is on his way over here, so we may as well get started now.

I would like to thank everyone for coming out this afternoon. The purpose of today's hearing is to examine the fiscal year 2011 President's budget request for the Veterans Health Administration (VHA) of the U.S. Department of Veterans Affairs (VA). The "Veterans Health Care Budget Reform and Transparency Act of 2009" provides for advanced appropriation for the VA medical care accounts and was enacted into law on October 22nd, 2009. In accordance with this Act, the President's budget requests fiscal year 2011 and 2012 funding for the VA medical care accounts.

The Administration requests $48.2 billion for VA medical care for fiscal year 2011, which includes the medical services, medical support, and compliance, and medical facility accounts of the VA. When medical care collections are included, the Administration's request is $51.5 billion for VA medical care, which is $4 billion or 8.6 percent above the 2010 enacted level.

In fiscal year 2012, the Administration requests $54.3 billion for VA medical care, which is about $3 billion or 5.3 percent above the 2011 request.

The fiscal year 2011 budget request addresses many of the shared priorities of this Subcommittee such as rural health, mental health, and homeless veterans.

The President's budget request for VA is a robust budget in the tradition of the significant funding increase that the VA will receive or has received in the past several years.

Through today's hearing we will examine the President's 2011 budget request for VHA, which includes a funding recommenda-

tion, as well as policy and legislative proposals for the medical care accounts of VHA.

In addition, we will examine the information technology (IT) and the construction resources for VHA, and we will explore whether the budget request for the VA health care system provides significant resources to meet the needs of our returning servicemembers, including those who deployed as part of the troop surge in Afghanistan.

Today we will hear from the VA's Under Secretary for Health, as well as Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars (VFW), who are co-authors of *The Independent Budget* (IB). We will also hear from the American Legion. I look forward to hearing testimonies.

[The prepared statement of Chairman Michaud appears on p. 27.]

Mr. MICHAUD. I would like to recognize Mr. Boozman for any opening statement he might have? Mr. Teague or Mr. Donnelly, do either of you have an opening statement?

Mr. TEAGUE. No, and for the sake of time I will defer to the questions.

Mr. MICHAUD. Thank you very much. Without any further ado, I would like to recognize our first panel, Dr. Robert Petzel who is the Under Secretary for Health. He is accompanied by Paul Kearns, Robert Neary, and Brandi Fate. I want to thank all of you for coming today. I want to congratulate you, Doctor, for your appointment as Under Secretary of Health. I will look forward to working with you as we try to take care of the needs of the brave men and women who serve this Nation of ours. I have heard a lot about you, and look forward to your testimony today.

So without any further ado, Doctor.

STATEMENT OF HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PAUL KEARNS III, FACHE, FHFMA, CPA, CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ROBERT L. NEARY, ACTING DIRECTOR, OFFICE OF CONSTRUCTION AND FACILITIES MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND BRANDI FATE, DIRECTOR, CAPITAL ASSET MANAGEMENT AND PLANNING SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. PETZEL. Chairman Michaud, Ranking Member Brown, and distinguished Members of the Subcommittee, thank you for this opportunity to present the President's fiscal year 2011 budget and fiscal year 2012 advanced appropriation requests for the Veterans Health Administration.

Our budget provides resources necessary to continue our aggressive pursuit of the President's two overarching goals, to transform VA into a 21st century organization and to ensure that we provide the highest quality of health care to our deserving veterans.

Before I begin, I would like to thank all of you and your colleagues in the Senate for your support as I take on the responsibility of managing the Nation's largest and best integrated health care system as the new Under Secretary for Health. There are

many challenges and opportunities ahead, and I look forward to working closely with you to improve the health and well-being of America's veterans. I also look forward to developing strong relationships with the veterans service organizations (VSOs), including those who appear today in support of *The Independent Budget*, and I thank them for their efforts on behalf to improve the lives of veterans.

During my confirmation, I pledged to the Senate that I would focus on three areas. Articulating a vision of our health care system and what it needs to become, more patient centered, providing more team care, and continuously improving itself. Number two, aligning the organization to achieve that vision. And number three, reducing the variation in our organizations, structures, business practices, and medical care.

I believe our budget supports these three strategic goals as well as the six high priority performance goals mentioned in my written statement.

VA's budget provides $51.5 billion for medical care in 2011, an increase of $4 billion over the previous year, or about an 8.5-percent increase. This level will allow us to continue providing timely, high-quality care to all enrolled veterans.

During 2011, we expect to treat 6.1 million unique patients, a 2.9-percent increase over the previous year. Among this total will be 439,000 veterans who have served in Iraq or Iran, an increase—in Afghanistan rather—an increase of nearly 15 percent from 2010. Our budget request provides $2.6 billion to meet the health care needs of this population, a 20-percent increase from the previous year, 2010. This estimate reflects also the surge of troops that we expect in Afghanistan.

The treatment of this newest generation of veterans has provided stimulation to us to improve the treatment for conditions such as post traumatic stress disorder and traumatic brain injury. We are increasing resources for an aging veteran population with chronic illness by increasing the funding for long-term care by 14 percent, and providing an almost 23-percent increase in money for non-institutional long-term care.

We will also strengthen access to health care for rural veterans through our new outreach and delivery initiatives, as well as expanding home-based primary care, telemental health, and telehealth services.

We will further expand health care eligibility for Priority 8 veterans in 2011. We estimate that approximately 100,000 new veterans will enroll because of this effort.

The 2011 budget provides $217.6 million to meet the gender specific health care needs of women veterans, an increase of more than 9 percent over the 2010 level. We will be delivering better primary care for women veterans, and this remains one of the Department's highest priorities.

This budget provides the resources required to enhance access in our health care system by activating new and improved facilities, expanding health care eligibility, and making greater investments in telehealth.

We are requesting a substantial investment for our homeless program as part of our plan to ultimately eliminate veteran homeless-

ness through an aggressive approach that includes housing, education, jobs, and health care.

VA will be successful in resolving these concerns by maintaining a clear focus on developing innovative business practices and delivery systems that will not only serve veterans and their families for many years to come, but will also dramatically improve the efficiency of our operations. By making appropriate investments today, we can ensure that higher value and better outcomes will endure for our veterans.

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

The 2011 budget request for VA major construction is $1.15 billion. The $467 million request for 2011 for minor construction is an integral component of our overall capital program.

Minor construction permits VA to realign critical services, make seismic corrections, improve patient safety, enhance access to health care, increase capacity for dental care, enhance patient privacy, improve treatment of special emphasis programs, and expand our research capability.

Further, minor construction resources will be used to comply with energy efficiency and sustainability design requirements.

VA's 298,000 employees are committed to providing the quality of service needed to serve our veterans and their families. They are our most valuable resource. VA is fortunate to have public servants that are not only creative thinkers, but also able to put good ideas into practice.

With such a workforce and the continuing support of Congress, I am confident we can achieve our shared goal of accessible, high-quality, timely care and benefits for our Nation's veterans.

Thank you again for this opportunity to appear, and my colleagues and I are prepared to answer your questions.

[The prepared statement of Dr. Petzel appears on p. 28.]

Mr. MICHAUD. Thank you very much Doctor, we really appreciate your testimony. As I stated in my opening remarks, I am looking forward to working with you.

I now recognize Mr. Teague for any questions he may have.

Mr. TEAGUE. Good afternoon, thanks for coming to all of you and thanks for participating in this hearing. And Mr. Chairman, Ranking Member, thank you for allowing me to ask a couple of questions here.

A couple a weeks ago when the Secretary said that after the 26.4 percent medical care budget increase since 2009 we are going to be working on reducing the rate of increase in the cost of the provision of health care by focusing on areas better leveraging acquisitions and contracting. Could you expand on that a little bit more?

Dr. PETZEL. Yes, thank you Congressman Teague.

Just to give you an example, I come from Minneapolis Network 23 where I was the network director, and in that network we con-

solidated our imaging or radiology services and consolidated our purchasing for the radiology services, to wit, we saved in the purchasing of seven new CAT scanners, about $3 million. This sort of consolidated purchasing across the entire system I think is going to provide us with substantial, substantial cost reductions. I also think that by standardizing our services, in again many of our networks, we are going to be able to realize substantial savings.

Just one more example, the Prosthetics Service several years ago began a process of standardizing some of their prosthetic equipment, and one of the things that they standardized was hips. We had about 35 different brands and varieties of artificial hips that we used when we did a hip replacement in patients. And we have consolidated that down to I believe about five different prosthetics that meet everybody's needs at a substantial savings. I think that doing this across the system is going to entail substantial savings.

Mr. TEAGUE. Coming from a rural district, and I mean a really rural district where we have a lot of people that have to travel 300 miles to get to a hospital, and knowing that there was an additional $30 million in the medical facilities account so that we could have more community based outpatient clinics (CBOCs) and everything open up, I was just wondering how many of those have we added, and how many do we intend to continue adding in the 2011 budget? And if so, how many?

Dr. PETZEL. By the end of 2010, and it is actually going to be spilling into 2011, because we are not going to be able to activate all of the CBOCs that we had planned for 2010, but by the end of that period we expect to have 862, I believe, community based outpatient clinics, and that is an increase, I think, of almost 100 over what we had in 2009. Fifty-one of these, Mr. Kearns is pointing out, are in rural areas. So there is going to be a substantial investment in 2010 extending into 2011 in rural CBOCs.

Mr. TEAGUE. Okay. Is there a list somewhere where we can see where they are projected to be? I mean, because as I say, with people traveling the distances that they do, it is pretty relevant in our district.

Dr. PETZEL. Post hearing we can provide you with a list I am quite certain, yes.

[The VA provided the answer in response to Question #2 of the Post-Hearing Questions and Responses for the Record, which appears on p. 55.]

Mr. TEAGUE. Very good, thank you, and thank you for attending today and for your answers. I yield back.

Mr. MICHAUD. Thank you. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

Dr. Petzel, in regard to the major construction funding, additional locations were put on the list to a total of 61 now and two were funded. What is your long-term plan?

Dr. PETZEL. The $1.1 billion in 2011, Congressman, is for five projects. Two of them—three of them rather—were ongoing.

Mr. DONNELLY. I am sorry, I should say two new places were funded.

Dr. PETZEL. And there were two new places, that is correct. Alameda and Omaha.

I will ask Mr. Neary in a minute to comment on the list and how we deal with that list, but there is a substantial list of major projects, and this makes I think a substantial dent in the monetary amount at least, but there still are, as you point out, a large number of projects on the list, and I would ask Mr. Neary if he could comment on the size of that list and how we move through it.

Mr. NEARY. Thank you, Doctor. Congressman Donnelly, as Dr. Petzel indicated, I think the major construction proposal for fiscal year 2011 is a very robust proposal, but we do have——

Mr. DONNELLY. But it only includes two, two new places.

Mr. NEARY. It only includes two new starts. We have been fortunate with the support of the Congress to receive funding levels in the approximately $1 billion range for the last 3 years, substantially higher than the past, so we are headed in the right direction, I think. We evaluate all the projects that are proposed and prioritize them to the extent that we believe the most important projects rise to the top of the list. We are working down that list, but it will take some time to go through the list that is displayed in the 5-year plan.

Mr. DONNELLY. So those 61 are included in a 5-year plan?

Mr. NEARY. In the volume that submits the construction budget and the last half of that volume is the VA's 5-year capital plan, and it identifies the projects that we have prioritized, yes.

Mr. DONNELLY. So is it your expectation that those 61 will all be started within a 5-year period?

Mr. NEARY. It is unlikely that they will all be started within 5 years. I believe that the value of that list is approximately $13 billion, and obviously the budgets that we are seeing are while good will take a little longer than 5 years to work through them.

Mr. DONNELLY. Thank you very much.

Mr. MICHAUD. Mrs. Halvorson.

Mrs. HALVORSON. Thank you, Mr. Chairman, and congratulations, Dr. Petzel, on your confirmation, and I know I just wanted to let you know that I worked very closely with Dr. Cross on a medical facility in my district that I am hoping to bring to Joliet, Silver Cross Hospital, I am sure your wonderful staff has kept you up to date, or if not, I am sure they will, and I just didn't know if there was any light that you would like to shed—shed any light on this for me maybe or any updates that maybe you want to know, or if there is any questions that you have for me.

Dr. PETZEL. Well, Congresswoman Halvorson, that is incredibly timely. I was just told not 5 minutes ago that we just finished a site visit.

Mrs. HALVORSON. Yes.

Dr. PETZEL. And the word that came back is that this is an excellent facility.

Mrs. HALVORSON. It is.

Dr. PETZEL. So we are very optimistic that the Silver Cross Medical Facility is going to meet our needs and it is going to work very well into our system.

Mrs. HALVORSON. Great, because it is something that is so very important to any district. And I know we had the district work period last week, and everywhere I went people wanted an update, and this is something that we are expecting to come to fruition,

and I just wanted to make sure that it was always on the forefront of your memory and on your radar screen. So very, very important to us.

Dr. PETZEL. And it is very important to us.

Mrs. HALVORSON. Because I think the more that—and I know Chairman Filner has been out there and I know Secretary Shinseki is coming out, and we haven't quite found the date yet, but—and you had another site visit, so I just wanted to reiterate our concern and how important it is to us.

We have also seen substantial increases in the past few years in my district in terms of the veterans that rely on the VA care, so I certainly have concerns. I think that the minor construction budget doesn't really reflect the increases in the need for veterans care, so I am really concerned about that. And maybe you can shed a little more light on why these budget slashes and why for the funds for the minor construction projects, especially in Illinois and in my area.

Dr. PETZEL. Thank you, Congresswoman. Again, I will let Mr. Neary comment in a minute.

Just to make a statement. The minor construction budget, as I understand it, is the second highest request that has been made for minor construction in the history of the VA. It is a large amount of money relative to what we have been seeing before, but as you point out, and I think as Mr. Neary will point out, it is not going to completely address our list of minor projects.

Mr. NEARY. Certainly correct. Similar to the major construction appropriation, in the last few years minor construction has been at an all time high in terms of funding levels. And as Dr. Petzel said, this is the second largest request that has been made for minor construction. The first largest being in fiscal year 2010, but it is less than fiscal year 2010, and we will be looking to ensure that those funds are used most judiciously to bring the most value to our facilities programs.

Mrs. HALVORSON. So just so you know we are just really concerned that it doesn't meet the needs. As the needs are going up, the last thing we need to do is cut those projects that we want to keep on track.

So you know, I appreciate you all being here, but my staff and I will be constantly letting you know what is going on in my district. So thank you all for being here. It is good to see you.

Mr. MICHAUD. Thank you. Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman, and thank you to the witnesses who came, and particularly Dr. Petzel, glad to have you on board, congratulations for this new level of service that you and all the other support folks in the VA.

I think we have a good health care budget in this cycle, and I am certainly pleased to support it.

I am a little disappointed in one project that we have been trying to move forward since 2006, what we always refer to as the Charleston model. This was a combination of services between the VA and the Medical University of South Charleston, and we actually put I think it was like $36.8 million in the Reauthorization Bill, I guess Benefits and Health Care Information Technology Act of 2006, but nothing has actually moved on it since then. And I no-

ticed in this particular budget there is no funding available and it hasn't been addressed.

And since we have all of you here in one room, if you all could kind of help me go through this and kind of give me an idea, you know, of exactly what might be going to take place, and if there is a timeline that you are working with that you might share it with me.

Dr. PETZEL. Thank you Congressman Brown. I am in a general sense familiar with the history of the project in Charleston, but not with the specifics, and I think I would ask Mr. Neary if he could—or Ms. Fate if she could comment on that, please.

Ms. FATE. Thank you, sir. Based on the assessment of the workload increases as well as the space deficiencies as well as the facility condition assessments of the Charleston VA, it was assessed that a new hospital wasn't the most advantageous for the Charleston VA Medical Center, but instead an expansion to decompress the facility, more in an outpatient setting.

So the request that has come forward is to acquire the Naval Hospital, and through their Base Realignment and Closure (BRAC) process—through the Navy's BRAC process. And so that project was submitted for consideration in the fiscal year 2011 process and was ranked 51 out of 61 priorities, and so it wasn't—and at the same time we are also waiting on the Navy to decide which facility is going to get the facility based on their BRAC process.

Mr. BROWN OF SOUTH CAROLINA. I know I talked about that with the Secretary and I know that he was concerned about funding, and I know that if it is going to be part of the BRAC process, it looks like it could be some kind of lateral transfer without any dollars involved. That is generally the way that the BRAC process works. I know that when they closed Joel's shipyard, most of that property actually deeded over to the City of North Charleston, and so I mean certainly if you are going to move it into a government entity, you certainly ought to be able to do that within the confines of the Federal Government.

But what concerns me about the Charleston model, and if you are familiar with the area—in fact we tried to get some money and we did get a few dollars in the stimulus where the flooding is such a major problem. The roads adjoining to the VA hospital are under water if the right rains come and the tide is at the right place, so we got $10 million in this last stimulus payout back in—last Wednesday, so that—what concerns me is right after Katrina hit New Orleans, we actually went down and saw some of the facilities, and we recognize that the VA hospital there in New Orleans was not damaged, but because of the flooding and because of the lack of power we assumed that building was not going to be used. Are you all tearing that down is what the—what are you—are you reusing the old VA hospital in New Orleans, or are you going to relocate it?

Dr. PETZEL. I will let Mr. Neary comment on that, Congressman.

Mr. BROWN OF SOUTH CAROLINA. Okay.

Mr. NEARY. Certainly. Presently the bulk of the former hospital is closed. We are operating an outpatient clinic in the facility, but we are in design for a new VA hospital that will be located a mile or two away, and we have funding. We have partially funded in

previous budgets. We have the final incriminate of funding in the fiscal year 2011 budget. We expect to beginning the first, all be it a small phase of construction in the next 2, 3 months, and then in fiscal year—later in this fiscal year and through 2011 we will be awarding further contracts to construct a new facility.

Mr. BROWN OF SOUTH CAROLINA. And I might bobtail a little bit on that. That is exactly my idea of the Charleston model, is we are basically in that same zone. The VA hospital is actually in a lower location than say some parts of Medical University.

We were hoping that by being more proactive we could be able to address the issue before another Hugo would come in, and we had Hugo back in 1989, which was I guess the same intensity as the storm that hit New Orleans back in I guess 2006, or 2005, when it was. But so we were hoping by putting that money in that Reauthorization Bill, it would give some initiative to actually jump start that project, and I was hoping that somehow or another we would be able to be moving.

The Medical University is actually in a rebuilding mode now. They are going to probably replace most of their facilities, and by doing so, we thought it would give us a good opportunity to be able to bring the VA and the Medical University closer together. Some 95 percent of the doctors that actually treat those patients at the VA hospital have affiliation with the Medical University, so it would seem like it would just be a proper thing to be able to bring them in a more closer proximity.

I know the VA hospital itself is in pretty good shape, but I am telling you the location we have is going to be at risk if we have another major storm that hits.

So, Dr. Petzel, I hate to just give it to you on the first day that you testify before us, but it is a major concern of ours. Like I said, we have been working with it since 2006. It seems like we are the only one that has the vision, and I am just trying to share that with other people, maybe somebody else might be able to sense the same problem that we find. But I am telling you it was pretty obvious to me when I went to that fine facility in New Orleans and recognized that it is not going to be able to—although it withstood the winds, the mold is going to actually take it down.

Dr. PETZEL. Well, Congressman Brown, I will review the circumstances in Charleston with our construction facilities management people, see where that stands right now, and become acquainted with the details.

Mr. BROWN OF SOUTH CAROLINA. I appreciate it. Thank you very much.

I apologize, my southern hospitality just slipped me for a minute. We would be happy to accommodate you any time you want to come.

Dr. PETZEL. Congressman, thank you very much.

Mr. BROWN OF SOUTH CAROLINA. Thank you.

Mr. MICHAUD. Thank you, Mr. Brown.

Medical IT, as you know, is an integral part of the VHA health care delivery system. My concern is whether VHA and the IT system are working collaboratively in a way that will help expedite the process of getting a facility online. If the fiscal year 2011 budget request includes about $930 million in medical IT support, which

is a decrease of about $150 million from the 2010 levels, what is the rationale for that decrease?

[The VA subsequently provided the following information:]

Facility activations are a top priority for Office of Information and Technology (OI&T). All field Information Technology (IT) managers are empowered to meet IT activation requirements in concert with the activation timelines established by VA facility leadership. OI&T Field Operations staff are members of the facility project planning teams that develop, schedule and activate new facilities, services and programs.

In response to the question regarding the rationale for budget decrease of medical IT, we offer the following:

There are numerous one time or unique fiscal year activities that occur in FY 2010 that are not occurring in FY 2011 or are recurring at a different funding level.

For example:

Life Cycle Management decreased by $28.939 million;
Wireless decreased by $47.967 million;
Engineering Support Contractor Service was reduced by $15 million to $0;
Enterprise backup solution was reduced by $16.5 million to $0; and
The National Archive Project was reduced by $12 million to $0.

Activations costs in FY 2010 are a one-time investment that will change in FY 2011 based on the nature, scope, and completion of ongoing construction work across the VA system. This includes major construction, minor construction, nonrecurring maintenance (NRM), and bringing online new Community Based Outpatient Clinics (CBOCs). The drop in funding from the FY 2010 Current Estimate to the FY 2011 President's Submission is the result of the a thorough review of the FY 2010 Medical IT Support needs (licensing and maintenance agreements), having taken place during the execution review for FY 2010. No such review has yet taken place for FY 2011. During the summer of 2010, OI&T, working with its VA business partners, will conduct a similar review of FY 2011 execution needs and necessary adjustments will be made to this and other programs prior to the start of FY 2011.

Mr. MICHAUD. My second question is, some folks within the VA system nationwide have been concerned that there has been a lag between VHA and IT that seems to be delaying some of the projects that are needed out there. So those are my two questions relating to IT.

Dr. PETZEL. Thank you, Mr. Chairman. I want to make just a general statement about VHA and IT. I have been working in the Central Office as the Acting Principal Deputy Under Secretary for the last 9 months, and I have been impressed with the change in tenor, if you will, that has occurred with the ascendance of Roger Baker as the Assistant Secretary for IT.

There is really a very, very new wind blowing through that organization, and the level of cooperation is probably much better than it had been before. And I am encouraged that we are going to be able to eventually be on the same path and get our needs met in an expeditious manner, but I think it is going to take some time.

Having said that, I don't know what the change in the IT medical budget is. We would have to get back to you after I talk with Mr. Baker.

[The VA subsequently provided the following information:]

Veterans Health Administration (VHA) and VA's OI&T are working very closely together throughout the entire lifecycle of project and program development. Staff, managers and leadership in both VHA and OI&T are demonstrating a strong and consistent commitment to completing projects on-time and on-cost.

VA, however, has experienced IT project delays. A review of these projects led to the development of the Program Management and Accountability System

(PMAS), an IT project management framework that uses the best practices from various management and accountability methods.

All programs and projects are now developed and managed under PMAS. This level of standardization in project management and development is a fundamental change in the way VA develops programs and conducts oversight and accountability. Key attributes of PMAS include: building in 6-month increments, frequent customer involvement, adherence to milestones with frequent milestone reviews, customer acceptance of functionality, and a practice of allowing only three strikes (missed milestones) before the project is halted or terminated. In the event of a halted or terminated project, the entire project, along with its managers, will come under intense scrutiny, which facilitates a culture of personal accountability. PMAS is already demonstrating its value in improving adherence to scheduled milestones and project delivery dates.

VA senior leadership continues its efforts to improve communication and coordination between VHA and OI&T, which is evidenced by the Deputy Secretary's personal involvement in monthly Operational Management Reviews of VHA/OI&T programs and projects. This commitment when combined with the recent implementation of PMAS accountability and reporting standards, has significantly enhanced VA's ability to quickly and efficiently produce and deploy systems to support the services that VA provides to our Nation's veterans.

Mr. MICHAUD. Thank you. I also know the VA has been working collaboratively with the U.S. Department of Defense (DoD) on the Virtual Lifetime Electronic Records (VLER). How is that project moving forward? Has it been fully developed? Are there any delays or any changes that need to be made?

Dr. PETZEL. Well thank you, Congressman. This is an incredibly interesting project. Virtual Lifetime Electronic Record is the beginning of the attempt to create a completely inter-operative medical record across the Nation. The first pilot was set up in San Diego between the VA, Kaiser Permanente and the DoD. It began modestly with just a very few elements being shared using the national health information network. The pilot tested very successfully. There are approximately 1,500 patients from both sides that are enrolled in this and for which we are sharing information.

As we speak, the amount of information that is available is being expanded, and we are also beginning to develop the second pilot site, which I believe is going to be in Hampton, Virginia. In our view, it has been a very successful pilot. It is going to require several years of development until it is fully implemented, but we believe that this is going to be the demonstration of how the Nation can be sharing its medical records not only within the government but across the private sector, and I am very encouraged.

Mr. MICHAUD. Thank you. Moving on to a different topic; grants to States for extended care facilities. There has been a reduction of about $15 million in that count. What is the rationale for this reduction? What I have heard from a lot of the State veterans nursing homes is that there is actually a backlog of about $405 million where the States have already committed dollars for construction.

Dr. PETZEL. I will ask Mr. Kearns to comment on that in a minute, but my understanding is that a significant amount of American Recovery Reinvestment Act (ARRA) money was used in the State homes grant program, and I think if you compare 2011 to 2010 and take out that stimulus money that went in, we see a rather substantial increase.

But Mr. Kearns, could you comment more specifically?

Mr. KEARNS. Yes, sir. Basically in stimulus funding we had $150 million for the grants, and that is progressing very nicely. And then it has to be matched with the States. We have another $85 million in this budget for fiscal year 2011. So we feel that we are going to be able to continue very good progress in that area.

Mr. MICHAUD. But where the States are already ready to go, why wouldn't you want to increase that amount so they can get those projects up and running?

Mr. KEARNS. I think we would need to get back with you on the specifics, sir. I do know that in a couple of the instances when we had the high priority items in the stimulus money, some of the States could not match with their funding—the timing didn't fit and they couldn't match so we had to slip that and put them into the next year.

So I think it varies State by State as to what their specific condition is as to whether they are ready to match at any given time, largely because of the current economic conditions. But we can get you the specifics back.

[The VA subsequently provided the following information:]

The backlog of approximately $405 million has been reduced to two projects with an estimated cost to the Department of Veterans Affairs of approximately $43 million. This was accomplished as a result of the FY 2010 regular appropriation of $175 million for the State Home Construction Grant Program, the additional American Recovery and Reconstruction Act appropriation of $150 million, and the withdrawal or deferral of certain projects at the request of the States. Currently, there is no Priority Group 1 backlog of renovation projects (including renovations to protect the lives and safety of veterans) or of new construction projects in States with a great need for new nursing home beds. Priority Group 1 projects are those for which the States have committed matching funds. VA is confident that the budget request of $85 million for FY 2011 will be sufficient to fund all new Priority Group 1 Life Safety and other renovation projects and all new construction projects in States with a great need for new beds.

Mr. MICHAUD. Thank you. And there has been actually an increase in mental health, about $410 million from fiscal year 2010 to fiscal year 2011. Are there any new mental health programs that you plan on implementing with the additional funding, or does that just reflect an ongoing need?

Dr. PETZEL. Excellent question, Chairman, and that basically is the ongoing needs. We do not have any specific new programs in mental health. We want to consolidate and make as vibrant the things that we have.

As you know through both our own actions and Congress's actions over the last 3 or 4 years there is been a huge increase in our mental health. We have added since 2005, 5,000 mental health workers, and just in this last year we added almost 2,000 new mental health workers. So we think we have the programs that we need, we think we have the people that we need, and it is a matter of making sure these programs work during this year.

Mr. MICHAUD. Also, in the previous budget we increased funding so we can start reenrolling Priority 8 veterans. What have you done specifically to increase reenrollment of Priority 8 veterans? Have you met your initial goal?

Dr. PETZEL. Thank you, Congressman. The goal was approximately 200,000 new enrollees in 2010. As you know we increased the threshold in the means test by approximately 10 percent, and

made eligible I think over 300,000 new enrollees theoretically, and we expected to see about 200,000 of those come.

There has been an extensive outreach program with the county veteran service officers. We have mailed letters to everybody that had been denied enrollment previously, but we have not met our goal. We have enrolled a substantial number of new Priority 8's and we have enrolled a larger number of Priorities 5 and 7 than previously. We think that some of these Priority 8's, because of the economic conditions, have moved into categories 5 and 7. And we look at those people as being people who would have otherwise been in our new Priority 8.

But I would ask Mr. Kearns if you can add anymore specifics to that.

Mr. KEARNS. No, sir, that is all. We are in the fiscal year 2011 budget raising that threshold from 10 percent to 15 percent, and we are aggressively marketing through different media sources to get to those potentially eligible veterans.

Mr. MICHAUD. Thank you. My last question relates to some of the earlier questions from Mr. Donnelly and others dealing with access to health care in rural areas. The Capital Asset Realignment for Enhanced Services (CARES) process identified several different access points. If you look at some of those access points it would probably be fair to say that a lot of them are probably at places where we also have a federally qualified health care facility.

Have you looked at the CARES process and determined whether or not the access points that were recommended under CARES are still valid? And if so, are you looking at working with the U.S. Department of Health and Human Services (HHS) to see whether or not there might be a qualified health care clinic in that area that might overlap? Can you collaborate with HHS to try to get more of these access points up and running sooner rather than later so we can start taking care of veterans in the really rural areas?

Dr. PETZEL. Thank you, Mr. Chairman. Each year, starting at the facility level, moving up through the network level, and finally coming to Washington we ask for an evaluation of access that includes a review of pending access points as well as new.

I think, as you realize, not only have we almost completed activation of all of the CBOCs that were identified in the CARES process, there have been many, many other CBOCs that have been added. I think since CARES began it would be numbered in the hundreds that we have added in terms of community based outpatient clinics.

So I think the process of making sure that the CARES, CBOCs are taken care of is well in hand.

The question whether we are maximizing the possibilities with the community health centers remains open, and I think that we need to have a renewed effort at looking at how we can interact with the community health centers. I am not familiar with what kind of efforts have been made in the past, but it is something I am interested in pursuing. They are another Federal agency and we should be in the process of cooperating with another Federal agency to see if we can maximize the benefit of the Federal dollars we had. So we will be examining that.

Mr. MICHAUD. Thank you, thank you, Doctor.

Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman. I guess I would like to follow up a little bit. I know that you have touched on this a little bit.

In regard to the mileage reimbursement, my question is where is the money coming from? Does that come from the Veterans Integrated Services Network (VISN) or does that come from the Central Office? Are we accounting for the fact of our rural districts, our rural hospitals? I would like to know all of the different factors that go to work in regard to the payment of that. I know that it has been discussed and we have a tremendous increase. Where is the money coming from that pays for that?

Dr. PETZEL. Thank you, Congressman. We have had extensive discussions about this. There is a 23-percent increase in the money in our budget for patient travel. I think the figure now is $798 million. That is part of our budget. It is distributed as part of, and correct me if I am wrong, Mr. Kearns, it is part of the veterans equitable resource allocation (VERA) distribution. So based on the workload that each one of the networks has they would be getting a portion of that money. Then it is the responsibility of the networks to ensure that money gets distributed to the place where it is needed.

Mr. BOOZMAN. But would there be some allocation based on the fact that maybe if you had a rural hospital that didn't have as much tertiary care and things, is it distributed that way also if there is more travel involved?

Dr. PETZEL. Congressman, I will ask Mr. Kearns in a minute to comment on that more specifically.

Let me give you my experience from the network that I used to direct in Minneapolis, which is quite rural. We would distribute the money for patient travel based upon previous years' experience. So we know that the Fargo VA medical center as an example——

Mr. BOOZMAN. Right.

Dr. PETZEL [continuing]. Has a disproportionately high need for money because they bring people from as far as 400 miles to the Fargo hospital from far western North Dakota. So our distribution would have been based upon previous use and current need. Whereas the Minneapolis VA medical center, which serves primarily an urban area, would not need proportionately as much travel money.

So the travel money wouldn't go out just based on the workload, it would go out with some cognizance of the ruralness or urbanness of the facility and its need.

Now, Mr. Kearns, you want to make a comment?

Mr. KEARNS. No, sir, that is correct. We do not separately allocate the travel money, it is part of the basic allocation to the networks, and the networks make that decision.

However, we do have a large increase in the budgeted fiscal year 2010 because the rate of 41.5 cents went up last year. We feel we will have the largest experience this year and that money is out in the system not specifically targeted to travel, so at specific locations if they experience more than they had, we would expect them to fund that, if they experience less they wouldn't have as much requirement in that area.

In this current budget, we are funding in fiscal year 2011 and 2012 average increases above that, but we are not planning in the budget to increase that rate of 41.5 cents.

Mr. BOOZMAN. Okay, very good. In regard to the extra cost for the fee-based services in New Orleans, where does that come from? Does that come from Central Office or is that coming from VISN 16? Is that a nationwide sacrifice or is that a sacrifice of that particular VISN?

Dr. PETZEL. Congressman, that money would be expected to come out of the budget from VISN 16. And that has been taken into account in terms of the total amount of money that VISN 16 would get, and then they would again distribute that money based upon the need.

So there is nobody else that is not getting care because we have an excessive fee basis need in New Orleans right now.

Mr. BOOZMAN. Okay. And the hospitals that are growing, in other words, that have the significant percentage of increase, 9, 10 percent increases, whatever it may be, do you account for that in your budgeting also?

Dr. PETZEL. Yes, Congressman, we do, and I will again let Mr. Kearns explain in a minute, I will just make a general statement.

The VERA model puts the money where the work is. That is the real salient feature of VERA. So if there is a facility that is growing more rapidly than another facility or a network that is growing, they are going to get more money than that facility that isn't growing as rapidly. Would you like to make a comment?

Mr. KEARNS. That is correct, sir. And then in addition to that, many times in those facilities that are growing some of those veterans also have health insurance so the collections will also grow, and those collections stay with the facility where the veterans are treated.

Mr. BOOZMAN. Okay. Thank you, Mr. Chairman. Again we appreciate your hard work. I know this is difficult, but like I said, we appreciate your service for veterans. Thank you.

Mr. MICHAUD. Mr. Snyder.

Mr. SNYDER. I am sorry I wasn't here for the earlier part of the meeting.

Dr. Petzel, what is status of funding for physicians? Do you have all physician slots filled that you want with adequate funding, or do you have slots that you would like to have filled and don't have adequate funding for?

Dr. PETZEL. Congressman, thank you for the question. I am going to have a little soliloquy about physician reimbursement for just a second if you don't mind.

First of all, we have enough money to purchase the services of all the physicians that we need. And fortunately with the relatively new physician pay bill that Congress is responsible for, we are able to pay in a general sense salaries that attract the physicians that we need. We do have occasions in some remote areas, some difficult-to-recruit areas even for the private sector, where we sometimes have difficulties recruiting. But, we have been able to meet the needs of our system for physician services.

Mr. SNYDER. So if somebody tells me that there is some empty physician slots some place and they are told the reason they are not being filled is there is not adequate funding that is inaccurate?

Dr. PETZEL. It would be inaccurate in my experience. I am not aware, and I have not been told about, any place that is not able to recruit its physicians because it doesn't have adequate budget.

Mr. SNYDER. Great, thank you.

Dr. PETZEL. And I would like to know about that. Specifically, if there is a place, let's talk to you about that. Please talk to us.

Mr. SNYDER. All right. Thank you.

Mr. MICHAUD. That is something we actually talked about beforehand, and that is a concern that I have, because I have heard the same thing about hiring freezes due to a lack of funding.

This Subcommittee will be looking in more detail at the VERA model. Getting back to Mr. Boozman's question about mileage reimbursement, I will use Togus as an example.

Dr. Petzel, you mentioned the VERA model puts the money where the work is, and that might be the cause of some of the problems that we are seeing in really rural areas. For instance, in Boston a lot of the medical care involves tertiary care and you have veterans who have to travel 9, 10, 12 hours to travel to Boston whereas they could actually get that care locally. But it is to the advantage of the VISN 1 office to have them come to Boston because that is where the money goes, rather than to really rural areas.

We will follow up with additional questions on a more detailed break out on how the VERA funding is distributed. We have also asked for specific detail on this information for VISN 1. I only want one VISN to really focus on, but we haven't received that information yet and we have followed up with further questions to try to get that break out so that we can really try to follow the money and assess what is happening out there and determine whether or not the VERA model is a good model. It could be a good model, but we are hearing concerns back in our respective States about how resources are being distributed and whether it might hamper the ability of some areas to put forward a new CBOC or access point, because that comes out of the operating money, and if you have the Central—VISN office—trying to control their budget then they might not be willing to move forward as aggressively as if they had money allocated for the creation of a new CBOC.

So these are some of the issues that we definitely would want to work with you on, Dr. Petzel. And hopefully, can try to take care of some of the concerns that we are hearing out there as well.

If there are no further questions I want to thank you, Dr. Petzel, and the panel for coming forward today, and I look forward to working with you. We will have some followup questions in writing as well. So thank you.

Dr. PETZEL. Thank you, Mr. Chairman, and thank you to the Subcommittee.

Mr. MICHAUD. I would like to now invite panel two to come forward. We have Mr. Blake Ortner from the Paralyzed Veterans of America, Mr. Eric Hilleman from the Veterans of Foreign Wars, and Mr. Joe Wilson from the American Legion.

I want to thank all three of you for coming forward today. I look forward to your testimony, and I also look forward to working with you as we move forward in dealing with issues important to veterans that serve this great Nation of ours.

So without any further ado, we will start out with Mr. Ortner.

STATEMENTS OF BLAKE C. ORTNER, SENIOR ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, ON BEHALF OF *THE INDEPENDENT BUDGET*; ERIC A. HILLEMAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES, ON BEHALF OF *THE INDEPENDENT BUDGET*; AND JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION

STATEMENT OF BLAKE C. ORTNER

Mr. ORTNER. Thank you, Mr. Chairman, Members of the Subcommittee. Paralyzed Veterans of America is pleased to present our views on the Veterans Health Administration's fiscal year 2011 budget in particular as it relates to construction.

PVA previously testified on the 2011 budget and it is addressed in my written testimony, so I would like to focus my oral comments on two key issues that PVA is concerned with regarding VA construction. That is VA research infrastructure funding shortfalls and maintaining critical VA health infrastructure.

In recent years, funding for VA maintenance and construction appropriations has failed to provide the resources needed to maintain, upgrade, and replace its aging research facilities. Consequently, many facilities have run out of adequate research space while ventilation, electrical supply, roofs, and plumbing deficiencies appear frequently on lists of urgently needed upgrades along with significant space reconfiguration.

In the 2003 CARES plan, VA listed over $468 million designated for new laboratory construction, renovation of existing space, and build-out costs for leased facilities, but then omitted these projects from the Secretary's final report.

In House Report 109–95, accompanying the 2006 VA Appropriations Act, the 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, directing VA to conduct a comprehensive review of its research facilities and report to the Congress.

Of three sites inspected, all scored poor with the total correction cost of over $26 million. By the end of fiscal year 2009, a total of 53 sites with 47 research programs were surveyed. Approximately 20 sites remain to be assessed in fiscal year 2010, but to date the combined total estimated cost for improvements exceeds $570 million. About 44 percent of the estimated correction costs constitute priority one deficiencies with an immediate need for correction. Five buildings that rated poor were main hospitals housing laboratories.

A significant cause of the VA research infrastructure's neglect is that there is no direct funding line nor any budgetary request

made for VA research facilities, nor does the VA medical and prosthetic research appropriation contain funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on local facility management to repair, upgrade, and replace research facilities and capital equipment. As a result, VA research competes with medical facilities direct patient care infrastructure needs.

PVA recommends the Administration and Congress establish a new appropriations account to independently define and separate VA research infrastructure funding and recommends an appropriation in fiscal year 2011 of $300 million dedicated exclusively to renovating existing research facilities.

Regarding critical VA health infrastructure, over the past year, VA has begun to discuss its desire to address its health infrastructure needs in a new way and acknowledged its challenges with aging infrastructure, changing health care delivery needs, limited funding for construction, and the timeliness of construction projects.

VA has noted, and we concur, that a decade or more is required from initial proposal until the doors actually open for veterans to receive care in a major medical facility.

Given these significant challenges, VA has developed a new model for health care delivery, the Health Care Center Facility Leasing Program, or HCCF. Under this proposal VA would obtain by long-term lease a number of large outpatient clinics built to VA's specifications. 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.

VA noted that in addition to the new HCCF facilities it would maintain its VA medical centers, larger independent outpatient clinics, community based outpatient and rural outreach clinics.

VA has argued that adopting this model would allow VA to quickly establish new facilities that would provide 95 percent of the care and services veterans need in their areas.

We concur that the HCCF model seems to offer a number of benefits in addressing capital infrastructure problems, including more modern facilities that meet current life safety codes. But while it offers some obvious advantages, the model could face significant challenges.

PVA is particularly concerned about the overall impact on the future of VA's system of care, including the potential unintended consequences on continuity of high-quality care and maintenance of its specialized medical programs for spinal cord injury, blindness, amputations, and other health challenges of seriously disabled veterans.

In conclusion, PVA agrees with VA's assertion that it needs a balanced capital assets program, but VA should not replace the majority or even a large fraction of medical centers with HCCFs; this would concern us. But we see this challenge as only a small part of the overall picture.

The emerging HCCF plan does not address the fate of 153 medical centers located throughout the Nation that are on average 55 years of age or older. It does not address long-term care needs of the aging veterans population, inpatient treatment of the chron-

ically and seriously mentally ill, the unresolved rural health access issues, or the lingering questions on improving VA's research infrastructure.

The major question is, what will VA's 21st century health infrastructure look like and how will it be managed and sustained?

Congress and the Administration must work together to secure VA's future to design a VA of the 21st century.

This concludes my testimony and I would be happy to answer any questions.

[The prepared statement of Mr. Ortner appears on p. 32.]

Mr. MICHAUD. Thank you very much. Mr. Hilleman.

STATEMENT OF ERIC A. HILLEMAN

Mr. HILLEMAN. Thank you, Chairman Michaud, Members of the Subcommittee.

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

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

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

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

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

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

CARES, a VA data-driven assessment of the current future construction needs gave VA a long-term roadmap that has helped guide its capital asset planning process over the past fiscal years. CARES showed a large number of significant construction priorities that would be necessary to fill the needs of VA in the future. And Congress has made significant end roads into these priorities. It has been a huge but necessary undertaking, and VA has made slow and steady progress in these critical areas.

The challenge for VA in the post-CARES era is that there are still numerous projects that need to be carried out, and the current backlog of partially funded projects that CARES has identified as large, this means that VA is going to continue to require significant appropriations for 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 status of CARES projects, including those in the planning and acquisition process. The top 10 major construction projects in queue require $3.25 billion in appropriations. This is just the tip of the iceberg. There are 82 additional ongoing or partially funded projects that demonstrate the construction need for VA to upgrade and repair its aging infrastructure and that continuous funding is necessary to address this backlog of projects.

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

It is clear that the VA needs a significant infusion of cash for its construction priorities. VA's own words and studies state this. The total major construction request that the IB estimates is $1.295 billion. The minor request is $785 million.

The IB recognizes that the money was provided for military and veterans construction in the American Recovery Reinvestment Act of 2009, and the Administration has requested lower than what the IB requested in this fiscal year.

We ask this Committee to examine VA's construction request with the money that was given in the American Recovery and Investment Act and weigh that against the growing list of construction, both major and minor projects that are outstanding.

We thank you for this opportunity to testify, Mr. Chairman, and we look forward to your questions.

[The prepared statement of Mr. Hilleman appears on p. 37.]

Mr. MICHAUD. Thank you. Mr. Wilson.

STATEMENT OF JOSEPH L. WILSON

Mr. WILSON. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to present the American Legion's views on VA's Veterans Health Administration's fiscal year 2011 budget request.

The following chart reflects the President's 2011 budgetary recommendations as well as those of the American Legion. Due to time constraint, we ask that you please review that at your leisure.

For the improvement of mental health care, VA's budget provides approximately $5.2 billion for mental health, or 8.5 percent over the 2010 enacted level. VA says this will expand inpatient residential and outpatient mental health programs with an emphasis on integrating mental health services with primary and specialty care. The American Legion supports this increase in funding.

In addition to improving mental health care, VA reported that the 2011 budget request will provide $217.6 million to meet the gender-specific health care needs of women veterans. The number of women veterans, currently 1.8 million, is growing rapidly, and women are increasingly relying on VA for their health care. The American Legion believes this provision of funding for women veterans will minimize many issues facing them and their families to include post traumatic stress disorder, depression, substance abuse, and other disorders.

According to VA, the 2011 budget request provides $51.5 billion for medical care, an increase of $4 billion, or 8.5 percent over the 2010 level.

In addition, this level will allow VA to continue to provide timely, high-quality care to all enrolled veterans. The American Legion agrees with the VA's 2011 budget request on the deliverance of medical care to adequately accommodate Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) and Vietnam veterans, as well as veterans from all other eras.

The 2011 budget contains $6.8 billion for long-term care. VA also reported that $250 million has been allotted to continual strengthening access to health care for 3.2 million enrolled veterans who reside in rural and highly rural areas.

The delivery of health care includes a variety of avenues to include new rural health outreach and delivery initiatives and expanded use of home-based primary care, mental health, and telemental health services. The American Legion supports VA's actions in providing access to care with the construction of new facilities as well as technologies. However, due to the vast number of rural venues, we urge that oversight be provided to ensure adequate funding is supplied to those areas.

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

In fiscal year 2011, VA will further expand health care eligibility for Priority Group 8 veterans to those whose incomes exceed the geographic and VA means thresholds by no more than 15 percent compared to the levels in effect to expanding enrollment in 2009. The American Legion again proposes this proper oversight by Congress to ensure adequate funding is in place to meet these enrollees as they arrive to receive health care.

For 2011, VA has allotted $163 million in home telehealth. In total, the VA home telehealth program cares for approximately 35,000 veteran patients. The American Legion concurs with the allotment of funding for the home telehealth program because it will serve to provide more access to care for veterans residing in rural and highly rural areas and reduce travel for health care.

According to VA more than 150,000 active and reserve component servicemembers leave active duty annually. This transition relies on the transfer of paper-based administrative and medical records from the Department of Defense to the veteran, the VA, or other non-VA health providers. VA agrees this paper-based transfer carries risk of errors or oversights and delays the claim process. The American Legion agrees with the establishment of the VLER.

The capital assessment realignment and enhancement services, or CARES initiative, identified approximately 100 major construction projects throughout the VA medical center system. Approximately 5 years have passed since the CARES initiative. During that time to present, more women and men servicemembers are transitioning from active duty to VA and presenting with multiple illnesses such as post traumatic stress disorder and mild traumatic

brain injury. Meanwhile the average age of VA's facilities is approximately 60 years.

In addition, the American Legion's 2009 "A System Worth Saving" publication reports space is one of the major overall challenges, which is due in part to many VA medical facilities being landlocked. The American Legion hereby urges Congress to assess the above-mentioned areas being funded in 2011 as well as the number of servicemembers and current veterans they anticipate will visit a VA medical facility to receive medical care. We contend this action may shed light on the actual need of each VA facility in their sincere effort to accommodate America's veterans.

Mr. Chairman and Members of the Subcommittee, thank you for allowing me the opportunity to present the views of the American Legion to you today. Thank you.

[The prepared statement of Mr. Wilson appears on p. 46.]

Mr. MICHAUD. Thank you very much, Mr. Wilson, and I want to thank the entire panel.

Did you mention, Mr. Wilson, the backlog is $785 million for minor construction?

Mr. WILSON. Did I mention the backlog? I didn't mention the backlog, no, sir.

Mr. MICHAUD. Well, the total cost of the 5-year plan is $6.5 billion for major construction.

And for minor construction, as far as the work that is needed? My point is, if you look at the major construction and you look at minor construction, clearly the total cost for minor construction is less than major construction. Have you done an analysis on the total number of veterans that might be affected by both major versus minor construction?

Mr. WILSON. Well, Mr. Chairman, if I can reserve that response for a later date to give you the full consensus of the American Legion. We are in the midst of conducting site visits for 2010, and during our research, as I have said, we are gathering numbers and we will have a full assessment—we should have a full assessment by the end of our traveling season which will be around July.

Mr. MICHAUD. After your full assessment and a look at the areas where a larger portion of the veteran's population can be affected in a positive way, would you encourage the Committee to put a real emphasis on minor construction, and on trying to get those facilities and CBOCs up and running sooner, rather than later, versus spending hundreds of millions of dollars for a major hospital when you can actually construct several other CBOCs and access points for the same cost?

Mr. WILSON. Again, that question when you are talking about minor construction and CBOCs and then a full VA medical facility, I would say that was two different conversations there.

When you are talking about a full facility, for example like Orlando, you are talking about approximately 400,000. They are going up from maybe under 100,000 to 400,000 veterans. So it is a big difference when you are talking about a full VA facility as opposed to CBOCs which are located in rural areas. And I can't generally say it is hit or miss, because however, this will be a hit because there will be an influx of veterans coming in from theater, they may also migrate into rural areas, which affects CBOCs.

So that is again, I would reserve that to our giving a full assessment; probably by July we will have this full assessment so we can respond appropriately.

Mr. MICHAUD. Okay, thank you. Mr. Hilleman, I believe I read in your testimony that you identified some shortfall of the design build construction process. What do you believe is the best method to deal with the design build type of construction? If that is not a good process what would be a good process?

Mr. HILLEMAN. Mr. Chairman, if I might answer this for the record I would appreciate that. I don't know that the VFW has an ideal model for the design build process or an ideal solution. We feel that the best solution would be one where the VA is collaborating with the Congress and the veterans service organizations to try and work something out that addresses all of our concerns. But I would be happy to get back to you for the record on that question.

Mr. MICHAUD. Okay. As you know Congress has appropriated additional funding to expand access to health care for Priority 8 veterans. What do your three organizations feel the VA has done to reenroll Priority 8 veterans? Do you think they have done a good job? And if not, what do you think that they could do differently to encourage the Priority 8 veterans to sign up for VA health care?

Mr. HILLEMAN. If I could lead off, Mr. Chairman.

The VFW has seen a number of Priority Group 8 veterans in the dark. Something that could be done to improve this is marketing. VA has had greater success as of late with its mental health marketing and some of its marketing to female veterans, and we would urge VA to do marketing, but we understand that it is a 5-year plan and VA plans to bring in 125,000 every year over the next 4 years. But in select marketing they may be able to increase Category 8 enrollments.

Mr. MICHAUD. What is your organization doing as well? Are you doing anything special to help Priority 8 veterans sign up?

Mr. HILLEMAN. We have been encouraging veterans to enroll that have contacted us about health care. We have made them aware of the passage in law authorizing dollars for Priority Group 8's. I believe there has been announcements in our magazine publicizing the open enrollment for specific Category 8's.

Mr. WILSON. Mr. Chairman, since 2003, the demographics have changed significantly now that women veterans are coming into the system at a high rate. Economics have changed and we question whether or not that was considered. I think approximately 260,000 were supposed to be enrolled by July of this year, and as you heard previously, that hadn't been accomplished. In addition, they were supposed to be on track to enroll 500,000 by 2013, however they are not on track.

So we think they are lagging behind. However, I compliment VA on inviting VSOs to Central Office to assist in this process to include getting the word out to veterans. The American Legion has also placed it on our Web site, and after hearing that today it encourages me to go back to my office and the drawing board and pretty much analyze a few notes and assess/ascertain what has happened from that point, as far as progress.

Mr. MICHAUD. What else are you doing other than putting it on your Web site? Because you could have some veterans out there

that are not members of the American Legion and might not think to go there. So what are you doing as an organization to really encourage veterans to sign up for VA health care?

I appreciate and have always encouraged the VA to do their part, but I think it is also important for the VSOs to be out there aggressively educating the public. It is part of your responsibility. I think when you consider the importance of trying to provide adequate health care benefits, for us to do our job to make sure veterans are taken care of, we have to get veterans enrolled. That is a concern that I have; yes, we are going to increase funding to reenroll Priority 8 veterans, but VA hasn't met their goal for the Priority 8 veterans, which I know all the VSOs think we need to do. If VA hasn't met the goal, then I think we all have a responsibility to do it.

For example, if you look at what is happening in the economy today, I have seen a lot of veterans who have never signed up for the VA because they had health care provided through their employer. Then they lose their job and they no longer have health care provided.

So has your organization met with other organizations, such as labor or other entities to really encourage them to get their members who are veterans to sign up? It is going to take a collaborative effort.

Mr. WILSON. Mr. Chairman, I will give you an example. Back in November the American Legion collaborated with other VSOs and the Washington Redskins to help veterans. The event was entitled, "Time Out for Veterans." We collectively informed veterans of reopening of priority groups in 2009. We also provided them information to contact us, as well as information to contact our Web site and the VA's Web site.

We partner with VA as well as other VSOs to place that assessment on our Web site, along with the means test and a link that led to VA's Web site.

To reiterate, we have conducted outreach in events such as "Time Out for Veterans" at FedEx Field.

Mr. MICHAUD. Okay, thank you. And PVA?

Mr. ORTNER. Yes, sir, I will hit the last part first there about what we are doing.

Obviously PVA is a smaller organization focusing on the catastrophically disabled. However, we use a lot of methods to do the outreach. Again, similar to the other organizations, we use our magazines. We have both sports magazines as well as our paraplegic news, which reaches a larger membership than just PVA. So there is outreach in that.

I think one of the key things that we have as well as some of the other organizations like DAV is our service officers. Service officers, the contact that they have with not only members of the organization, but members of, you know, regular veterans as well, getting the word out through that does help a lot.

Then also, of course, we have our chapters throughout the Nation that provide information primarily again to those individuals that may be members, but the word gets out to others as well.

Going back to what the VA is doing, echoing again my colleagues, I think the VA has done a good job of getting information out there, but I think it is an issue of who they are contacting. As

an OEF/OIF veteran myself I have had a whole lot of stuff come to me talking to me as an OIF or an OEF veteran, but that is everything I have been seeing. I haven't seen anything else on, you know, just being a regular veteran or a, you know, a Gulf War veteran or anything like that.

So I think that is probably where VA could improve is just, you know, maybe cast a wider net. Now whether they are doing that because they are trying to limit the number coming in, which is understandable, you know, they have a plan to increase the numbers, but again, as was mentioned also, you know, information going out to the women veterans.

So I think it would be possible for the VA to cast a wider net, but nowadays there seems to be the greatest interest in OIF and OEF veterans, and I think some of those others may be left out a bit.

And your comment about the effects of the economy now I think that makes it even more important for the VA to reach out to those others to get those individuals that may not be aware of it due to the health care losses.

Mr. MICHAUD. Thank you. Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman. I really don't have any questions. We as always appreciate you guys coming over and offering us good advice and commenting about your concerns. We really do appreciate your help.

I want to thank you, Mr. Chairman and Mr. Brown for, in such a timely fashion, getting Dr. Petzel over and his team to visit with us.

I want to congratulate you on your appointment. I know that you are going to do a great job and we really do look forward to working with you, and then all of us together, the Committee, or VSOs that do such a tremendous job, to continue to push forward for veterans and providing veterans opportunities. So thank you very much.

Mr. MICHAUD. Thank you, Mr. Boozman.

Once again I would like to thank this panel for your testimony today. I look forward to working with your organizations to do what we can to make sure that veterans get the health care that they need and deserve. And I think it is important for all of us to recognize that it is not just the VA's responsibility to try to get veterans into the system. I think it is all of our responsibility to do that.

I am reminded of a round table discussion we had with Judge Russell from New York who was instrumental in getting the Veterans Court established. He made very clear when he was talking to groups that when he asked them how many in the room were veterans he had so many put their hands up. Then, when he rephrased the question to ask how many served in the services, more hands went up. There are veterans out there who do not feel that they are veterans because they did not serve in World War II or were not on active duty, and I think it is an educational process that all of us have to undertake, and hopefully we will be able to do what we can to get the word out there to those veterans who should be in the system to ultimately get them into the system, be-

cause it will benefit all of us in the long run, and it will definitely help the VA as well.

Once again, I want to thank this panel as well as the previous panel. I look forward to working with each of you as we move forward. Thank you.

No other comments. The hearing is adjourned.

[Whereupon, at 2:28 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

The Subcommittee on Health will now come to order. I thank everyone for attending this hearing. The purpose of today's hearing is to examine the fiscal year 2011 President's budget request for the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA).

The "Veterans Health Care Budget Reform and Transparency Act of 2009" provides for advance appropriations for the VA medical care accounts and was enacted into law on October 22, 2009. In accordance with this Act, the President's budget requests fiscal year 2011 and 2012 funding for the VA medical care accounts.

The Administration requests $48.2 million for VA medical care in FY 2011, which includes the medical services, medical support and compliance, and medical facilities accounts of the VA. When medical care collections are included, the Administration requests $51.5 billion for VA medical care, which is $4 billion or 8.6 percent above the 2010 enacted level. In fiscal year 2012, the Administration requests $54.3 billion for VA medical care, which is about $3 billion or 5.3 percent above the 2011 request.

The fiscal year 2011 budget request addresses many of the shared priorities of this Subcommittee, such as rural health, mental health, and homeless veterans. The President's budget request for the VA is a robust budget in the tradition of the significant funding increases that the VA has received in the past several years.

Through today's hearing, we will examine the President's 2011 budget request for VHA, which includes the funding recommendations as well as policy and legislative proposals for the medical care accounts of VHA. In addition, we will examine the IT and construction resources for VHA and will explore whether the budget request for the VA health care system provides sufficient resources to meet the needs of our returning servicemembers, including those who deployed as part of the troop surge to Afghanistan.

Today, we will hear from the VA's Under Secretary for Health, as well as Paralyzed Veterans of America and Veterans of Foreign Wars who are the co-authors of *The Independent Budget*. We will also hear from the American Legion. I look forward to hearing their testimonies.

Prepared Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman, for holding this hearing today and I'm especially thankful that the weather has finally cooperated enough to allow us to meet and discuss the Veterans Health Administration's fiscal year 2011 budget. I think one thing we can all agree on is the immense pride we feel in the brave men and women who have served our Nation so honorably in uniform and our commitment to ensuring that they are adequately cared for when they return home from battle. Proper funding of VHA is vital to achieving this goal.

This year, the Administration is requesting funding for health care in the amount of $51.5 billion, an increase of $4 billion from last year's request. Among the many worthy goals included in this budget are initiatives to improve mental health care, to better meet the unique needs of female veterans, to expand health care eligibility to Priority 8 veterans, and to improve access to care for veterans in rural areas. I look forward to working with my esteemed colleagues in both parties on these important issues in the coming months.

However, while I support this budget request overall, I do want to express my disappointment that funding has still not been appropriated for the "Charleston Model"—a joint venture between the Ralph H. Johnson VA Medical Center and the Medical University of South Carolina to design, construct, and operate a co-located,

joint-use medical facility in Charleston, South Carolina. It has been 5 years since Congress authorized $36.8 million for this project in the Veterans Benefits, Health Care, and Informational Technology Act of 2006. If properly funded, this partnership would not only ensure high-quality care for veterans in the Charleston area, but could also be used to improve access and quality of care in areas across the United States. Such an endeavor is too important for this Committee to overlook and I strongly encourage we allow this enterprise to go unfunded no longer.

I'd also like to take a brief moment to congratulate Dr. Petzel, who recently took the oath of office to become the new VA Under Secretary for Health. Dr. Petzel has been with us as Acting Under Secretary since last May and before that served veterans as Director of the Midwest Health Care Network and Chief of Staff for the Minneapolis VA Medical Center. Dr. Petzel, I'm glad to have you with us officially and I look forward to working with you.

Once again, thank you, Mr. Chairman and all of our witnesses for appearing here this afternoon. I look forward to a fruitful discussion and I yield back the balance of my time.

Prepared Statement of Hon. Robert A. Petzel, M.D.,
Under Secretary for Health, Veterans Health Administration,
U.S. Department of Veterans Affairs

Chairman Michaud, Ranking Member Brown, and distinguished Members of the Subcommittee. Thank you for this opportunity to present the President's fiscal year 2011 budget and fiscal year 2012 advance appropriations request for the Veterans Health Administration. Our budget provides the resources necessary to continue our aggressive pursuit of the President's two overarching goals for the Department—to transform VA into a 21st century organization and to ensure that we provide the highest quality health care to our veterans.

We will remain focused on producing the outcomes veterans expect and have earned through their service to our country. To support VA's efforts, the President's budget provides $125 billion in 2011—almost $60.3 billion in discretionary resources and nearly $64.7 billion in mandatory funding. Our discretionary budget request represents an increase of $4.3 billion, or 7.6 percent, over the 2010 enacted level.

Delivering World-Class Medical Care

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

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

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

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

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

Extended Care and Rural Health

VA's budget for 2011 contains $6.8 billion for long-term care, an increase of $858.8 million (or 14.4 percent) over the 2010 level. In addition, $1.5 billion is included for non-institutional long-term care, an increase of $276 million (or 22.9 percent) over 2010. By enhancing veterans' access to non-institutional long-term care, VA can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes.

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

Home Telehealth

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

Expanding Access to Health Care

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

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

Meeting the Medical Needs of Women Veterans

The 2011 budget provides $217.6 million to meet the gender-specific health care needs of women veterans, an increase of $18.6 million (or 9.4 percent) over the 2010 level. The delivery of enhanced primary care for women veterans remains one of the Department's top priorities. The number of women veterans is growing rapidly and women are increasingly reliant upon VA for their health care.

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

VA's 2011 health care budget also focuses on two concerns that are of critical importance to our veterans—easier access to benefits and services, and ending the downward spiral that results in veterans' homelessness.

This budget provides the resources required to enhance access in our health care system. We will expand access to health care through the activations of new or improved facilities, by expanding health care eligibility to more veterans, and by making greater investments in telehealth. We are also requesting a substantial investment for our homelessness programs as part of our plan to ultimately eliminate veterans' homelessness through an aggressive approach that includes housing, education, jobs, and health care.

VA will be successful in resolving these concerns by maintaining a clear focus on developing innovative business processes and delivery systems that will not only serve veterans and their families for many years to come, but will also dramatically

improve the efficiency of our operations by better controlling long-term costs. By making appropriate investments today, we can ensure higher value and better outcomes for our veterans. The 2011 budget also supports many key investments in VA's six high-priority performance goals. I will address several of these goals related to health care now.

Eliminating Veteran Homelessness

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

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

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

Improving Mental Health Care

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

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

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

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

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

Advance Appropriations for Medical Care in 2012

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

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

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

Investments in Medical Research

VA's budget request for 2011 includes $590 million for medical and prosthetic research, an increase of $9 million over the 2010 level. These research funds will help VA sustain its long track record of success in conducting research projects that lead to clinically useful interventions that improve the health and quality of life for veterans as well as the general population.

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

Capital Infrastructure

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

Major Construction

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

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

Minor Construction

The $467.7 million request for 2011 for minor construction is an integral component of our overall capital program. In support of the medical care and medical research programs, minor construction funds permit VA to realign critical services; make seismic corrections; improve patient safety; enhance access to health care; increase capacity for dental care; enhance patient privacy; improve treatment of special emphasis programs; and expand our research capability. Further, minor construction resources will be used to comply with energy efficiency and sustainability design requirements.

Summary

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

The 298,000 employees of VA are committed to providing the quality of service needed to serve our veterans and their families. They are our most valuable resource. VA is fortunate to have public servants that are not only creative thinkers, but also able to put good ideas into practice. With such a workforce, and the con-

tinuing support of Congress, I am confident we can achieve our shared goal of accessible, high-quality and timely care and benefits for veterans.

Prepared Statement of Blake C. Ortner,
Senior Associate Legislative Director, Paralyzed Veterans of America,
on Behalf of *The Independent Budget*

Chairman Michaud, Ranking Member Brown, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) is pleased to present our views on the Department of Veterans Affairs (VA) Veterans Health Administration's (VHA) fiscal year 2011 budget, in particular as it relates to construction. As one of the four co-authors of *The Independent Budget* (IB), much of our testimony will directly correspond to testimony last week on the views of *The Independent Budget* regarding the funding requirements for the VA health care system for FY 2011.

When looking back on 2009, it is fair to say that the 111th Congress took a historic step toward providing sufficient, timely, and predictable funding, and yet it still failed to complete its appropriations work prior to the start of the new fiscal year on October 1. The actions of Congress last year generally reflected a commitment to maintain a viable VA health care system. More important, Congress showed real interest in reforming the budget process to ensure that the VA knows exactly how much funding it will receive in advance of the start of the new fiscal year. This is particularly critical to VHA. With the President's signature on P.L. 111–81, the "Veterans Health Care Budget Reform and Transparency Act," and the enactment of advance appropriations, the VA can properly plan to meet the health care needs of the men and women who have served this Nation in uniform.

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

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

Funding for FY 2011

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

However, PVA continues to be seriously concerned about reports of VA's continued inappropriate billing of service connected veterans for service connected injuries as well as non-service connected veterans being billed multiple times for the same treatment. Inappropriate charges for VA medical services places unnecessary financial stress on individual veterans and their families. These inaccurate charges are not easily remedied and their occurrence places the burden for correction directly on the veteran, their families or caregivers. PVA believes that many veterans are not aware of these mistakes and simply submit full payment to VA when a billing statement arrives at their home. If Congress and the Administration are going to continue to rely on massive collections estimates and dollars actually collected to support the VA health care budget, then serious examination of how the VA is achieving these numbers is necessary.

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health care funding level. For FY 2011, *The Independent Budget* recommends approximately $40.9 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

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

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

Finally, our increase in workload includes the projected enrollment of new Priority Group 8 veterans who will use the VA health care system as a result of the Administration's plan to incrementally increase the enrollment of Priority Group 8 veterans by 500,000 enrollments by FY 2013. We estimate that as a result of this policy decision, the number of new Priority Group 8 veterans who will enroll in the VA will increase by 125,000 in each of the next 4 years. Based on the Priority Group 8 empirical utilization rate of 25 percent, we estimate that approximately 31,250 of these new enrollees will become users of the system. This translates to a cost of approximately $125 million.

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

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

For Medical Support and Compliance, *The Independent Budget* recommends approximately $5.3 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.7 billion. Our recommendation once again includes an additional $250 million for nonrecurring maintenance (NRM) provided under the Medical Facilities account. This would bring our overall NRM recommendation to approximately $1.26 billion for FY 2011. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding still lags behind the recommended 2 to 4 percent of plant replacement value. Based on that logic, the VA should actually be receiving at least $1.7 billion annually for NRM.

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

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

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 followthrough 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 altogether. For FY 2011, *The Independent Budget* recommends approximately $1.295 billion for Major Construction and $785 million for Minor Construction. The Major Construction recommendation includes approximately $100 million for research infrastructure and the Minor Construction recommendation includes approximately $200 million for research facility construction needs.

We note that the budget request reduces funding for Major Construction and slashes funding for Minor Construction. Despite additional funding that has been provided in recent years to address the construction backlog and maintenance needs facing VA, a great deal remains to be done. We cannot comprehend what policy decisions could justify such a steep decrease in funding for Minor Construction. Specifically, there are two areas where PVA is significantly concerned.

VA Research Infrastructure Funding Shortfalls

In recent years, funding for the VA maintenance and construction appropriations has failed to provide the resources needed by VA to maintain, upgrade, and replace its aging research facilities. Consequently many VA facilities have run out of adequate research space. Also, ventilation, electrical supply, roofs and plumbing deficiencies appear frequently on lists of urgently needed upgrades along with significant space reconfiguration. In the 2003 *Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan*, VA listed $468.6 million designated for new laboratory construction, renovation of existing research space, and build-out costs for leased research facilities. However, these capital improvement projects were omitted from the Secretary's final report on capital planning consequential to the CARES effort.

In House Report 109–95 accompanying the "FY 2006 VA Appropriations Act," 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." In the same report, the Committee directed VA to conduct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies." VA piloted the evaluation instrument and methodology in FY 2006 at three sites—Central Arkansas Veterans Health System, Little Rock; VAMC Salt Lake City; and VA New York Harbor Health Care System (Manhattan and Brooklyn campuses). All three sites scored within the "poor" range (D on an A to F scale) with a total correction cost of over $26 million.

In FY 2008, the VA Office of Research and Development (ORD) followed up with an as yet incomplete examination of all VA research infrastructure, for physical condition, capacity for current research, as well as needed program growth and sustainability of VA space to conduct research. According to an October 26, 2009, ORD report to the VA National Research Advisory Committee, surveys to date support the pilot findings: "There is a clear need for research infrastructure improvements throughout the system, including many that impact on life safety."

By the end of FY 2009, a total of 53 sites within 47 research programs will have been surveyed. Approximately 20 sites remain to be assessed in FY 2010. To date, the combined total estimated cost for improvements exceeds $570 million. About 44 percent of the estimated correction costs constitute "priority 1" deficiencies—those with an immediate need for correction to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and correct life-safety hazards. Furthermore, only six buildings (of 38 buildings surveyed) at five sites were rated above the "poor" range. Three of the seven buildings rated above "poor" were structures housing the main hospital. Five buildings that rated "poor" were main hospitals housing laboratories.

A significant cause of the VA research infrastructure's neglect is that there is no direct funding line, nor any budgetary request made, for VA research facilities. Nor does the VA Medical and Prosthetic Research appropriation contain funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on local facility management to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with medical facilities' direct patient care infrastructure needs (such as elevator replacement, heating and air conditioning upgrades, operating

room equipment and space upgrades, outpatient clinic space construction or renovations, and capital equipment upgrades and replacements such as X-ray machines and MRIs) for funds provided under either the VA Medical Facility appropriation account or the VA Major and Minor Construction appropriations accounts. VA investigators' success in obtaining funding from non-VA sources exacerbates VA's research infrastructure problems because non-VA grantors typically provide no funding to cover the costs to VA medical centers of housing extramurally funded projects.

We anticipate VA's ongoing research facilities assessment will identify a need for research infrastructure funding significantly greater than the 2003 Draft National CARES report. As VA moves forward with its research facilities assessment, we urge Congress to require VA to submit the resulting report to the House and Senate Committees on Appropriations and Veterans' Affairs by June 1, 2010. Surfacing this key report will ensure that the Administration and Congress are well informed of the deteriorating condition of VA's research infrastructure and of its funding needs so these may be fully considered in the budget formulation process.

In accordance with the recommendations of *The Independent Budget*, to address the VA research infrastructure's defective funding mechanism, PVA recommends the Administration and Congress establish a new appropriations account to independently define and separate VA research infrastructure funding needs from capital and maintenance funding for direct VA medical care. The account should be subdivided for major and minor construction, and for maintenance and repair needs. This revision in appropriations accounts will empower VA to address research facility needs without interfering with direct health care infrastructure. We believe correction of the known infrastructure deficiencies should not be further delayed and consistent with the recommendations of *The Independent Budget*, we recommend an appropriation in FY 2011 of $300 million dedicated exclusively to renovating existing research facilities to address the current and well-documented shortfalls in research infrastructure.

Maintain Critical VA Health Infrastructure

Over the past year, VA has begun to discuss its desire to address its health infrastructure needs in a new way. VA has acknowledged its challenges with aging infrastructure; changing health care delivery needs, including reduced demand for inpatient beds and increasing demand for outpatient care and medical specialty services; limited funding available for construction of new facilities, that are growing prohibitively expensive; frequent delays in constructing and renovating space needed to increase access, and particularly the timeliness of construction projects. VA has noted, and we concur, that a decade or more is required from the time VA initially proposes a major medical facility construction project, until the doors actually open for veterans to receive care in that facility.

Given these significant challenges, VA has developed a new model for health care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF proposal, in lieu of the traditional approach to major medical facility construction, VA would obtain by long-term lease, a number of large outpatient clinics built to VA specifications. 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. Inpatient needs at such sites would probably be managed through contracts with affiliates or local private medical centers, although today we are unclear on how such arrangements would be managed.

VA noted that, in addition to its new HCCF facilities, it would maintain its VA medical centers (VAMCs), larger independent outpatient clinics, community based outpatient clinics (CBOCs) and rural outreach clinics. VA has argued that adopting the HCCF model would allow VA to quickly establish new facilities that would provide 95 percent of the care and services veterans need in their catchment areas, specifically primary care, and a variety of specialty services, mental health, diagnostic testing and same-day ambulatory surgery.

We concur with VA that the HCCF model seems to offer a number of benefits in addressing its capital infrastructure problems including more modern facilities that meet current life-safety codes; better geographic placements; increased patient safety; reductions in veterans' travel costs and increased convenience; flexibility to respond to changes in patient loads and technologies; potential savings in operating costs and in facility maintenance; and, reduced overhead in maintaining outdated medical centers.

While it offers some obvious advantages, the HCCF model could face significant challenges. PVA is particularly concerned about the overall impact on the future of VA's system of care, including the potential unintended consequences on continuity of high-quality care; maintenance of its specialized medical programs for spinal cord

injury, blindness, amputations and other health challenges of seriously disabled veterans; delivery of comprehensive services; its recognized biomedical research and development programs; and the impact on VA's renowned graduate medical education and health professions training programs, in conjunction with longstanding affiliations with nearly every health professions university in the Nation.

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

In general, the HCCF proposal could be a positive development, with good potential. Leasing has the advantage of avoiding long and costly in-house construction delays and can be adaptable, especially when compared to costs for renovating existing VA major medical facilities. Leasing options have been particularly valuable for VA as evidenced by the success of the leased space arrangements for many VA community based outpatient clinics and Vet Centers. However, VA says it will contract for these essential inpatient services with VA affiliates or community hospitals if needed. First and foremost, VA must provide assurances that this approach will not negatively impact safety, quality and continuity of care, and permanently privatize many services we believe VA should continue to provide. We have testified on this topic and have expressed objections in the Contract Care Coordination and Community Based Outpatient Clinics sections of *The Independent Budget*.

We agree with VA's assertion that it needs a balanced capital assets program, of both owned and leased buildings, to ensure demands are met under current projections. Likewise, we agree with VA that the HCCF concept could provide modern health care facilities relatively quickly that might not otherwise be available due to the predictable constraints of VA's major construction program. On the other hand, if VA plans to replace the majority or even a large fraction of all VAMCs with HCCFs, such a radical shift would pose a number of concerns for us. But we see this challenge as only a small part of the overall picture related to VA health infrastructure needs in the 21st century. The emerging HCCF plan does not address the fate of VA's 153 medical centers located throughout the Nation that are on average 55 years of age or older. It does not address long-term care needs of the aging veteran population, inpatient treatment of the chronically and seriously mentally ill, the unresolved rural health access issues, or the lingering questions on improving VA's research infrastructure. The major question is what will VA's 21st century health infrastructure look like and how it will be managed and sustained? Fully addressing these and related questions is extremely important and will impact generations of sick and disabled veterans.

Congress and the Administration must work together to secure VA's future to design a VA of the 21st century. It will take the joint cooperation of Congress, veterans' advocates, and the Administration to support this reform, while setting aside resistance to change, even dramatic change, when change is demanded and supported by valid data. Accordingly, we urge the Administration and Congress to live up to the President's words by making a steady, stable investment in VA's capital infrastructure to bring the system up to match the 21st century needs of veterans.

Finally, one of our community's frustrations with respect to VA's infrastructure plans is lack of consistent and periodic updates, specific information about project plans, and even elementary communications. We ask VA to improve the quality and quantity of communication with the VSOs, enrolled veterans, concerned labor organizations and VA's own employees, affiliates and other stakeholders, as the VA capital and strategic planning process moves forward. We believe that all of these groups must be made to understand VA's strategic plan and how it may affect them, positively and negatively. Talking openly and discussing potential changes will help resolve the understandable angst about these complex and important questions of VA health care infrastructure. While we agree that VA is not the sum of its buildings, and that a veteran patient's welfare must remain at the center of VA's concern, VA must be able to maintain an adequate infrastructure around which to build and sustain "the best care anywhere." If VA keeps faith with these principles, we are prepared to aid VA in accomplishing this important goal.

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

Prepared Statement of Eric A. Hilleman, Director, National Legislative Service, Veterans of Foreign Wars of the United States, on Behalf of *The Independent Budget*

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

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

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

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

CARES—VA's data-driven assessment of their 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 completed 5 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 or acquisition process. Table 4–5: (page 7.4–49) shows a need of future appropriations to complete these projects of $3.25 billion.

Project	**Future Funding Needed ($ in Thousands)**
Denver	$ 492,700
San Juan	$ 122,920
New Orleans	$ 370,000
St. Louis	$ 364,700
Palo Alto	$ 478,023
Bay Pines	$ 80,170
Seattle	$ 38,700
Seattle	$ 193,830
Dallas	$ 80,100
*Louisville	$1,100,000
TOTAL	**$3,246,143**

This amount represents just the backlog of current construction projects. It does reflect the Administration's FY 2011 proposed appropriation toward Denver, New Orleans, and Palo Alto.

*Louisville's cost estimate is found in table 5–6, on page 7.5–93.

Meanwhile, VA continues to identify and re-prioritize potential major construction projects. These priorities, which are assessed using the rigorous methodology that guided the CARES decisions, are released in the Department's annual Five Year Capital Asset Plan, which is included in the Department's budget submission. The most recent one was included in Volume IV and is available on VA's Web site: http://www4.va.gov/budget/docs/summary/Fy2011__Volume__4-Construction__and__5__Year__Cap__Plan.pdf.

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

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

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

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

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

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

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

Increase Spending on Nonrecurring Maintenance

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

For years, the Independent Budget Veteran Service Organizations (IBVSOs) have highlighted the need for increased funding for the nonrecurring maintenance (NRM) account. NRM consists of small projects that are essential to the proper maintenance 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. 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 just to fill current maintenance needs and levels, but also to dip into the extensive backlog of maintenance requirements VA has. VA monitors the condition of its structures and systems through the Facility Condition Assessment (FCA) reports. VA surveys each medical center periodically, giving each building a thorough assessment of all essential systems. Systems are assigned a letter grade based upon the age and condition of various systems, and VA gives each component a cost for repair or replacement.

The bulk of these repairs and replacements are conducted through the NRM program, although the large increases in minor construction over the last few years have helped VA to address some of these deficiencies.

VA's 5-Year Capital Plan discusses FCAs and acknowledges the significant backlog of the number of high-priority deficiencies—those with ratings of D or F—that had replacement and repair costs of over $9.4 billion, found on page 7.1–18. VA estimates that 52 percent of NRM dollars are obligated toward this cost.

VA uses the FCA reports as part of its Federal Real Property Council (FRPC) metrics. The Department calculates a Facility Condition Index, which is the ratio of the cost of FCA repairs to the cost of replacement. According to the FY 08 Asset Management Plan, this metric has gone 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 by moving money away from older hospitals, such as in the northeast, to newer facilities where patient demand is greater, even if the maintenance needs are not as high. We were happy to see that the conference reports to the VA appropriations bills required NRM funding to be apportioned outside the VERA formula, and we would hope that this continues into the future.

Another issue related to apportionment of funding came to light in a May 2007 Government Accountability Office (GAO) report. They found that the bulk of NRM funding is not actually apportioned until September, the final month of the fiscal year. In September 2006, GAO found that VA allocated 60 percent of that year's NRM funding. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and since NRM funding is year-to-year, it means that it could lead to wasteful or unnecessary spending as hospital managers rushed in a flurry to spend their apportionment before forfeiting it back. We cannot expect VA to perform a year's worth of maintenance in a month. It is clearly poor policy and not in the best interest of veterans. The IBVSOs believe that Congress should consider allowing some NRM money to be carried over from one fiscal year to another. While we would hope that this would not resort to hospital managers hoarding money, it could result in more efficient spending and better planning, rather than the current situation where hospital managers sometimes have to spend through a large portion of maintenance funding before losing it at the end of the fiscal year.

Recommendations

VA must dramatically increase funding for nonrecurring maintenance in line with the 2 percent–4 percent total that is the industry standard so as to maintain clean, safe and efficient facilities. VA also requires additional maintenance funding to allow the Department to begin addressing the substantial maintenance backlog of FCA-identified projects.

Portions of the NRM account should be continued to be funded outside of the VERA formula so that funding is allocated to the facilities that actually have the greatest maintenance needs.

Congress should consider the strengths of allowing VA to carry over some maintenance funding from one fiscal year to another so as to reduce the temptation some VA hospital managers have of inefficiently spending their NRM money at the end of a fiscal year for fear of losing it.

Inadequate Funding and Declining Capital Asset Value

VA must protect against deterioration of its infrastructure and a declining capital asset value

The last decade of underfunded construction budgets has meant that VA has not adequately recapitalized its facilities. Recapitalization is necessary to protect the value of VA's capital assets through the renewal of the physical infrastructure. This ensures safe and fully functional facilities long into the future. VA's facilities have an average age approaching 60 years, and it is essential that funding be increased to renovate, repair, and replace these aging structures and physical systems.

As in past years, the IBVSOs cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). It found that from 1996–2001, VA's recapitalization rate was just 0.64 percent. At this rate, VA's structures would have an assumed life of 155 years.

The PTF cited a PriceWaterhouseCoopers study of VA's facilities management programs that found that to keep up with industry standards in the private sector and to maintain patient and employee safety and optimal health care delivery, VA

should spend a minimum of 5 to 8 percent of plant replacement value (PRV) on its total capital budget.

The FY08 VA Asset Management Plan provides the most recent estimate of VA's PRV. Using the guidance of the Federal Government's Federal Real Property Council (FRPC), VA's PRV is just over $85 billion (page 26).

Accordingly, using that 5 to 8 percent standard, VA's capital budget should be between $4.25 and $6.8 billion per year in order to maintain its infrastructure.

VA's capital budget request for FY 2009—which includes major and minor construction, maintenance, leases and equipment—was just $3.6 billion. We greatly appreciate that Congress increased funding above that level with an increase over the Administration request of $750 million in major and minor construction alone. That increased amount brought the total capital budget in line with industry standards, and we strongly urge that these targets continue to be met and we would hope that future VA requests use these guidelines as a starting point without requiring Congress to push them past the target.

Recommendation

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

Maintain VA's Critical Infrastructure

The IBVSOs are concerned with VA's recent attempts to back away from the capital infrastructure blueprint laid out by CARES and we are worried that its plan to begin widespread leasing and contracting for inpatient services might not meet the needs of veterans.

VA acknowledges three main challenges with its capital infrastructure projects. First, they are costly. According to a March 2008 briefing given to the VSO community, over the next 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 multi-year examination of all VA research infrastructures 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 veteran's 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, 2010. 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 60 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 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 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 1750's, to use as a training space for about $1.2 million. VA could restore the 1881 Milwaukee Ward Memorial Theater for use as a multi-purpose facility at a cost of $6 million. This is much less than the cost of a new facility.

As part of its adaptive reuse program, VA must ensure that the facilities that it leases or sells are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds.

We encourage the use of P.L. 108–422, the Veterans Health Programs Improvement Act, which authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property.

Recommendation

VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

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

Prepared Statement of Joseph L. Wilson, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on the Department of Veterans Affairs (VA) Veterans Health Administration's (VHA) fiscal year (FY) 2011 budget request. To date, the VHA provides integrated health care services to eligible veterans through 153 medical centers, 755 Outpatient Clinics, and 232 Vet Centers in all 50 States, including the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. In 2009, Congress enacted Public Law 111–81, the "Veterans Health Care Budget Reform and Transparency Act" which requires VA to submit this request for advance appropriations with its President's budget submission each year.

The American Legion proposes the following budgetary recommendations for selected programs within the VA Veterans Health Administration for FY 2011:

Program	FY 10 Funding	President's Request	Legion's Request
Medical Services	$37.7 billion	$40.5 billion	❤
Medical Support and Compliance	$4.9 billion	$5.3 billion	❤
Medical Facilities	$4.9 billion	$5.7 billion	❤
Medical Care Total	**$48.1 billion**	**$51.5 billion**	**$48 billion (includes medical and prosthetics research)**
Major Construction	$1.2 billion	$1.2 billion	**$2 billion**
Minor Construction	$703 million	$467.7 million	**$1.5 billion**
Medical and Prosthetics Research	$581 million	$590 million	**$700 million**
Medical Care Recovery Fund	($3 billion)	($3.4 billion)	*

*Third-party reimbursements should supplement rather than offset discretionary funding.

Improving Mental Health Care

VA recently stated that the 2011 budget request will continue to improve the quality, access, and value of mental health care provided to veterans. VA's budget provides approximately $5.2 billion for mental health, an increase of $410 million, or 8.5 percent, over the 2010 enacted level. In addition, VA says this will expand inpatient, residential, and outpatient mental health programs with an emphasis on integrating mental health services with primary and specialty care.

The American Legion supports this increase in funding and contends that appropriate increases in mental health should be frequently evaluated due to the influx of men and women servicemembers diagnosed with Post Traumatic Stress Disorder (PTSD) and traumatic brain injury (TBI), depression, and substance use disorders.

Meeting the Medical Needs of Women Veterans

VA reported that the 2011 budget request will provide $217.6 million to meet the gender-specific health care needs of women veterans. The delivery of enhanced primary care for women veterans remains one of the Department's top priorities. The number of women veterans is growing rapidly and women are increasingly reliant upon VA for their health care.

The American Legion believes the provision of funding to ensure women veterans receive complete, comprehensive care will minimize many issues facing them and their families, to include PTSD, depression, substance abuse, and other disorders.

Delivery of Medical Care

According to VA, the 2011 budget request provides $51.5 billion for medical care, an increase of $4 billion, or 8.5 percent, over the 2010 level. VA says this level will allow them to continue providing timely, high-quality care to all enrolled veterans.

VA states their total medical care level is comprised of funding for medical services ($40.5 billion), medical support and compliance ($5.3 billion), medical facilities ($5.7 billion), and resources from medical care collections ($3.4 billion). VA also stated that the 2011 budget will reduce the number of homeless veterans and expand access to mental health care, as well as accomplish other outcomes that improve veterans' quality of life, including:

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

During FY 2011, VA anticipates treating nearly 6.1 million unique patients, a 2.9-percent increase over 2010. Among the total to be treated are over 439,000 veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom.

The American Legion agrees with the VA's 2011 budget request on the deliverance of medical care. We also applaud Congress on the approval of funding to adequately accommodate OEF/OIF and Vietnam veterans as well as veterans from other areas.

Extended Care and Rural Health

VA's budget request for FY 2011 contains $6.8 billion for long-term care. VA also reported that $250 million has been allotted to continue strengthening access to health care for 3.2 million enrolled veterans living in rural and highly rural areas through a variety of avenues, including new rural health outreach and delivery initiatives and expanded use of home-based primary care, mental health, and telehealth services. VA intends to expand use of cutting edge telehealth technology to broaden access to care while at the same time improve the quality of our health care services.

The American Legion supports VA's actions in providing access to care with new facilities as well as technologies. However, due to the vast number of rural venues, we urge that oversight be provided to ensure funding reaches these areas.

Expanding Access to Health Care

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

In FY 2011, VA will further expand health care eligibility for Priority Group 8 veterans to those whose incomes exceed the geographic and VA means test thresh-

olds by no more than 15 percent compared to the levels in effect prior to expanding enrollment in 2009. This additional expansion of eligibility for care will result in an estimated 99,000 more enrollees in 2011 alone, bringing the total number of new enrollees from 2009 to the end of 2011, to 292,000.

Home Telehealth

For FY 2011, VA has also allotted $163 million in home telehealth. The Secretary says they are taking greater advantage of the latest technological advancements in health care delivery which will allow VA to closely monitor the health status of veterans and improve access to care for veterans in rural and highly rural areas. In total, the VA home telehealth program cares for approximately 35,000 veteran patients.

The American Legion concurs with the allotment of funding for the Home Telehealth program because it will serve to provide more access to care for veterans residing in rural and highly rural areas and reduce travel for health care.

Establishing a Virtual Lifetime Electronic Record

According to VA more than 150,000 active and Reserve component servicemembers leave active duty annually. This transition relies on the transfer of paper-based administrative and medical records from the Department of Defense (DoD) to the veteran, the VA or other non-VA health care providers. VA agrees this paper-based transfer carries risks of errors or oversights and delays the claim process.

The VA is currently building a fully interoperable electronic records system that will provide every member of our armed forces a Virtual Lifetime Electronic Record (VLER), which will enhance the timely delivery of high-quality benefits and services by capturing key information from the day they put on the uniform, through their time as veterans, until the day they are laid to rest. The Secretary of VA also stated VA has $52 million in IT funds in 2011 to continue the development and implementation of this Presidential priority.

The American Legion agrees with the establishment of the VLER. As with many programs, we remain adamant that proper oversight be placed on the implementation of this record. The storing of such records is extremely vital to the health and welfare of each and every veteran.

The Capital Asset Realignment for Enhanced Services (CARES) initiative identified approximately 100 major construction projects throughout the VAMC system, DC, and Puerto Rico. Approximately 5 years have passed since the CARES initiative. In addition, more women and men servicemembers are transitioning from active duty to VA and presenting with multiple illnesses, such as PTSD and mild TBI. Meanwhile, the average age of VA's facilities is approximately 45 years. The American Legion's 2009 "A System Worth Saving" publication reports "space availability" as one of the major overall challenges.

The American Legion hereby urges Congress to assess the abovementioned areas they funded for FY 2011, as well as the number of servicemembers and current veterans they anticipate to visit a VA medical facility to receive medical care. We contend this action will shed light on the actual need of each VA facility in their sincere effort to accommodate America's veterans.

Conclusion

Mr. Chairman and Members of the Subcommittee, The American Legion appreciates the commitment of this Subcommittee, and remains fully committed to working with you to ensure all of this Nation's veterans are provided with timely access to the quality health care they deserve, are entitled to receive. It is imperative we remain vigilant in our efforts to adequately accommodate them as they continue to adjust to the civilian community.

Thank you for allowing me the opportunity to present the views of The American Legion to you today.

Statement of Barbara F. West, Executive Director,
National Association for Veterans' Research and Education Foundations

The National Association of Veterans' Research and Education Foundations (NAVREF) appreciates the opportunity to submit a statement for the record of the February 23, 2010, hearing of the Health Subcommittee of the House Committee on Veterans Affairs.

NAVREF is proud to be the voluntary membership association of the more than 80 nonprofit research and education corporations (NPCs) established by Department

of Veterans Affairs (VA) medical centers and operated in accordance with 38 USC §§ 7361–7366. Last year, NPCs administered over $250 million in private sector and non-VA Federal funding on behalf of VA investigators and educators conducting approximately 4,000 research studies and education activities at VA facilities across the Nation.

The purpose of this statement is to convey NAVREF's views on VA's request for legislative authority to establish a "Central Nonprofit Corporation for VA Research." VA's proposal is described in *Volume II, Medical Programs and Information Technology Programs* of the Department's *FY 2011 Funding and FY 2012 Advance Appropriations Request*, pages 1I–20 and 1I–21.

Despite careful consideration, NAVREF is unable to support VA's proposal for a central nonprofit because:

- VA fails to make a compelling case for what a central VA nonprofit could accomplish that the existing NPCs cannot;
- The proposal contains so little detail about how VA and a central VA nonprofit would interact that NAVREF is forced to consider potentially problematic possibilities; and
- Absent from VA's justification is how a central VA nonprofit would further VA's research mission which is to "discover knowledge, develop VA researchers and health care leaders, and create innovations that advance health care for our veterans and the Nation."

NAVREF and its member NPCs fully appreciate the advantages of public/private nonprofit partnerships. As "flexible funding mechanism[s] for the conduct of VA research" [38 USC § 7361(a)], NPCs confer substantial advantages on VA medical centers. Through careful stewardship of funds entrusted to them by private sector grants, cooperative research and development agreements (CRADAs) for industry-sponsored studies and non-VA Federal awards, NPCs have provided innumerable benefits to the VA facility research programs and VA investigators. Over the 22 years since they were first authorized by Congress, NPCs have helped to foster vibrant VA research enterprises at VA medical centers across the country through contributions of research personnel; equipment; supplies; facility improvements; compliance training; grant writing, submission and management services; travel support and much more. Because VA already has more than 80 nonprofits, we feel that it is incumbent on VA to make a more convincing case for authority to establish a new and untested form of VA nonprofit. Toward that end, we recommend that in order for a central VA nonprofit to warrant consideration:

1. **VA should provide compelling justification for a central VA nonprofit that clearly articulates what the proposed central VA nonprofit could accomplish that the existing NPCs cannot.**

In our view, some NPCs are already accomplishing the stated objectives of the central VA nonprofit, and more could do so if given the opportunity, particularly under the updated NPC authority that is presently close to final enactment in H.R. 2770 and title VIII of S. 1963.

VA's justification for a central VA nonprofit hinges in part on its desire to "carry out national medical research and education projects." However, VA has a long history of successfully managing complex, multi-site studies involving thousands of subjects through its Cooperative Studies Program (CSP) and its Health Services Research and Development (HSR&D) program. As a result, we are uncertain of the need for a central VA nonprofit to accomplish what has long been a major strength of the VA research program.

Also, while the updated NPC authority awaiting enactment will clarify that NPCs may administer multi-site studies, they have been doing so for years [see Multi-Center Studies, OGC Opinion 023 (11/4/99)]. Further, NPCs have increasingly partnered with VA to administer non-VA funds for CSP studies since the longstanding relationship between the Office of Research and Development (ORD) and the Friends Research Institute (FRI) had to be terminated in 2004 when misuse of non-VA funds directed to FRI for CSP studies came to light. [See OIG administrative investigation Report No. 03–03053–115; March 22, 2004]. (**Please note** that FRI is not one of the more than 80 VA NPCs. ORD's relationship with FRI pre-dated authorization of the NPCs in 1988 but continued until 2004.)

Since termination of the FRI relationship, NPCs associated with medical centers where VA has CSP Coordinating Centers (CSPCCs)—Hines, Illinois; Palo Alto, California; West Haven, Connecticut; and Perry Point near Baltimore, Maryland—have worked closely with CSPCC personnel to set up efficient systems and MOUs that allow accountable management of non-VA Federal funding, and private sector funds contributed by industry partners, for CSP and other centrally directed VA studies.

Recent examples include NPC facilitation of the ACCORD (diabetes) and ALLHAT (hypertension) studies and the shingles vaccine trials. Additionally, an NPC not associated with a CSPCC currently administers over $15 million annually in NIH funding for multi-site studies led by a single VA principal investigator.

Another justification that VA uses in support of a central VA nonprofit is found in the statement, "While current NPCs work well with their current authority to manage studies in their specific jurisdictions, few of the individual NPCs have all the skill sets needed to coordinate more complex efforts." Although some NPCs may lack all the "skill sets" needed to coordinate more complex efforts, we believe that more could readily acquire those skills—or hire new personnel with the necessary skills—if given greater opportunity for responsibility for multi-site studies. It should be noted that many NPCs—even some of those associated with relatively large VA research programs—have not reached their full potential because so much non-VA funding for research performed in VA facilities is administered by entities other than VA or NPCs, primarily universities and university-affiliated nonprofits.

2. VA should establish that centralized administration of research is an appropriate model for VA.

First, it should be noted that the purposes of the central VA nonprofit stated in the proposal are strikingly similar to the statutory authority given to the Department of Defense (DoD) to establish the Henry M. Jackson Foundation (HJF) for the Advancement of Military Medicine (10 USC § 178) in 1985. HJF has one primary university affiliation (Uniformed Services University of the Health Sciences), has relationships with more than 160 military medical and other organizations worldwide, and employs 1,800 personnel providing a broad array of research and clinical services.

We are uncertain how well the HJF model would suit VA even though we understand that VA does not intend for the central VA nonprofit to supplant medical center-based NPCs, except possibly where the research programs are very small. The centralized HJF model was considered when legislation proposing the NPCs was the subject of congressional hearings (H. Rept. 100–373). It is our understanding that after review, the centralized model was rejected in favor of a decentralized approach more suitable for VA which has affiliations with 107 medical schools and more than 5,000 affiliation agreements with some 1,200 other health professional colleges and universities.

For over 20 years, VA's decentralized approach using local NPCs has demonstrated effective support of the VA research and education missions through onsite (most NPC offices are located in VA facilities or very nearby) research support services for VA investigators while working closely with the medical center personnel responsible for the conduct and oversight of research at each facility. Indeed, for a short time VA had centralized research support offices—the Eastern and Western Research and Development Offices (ERDO and WRDO). These offices administered VA-appropriated funds for sites with just a few projects, but they were closed after a few years.

We agree that it makes little sense for facilities with very few research projects to incur the effort, expense and responsibility of maintaining their own NPC. However, legislation already passed by the House and Senate in H.R. 2770 and title VIII of S. 1963 respectively, and presently awaiting final resolution of their minor differences, offers a means for these facilities to access the benefits of NPCs through voluntarily sharing one NPC among two or more VAMCs. By pooling funds, consolidating management and avoiding duplication, such as having one audit instead of three, or one executive director instead of three, "multi-medical center research corporations" (MMRCs) will preserve the advantages of the close relationship NPCs have with the facilities and investigators they serve while reducing overhead. These MMRCs will offer smaller research programs a locally accountable option which is likely to be nearby, if not onsite, for management of their research projects and education activities. We see no need for the option of remote, possibly Washington-based, services a central VA nonprofit would offer.

3. To preserve the integrity of the intramural nature of the VA research program, VA should clarify that the central VA nonprofit would accept only non-VA Federal and private sector funds.

We further question the suitability of an HJF-like authority for VA because, unlike DoD and NIH, which have authority to conduct research both intra- and extramurally, a core tenet of the VA Research and Development program is that it is solely an **intramural** research program. If—and that is a big "if" because the proposal contains so few details—authority for the central VA nonprofit would encompass reciprocal contracting or the ability to pass VA-appropriated funds through to

VA or non-VA entities (as HJF does for some DoD funds), we believe that would compromise the long held intramural nature of the VA research program. Ultimately, this would reduce its effectiveness as a recruitment and retention tool for high-quality clinician-investigators who in turn focus their research on conditions prevalent among veterans and who provide optimum care for veterans. We may be reading too much into the proposal, but we feel it is important to state that NAVREF would be opposed to any measures that could have the unintended consequence of altering the intramural nature of VA research.

4. VA should describe what legal mechanisms available to VA would be used to engage with a central VA nonprofit.

Although we are unable to discern from the proposal how VA and the central VA nonprofit would interact to each other (what are "cooperative arrangements"?), it appears that justification for the central VA nonprofit may entail plans for VA to use VA-appropriated funds to contract with the central VA nonprofit for services. We regularly hear that VA hiring mechanisms are ill-suited for research projects because these require prompt hiring to meet time-limited funder deadlines and the ability to terminate employees when their services are no longer needed. These problems may be an underlying reason for seeking a central VA nonprofit authority which perhaps would function as a private sector contractor to meet VA's fluctuating research staffing needs. However, in our view contracting with a central VA nonprofit may be problematic from the perspective of compliance with Federal hiring and contracting statutes and regulations. As a result, we encourage the Subcommittee to determine how VA and the central VA nonprofit would engage with each other.

It should be noted that to the extent allowed by law, NPCs already routinely help VA research facilities meet their temporary staffing needs using the Intergovernmental Personnel Act (IPA) authority (5 USC §§ 3371–3375 and 5 CFR part 334). This allows VAMCs to work with NPCs to acquire the services of skilled research personnel, who are considered to be VA employees for most purposes except pay and benefits, quickly and only for the time their services are needed.

5. Compliance with Federal ethics statutes applicable to Federal employees regarding conflicts of interest as well as membership on the board of directors and staffing by VA or non-VA personnel should be addressed satisfactorily before congressional approval is given.

It has taken over 20 years of regular consultation with VA policymakers, attorneys, and overseers; two modifications of the original NPC authority; and most recently, a thorough updating and clarification of the NPC authority, to resolve the many ambiguities inherent in the public/private partnership embodied in the NPCs. To avoid similar protracted uncertainty, a number of matters not addressed in the proposal should be resolved before the Subcommittee considers approving an authority for a central VA nonprofit.

For example, would VA personnel serve on the board of the central VA nonprofit? How much influence would VA personnel have over funding, management and expenditures of the central VA nonprofit? Also, how would potential conflicts of interest be addressed? It took VA and NAVREF many years to grasp the implications of the Federal ethics statutes, particularly those found at 18 USC § 208 and § 209, when applied to VA personnel associated with NPCs, and to manage potential conflicts. In our view, these questions should be fully answered in advance to avoid putting VA employees who may interact with the central VA nonprofit at risk of unwittingly violating Federal ethics statutes.

6. Congress should ensure that funds that could be appropriately managed by local mechanisms may not be directed to the central VA nonprofit.

As noted above, we firmly believe in the advantages of local administration and local accountability for VA research. Also, it is important to note that ultimately, every research project requires a PI and a site where the research is actually conducted. As a result, and assuming the central VA nonprofit would not have its own laboratories or patients, we are concerned that the central VA nonprofit may add an unnecessary layer of bureaucracy and administrative expense to VA research. Consequently, we feel there must be a compelling reason for a central VA nonprofit to administer a project as opposed to longstanding local mechanisms such as NPCs.

Additionally, we are having difficulty envisioning what "national medical research and education projects" VA would engage in that NPCs could not administer. VA's genomic research initiative has been cited as an example, but we have not yet fully grasped why a designated NPC could not accept non-VA Federal or private sector

funds made available for this initiative. Nor have we been able to discern how a central nonprofit would fulfill the regulatory requirements for local oversight of human subjects research.

Further, we encourage the Subcommittee to ask VA how the central VA nonprofit would allow VA to "compete for non-VA funding at a national level." NPCs and VA-affiliated universities have historically supported VA PIs in their applications for non-VA funding whatever the source, scope or amount. We are uncertain what funding "at a national level" means or what types of non-VA funding a central VA nonprofit could apply for that excludes applications submitted by VA PIs through NPCs or VA-affiliated universities. That said, if a central VA nonprofit were to compete for the same non-VA Federal and private sector research funding opportunities as PIs supported by NPCs, the result may be a reduction in NPCs' ability to provide much needed research infrastructure support at the facility level.

7. There must be sufficient justification for the substantial investment of funds and effort establishing a central VA nonprofit would require.

While we assume that statutory approval to establish a central VA nonprofit would also authorize startup funding from the R&D appropriation, we are concerned about the use of R&D appropriated funds for two reasons. First, allocating $200,000 for startup of a central VA nonprofit would take funds away from ongoing VA research. Second, the proposed budget of $200,000 for each of the first 2 years appears far too low, particularly if this nonprofit would be incorporated and managed in the Washington, DC area. Even if VA relied on VA attorneys and accountants to assist with incorporation and filing for exemption from Federal taxes, and VA provided office space, utilities and other government resources, a central VA nonprofit would require an executive director experienced in nonprofit establishment and management as well as skilled in research administration. Additionally, it is likely that a central VA nonprofit would require a bookkeeper experienced in nonprofit accounting and administrative staff. Annual salaries alone are likely to add up to far more than $200,000 during the first few years.

Also, 2 years seems to be a very short timeframe for the central VA nonprofit to become self-sustaining. It would have to charge funders for its administrative services as well as those of any organizations to which it passes through funds. VA should anticipate that some funders would pay little or no indirect costs and as a nonprofit affiliated with a Federal agency, its Federal indirect cost rate is likely to be relatively low because Federal agencies will not fund facility costs of another Federal agency. These factors clearly portend a much higher cost to the Federal budget than the unrealistic startup estimate noted in the proposed budget and continuing for a longer time period. In our view $400,000 for each of the first 3 years would be a more realistic estimate.

Conclusion

Strikingly missing from the central VA nonprofit's purposes is any discussion of how a central VA nonprofit would benefit veterans or further VA's research mission. We do not view serving as a "focus for interdisciplinary interchange and dialogue" among VA personnel and researchers from other Federal and non-Federal entities as appropriate justification for a central VA nonprofit. Rather, the ultimate test should be whether it would foster advances in treatments for conditions prevalent among veterans and high-quality care for the veteran population VA serves.

Again, NAVREF is unable to take a position in support of VA's proposal for a central nonprofit. If VA pursues such an authority, we hope that the above discussion offers the Subcommittee a framework for determining why such an authority is needed when there are already so many VA-affiliated nonprofits providing a wide variety of services in support of VA research and education.

Thank you for considering our views. Questions or comment may be directed to Barbara West, Executive Director, NAVREF, at bwest@navref.org or 301–656–5005.

POST–HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
March 9, 2010

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20240

Dear Secretary Shinseki:

Thank you for the testimony of Dr. Robert A. Petzel, Under Secretary for Health, at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "The Veterans Health Administration's Fiscal Year 2011 Budget" that took place on February 23, 2010.

Please provide answers to the following questions by April 20, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. VA requests $250 million in fiscal year 2011 for the Office of Rural Health. In 2009, there was $190 million in carryover funds which are available to be spent in 2010. Why is VA having difficulty spending this money? What steps has VA taken to ensure that resources are spent in a timely manner in the fiscal year that the funds were appropriated?
2. As you know, for fiscal year 2010, Congress provided an additional $30 million for the Medical Facilities account so that VA can open new CBOCs in rural areas. Does the fiscal year 2011 budget continue and expand on this effort? Also, please identify the total number of new CBOCs, be they new constructions or leases, that are supported by the fiscal year 2011 budget request.
3. It is my understanding that VA has implemented a systemwide screening for returning OEF/OIF veterans for depression, PTSD, TBI, and problem drinking. How much funding is requested in the fiscal year 2011 budget to continue this screening? To date, what are some key findings of this screening? For example, how many are screened positive and receive treatment?
4. How much funding is requested in the fiscal year 2011 budget to continue VA's suicide prevention hotline? How does this compare to what VA spent in 2009 and will spend in 2010? Also, what are the latest program data on the hotline?
5. In a June 2009 press release, VA committed to expanding the enrollment of Priority Group 8 veterans into the VA system by more than 500,000 by fiscal year 2013. How much additional funding is needed to fulfill this commitment in the outyears? Finally, what steps is VA taking to ensure that the expanded enrollment is implemented in a responsible manner so that it does not overwhelm the current VA health care system?
6. The President has committed to deploying an additional 30,000 U.S. troops to Afghanistan. Does VA have a clear sense of the numbers of deploying and returning servicemembers so that VA can plan properly for the VA health care system to meet the increasing health care needs? Please describe the nature and the extent of the coordination and communication between VA and DoD.
7. VA expects to provide over $4 billion to help homeless veterans in fiscal year 2011. Of this, $3.4 billion is for medical services and nearly $800 million is for specific homeless programs. Of the $800 million, a relatively small portion of funds is dedicated to prevention efforts. Please explain how prevention fits into VA's overall strategy to end homelessness among our veterans.
8. VA informs that investments in homeless initiatives in fiscal year 2011 will emphasize education, jobs, prevention and treatment programs. Please explain the details of the education and jobs investments.
9. The fiscal year 2011 budget includes several legislative proposals to help caregivers of veterans. This includes health coverage through CHAMPVA, travel expenses, and education and training. As you know, both the House and Senate passed caregiver bills. What specific population of eligible veterans and caregivers do the fiscal year 2011 legislative proposals intend to target?

10. With the funds requested in the fiscal year 2011 budget, VA expects to spend about $218 million for women veterans. This includes a new peer call center and social networking site. Please expand on the details of the call center and social networking site proposals.

11. What is VA's long-term strategy to improve the care provided to women veterans and how does the fiscal year 2011 budget request for women veterans fit into this long-term strategy?

12. During the past year, the Committee has become concerned over reports that there are problems in the implementation of the NDAA fiscal year 2008 and NDAA fiscal year 2009 sections regarding the joint establishment of the Defense and VA Centers of Excellence for Vision, Hearing, and Limb Extremity 'orthopedic injury.' We would like to know what VA staff has been appointed to these three centers, the budget for this year as well as fiscal year 2011–2012, and locations of these joint centers.

13. The Committee has been told that strong concerns over the organizational structure of these three Centers of Excellence have resulted in numerous meetings and delays in implementation. Where do the Directors and Deputy Directors report to, in both DoD and within VHA?

14. The 2011 budget provided $590 million for medical and prosthetic research, which is $9 million above the 2010 enacted level. However, this increase does not keep pace with the estimated inflation for biomedical research and development. Does this mean that VA will have to decrease staff and/or award fewer grants?

15. The 2011 budget includes a legislative proposal to create a central nonprofit corporation for VA research. It is my understanding that the VA already has more than 80 research and education nonprofit corporations, or NPCs. What could a central VA nonprofit do that the existing NPCs cannot? Please be specific in your response.

16. In an effort to better understand the need for the legislative proposal to create a central nonprofit corporation, I would like to know if there are opportunities for non-VA support for research that VA is unable to accommodate through its own authorities, through the NPCs or through VA-affiliated universities. If yes, please give specific examples.

17. Also related to the legislative proposal to create a central nonprofit corporation, I would like to know whether under the current law, regulations, or policies, there are specific impediments to VA research that central nonprofit is intended to overcome.

18. Of the $48.2 billion requested in fiscal year 2011 for the medical care accounts, about 80 percent of the funds are distributed to the 21 VISNs using the VERA General Purpose Fund and 20 percent is distributed to select VISNs for special programs and initiative using the VERA Specific Purpose Fund. In the fiscal year 2012 budget request, the projected funding distribution using the VERA Specific Purpose Fund decreases to about $290 million compared to the fiscal year 2011 request. It is my understanding that the VERA Specific Purpose Fund provides resources for special programs such as mental health and homeless grants. As these are priority initiatives, what is the rationale for decreasing the funding set-aside for the VERA Specific Purpose Fund?

19. After years of no major hospital construction, there are now a few projects in the pipeline scheduled for completion. I believe the first one is scheduled to open in 2012. At what point are budgetary arrangements going to be made to ensure activation or to bring them online? For example, if a facility is opening in 2012, would activation funds be included in the fiscal year 2011 budget?

20. Of the budget request for medical facilities, how much is for facility activation? How does VA develop the budget request for facility activation and how do you disseminate the facility activation funding? In other words, must localities apply for this funding or are the funds set aside for a defined list of facilities?

21. In 2010, resident engineers were funded from the GOE account. The 2011 budget requests $24 million to fund 140 resident engineers in the major constructions account, but these funds would be used to reimburse the GOE ac-

count. What is the rationale for requesting funding for resident engineers under the major construction account only to reimburse the GOE account? Why not keep the funding for the resident engineers in the GOE account? Also, how many resident engineers were funded in 2010 and please justify whether 140 resident engineers in 2011 is sufficient to oversee the major construction projects of VA.

22. The budget proposes $468 million for minor construction programs in 2011, of which $387 million is for VHA. This represents a decrease of $235 million from 2010. Please explain the proposed decrease in funding when VA facilities are aging and minor construction demands continue to grow.

23. VA requests about $1.3 billion for medical IT investments to develop the next generation health care system known as Health*e*Vet to enhance and supplement the current legacy system, VistA. This is a decrease of about $150 million from the 2010 level. In light of this focus on Health*e*Vet, what is the rationale for the decrease in funding in 2011?

24. Please provide an update on VA's collaboration with DoD to create Virtual Lifetime Electronic Records (VLER). How much is requested in the fiscal year 2011 budget for the VLER initiative and what is the full project cost in the out-years in fiscal year 2012 and beyond to fully develop and implement VLER?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by April 20, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record

Submitted by Chairman Michaud
U.S. House of Representatives Committee on Veterans' Affairs
Subcommittee on Health

February 23, 2010

The Veterans Health Administration's (VHA) Fiscal Year 2011 Budget

Question 1: VA requests $250 million in fiscal year 2011 for the Office of Rural Health. In 2009, there was $190 million in carryover funds which are available to be spent in 2010. Why is VA having difficulty spending this money? What steps has VA taken to ensure that resources are spent in a timely manner in the fiscal year that the funds were appropriated?

Response: Congress provided the Veterans Health Administration (VHA) Office of Rural Health (ORH) with $250 million in 2 year funds (fiscal year 2009/2010) for rural health care initiatives. Since December 2008, $213 million have been distributed to the Veterans Integrated Service Networks (VISNs) and VHA program offices. Of the $213 million allocated, $212 million has either already been obligated or is specifically identified for obligation before the end of Fiscal Year (FY) 2010.

There are several reasons why rural health care dollars have been delayed in obligation, which fall into three broad categories. First, the pool of qualified bidders willing to contract with Department of Veterans Affairs (VA) to provide health care in rural communities is limited. Second, identifying qualified employees in highly rural areas has proven difficult, and finding health care workers willing to move to isolated areas has also been a challenge. Third, identifying appropriate physical space for clinical activities in rural areas that meet privacy standards has been a challenge, as well. Frequently, the space has required significant alteration, thus causing delays in construction and obligating dollars for completion of these projects.

Please be assured, however, that additional project enhancements and/or new projects are currently under consideration, which will result in obligating the remaining $38 million before the end of FY 2010.

Question 2: As you know, for fiscal year 2010, Congress provided an additional $30 million for the Medical Facilities account so that VA can open new CBOCs in rural areas. Does the fiscal year 2011 budget continue and expand on this effort? Also, please identify the total number of new CBOCs, be they new constructions or leases that are supported by the fiscal year 2011 budget request.

Response: VA is committed to enhancing access to health care for veterans residing in rural and highly rural areas. On March 30, 2010, a Report to Congress was provided to the Committee on Appropriations of both Houses of Congress to detail an expenditure plan for the $30 million funding for community based outpatient clinics (CBOCs) in rural areas. VA has invested a total of $62.1 million ($30 million as directed and $32.1 million from rural health funding) in FY 2010 and is planning to invest $87.8 million in FY 2011 rural health funding for 51 of the FY 2010 activated CBOCs located in rural counties (see attached list of CBOCs and funding plan) for a total 2-year investment of $149.9 million. This investment will sustain the 51 CBOCs in 11 VISNs for the first 2 years of operation. The FY 2011 budget will continue the operation of the rural CBOCs, which were opened in FY 2010 and funded with the $30M. At this time, plans for any additional CBOCs in FY 2011 are part of an ongoing evaluation and assessment process to address the health care needs of our veterans.

Question 3: It is my understanding that VA has implemented a systemwide screening for returning OEF/OIF veterans for depression, PTSD, TBI, and problem drinking. How much funding is requested in the fiscal year 2011 budget to continue this screening? To date, what are some key findings of this screening? For example, how many are screened positive and receive treatment?

Response: No additional funding will be required as the screening activity is built into the existing budget. Cumulatively from the first quarter of FY 2002 through the fourth quarter of FY 2009 (the most recent complete data available) among Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans who have been treated at VA medical centers and clinics, 129,654 have been seen for at least a provisional diagnosis of post traumatic stress disorder (PTSD), 90,936 for depression, and 24,454 for alcohol dependence. These numbers represent veterans who have received a diagnosis from at least one provider during at least one clinical encounter. They should be considered to be provisional diagnoses that may have changed during subsequent encounters when more information became available.

An FY 2008 records review of a small representative sample of veterans from all service eras has data to address the question of veterans screened and referred for treatment. Of that sample, 7,231 veterans screened positive for the possibility of PTSD, and of that population 1,724 (23.8 percent) were documented as being positive for PTSD and referred for further intervention/treatment. The number of OEF/OIF veterans in the study sample was too small to be effectively broken out. The question of OEF/OIF veterans screened and followed up for treatment will continue to be explored using VA databases.

From April 2007 through December 2009, VA has screened 383,054 OEF/OIF veterans for possible mild traumatic brain injury (TBI). Of these, 71,158 screened positive for potential mild TBI and were referred for comprehensive followup evaluations. To date, 27,287 have received a confirmed diagnosis of having suffered a mild TBI; all are referred for ongoing treatment as necessary for their medical condition. Over 90 percent of all veterans who screen positive have been determined not to have suffered a TBI, but all who are screened and report current symptoms are evaluated and treated as appropriate for their condition and symptoms.

In FY 09, VA screened over 96 percent of eligible veterans for alcohol misuse with a validated screening measure and screening remains at 97 percent in FY 10 to date. Data on alcohol misuse screening prevalence and followup are available for 737 OEF/OIF veterans included in a FY 2007 national sample of VA outpatients randomly selected for standardized medical record review for quality monitoring. Age adjusted prevalence of alcohol misuse was higher in OEF/OIF men than non-OEF/OIF men (21.8 percent vs. 10.5 percent), but did not differ reliably within the smaller sample of OEF/OIF and non-OEF/OIF women (4.7 percent vs. 2.9 percent). Age adjusted rates of documented advice or feedback (31.6 percent vs. 34.6 percent) and referral (24.1 percent vs. 28.9 percent) were not significantly different between OEF/OIF and non-OEF/OIF men who screened positive for alcohol misuse. Overall, OEF/OIF men were more likely to screen positive for alcohol misuse than non-OEF/OIF men and approximately half of all those with alcohol misuse had documented counseling and/or referral to alcohol treatment.

Question 4: How much funding is requested in the fiscal year 2011 budget to continue VA's suicide prevention hotline? How does this compare to what VA spent in 2009 and will spend in 2010? Also, what are the latest program data on the hotline?

Response: Suicide Hotline budget for FY 2009 and FY 2010 are as follows:

FY 2009: $11,177,433
FY 2010: $15,068,350 (projected)

The increase from 2010 reflects both increased utilization of the program and enhancements to its activities, including growth of the online Internet chat service, and increases in services for active duty personnel. In general, staffing and costs for the hotline are based on projections of the demand for its services.

Question 5: In a June 2009 press release, VA committed to expanding the enrollment of Priority Group 8 veterans into the VA system by more than 500,000 by fiscal year 2013. How much additional funding is needed to fulfill this commitment in the outyears? Finally, what steps is VA taking to ensure that the expanded enrollment is implemented in a responsible manner so that it does not overwhelm the current VA health care system?

Response: VA's base budget request already includes funding for the expanded enrollment commitment. VA is closely monitoring observed demand for enrollment and patient access, and proposes expansion of enrollment based on the availability of resources to meet current and projected demand through subsequent relaxations of enrollment restrictions.

Question 6: The President has committed to deploying an additional 30,000 U.S. troops to Afghanistan. Does VA have a clear sense of the numbers of deploying and returning servicemembers so that VA can plan properly for the VA health care system to meet the increasing health care needs? Please describe the nature and the extent of the coordination and communication between VA and DoD.

Response: Due to operational readiness issues and sensitivity surrounding actual plans for military deployments, VA utilizes data from the Congressional Budget Office (CBO) to project the overall number of servicemembers that may seek care at VA in any given year. The VA enrollee health care projection model projects separate OEF/OIF veteran enrollment and utilization. The model is updated annually to reflect VA's most recent experience among the OEF/OIF veteran population. The overall FY 2011 and FY 2012 funding levels for medical care takes into account the impact of publically announced increases in troop deployment levels.

Question 7: VA expects to provide over $4 billion to help homeless veterans in fiscal year 2011. Of this, $3.4 billion is for medical services and nearly $800 million is for specific homeless programs. Of the $800 million, a relatively small portion of the funds is dedicated to prevention efforts. Please explain how prevention fits into VA's overall strategy to end homelessness among our veterans.

Response: Prevention is one of VA's six strategic pillars of intervention and services to end homelessness among veterans. VA will enhance prevention by offering grants to assist vulnerable veterans and their families; enhance health care and benefits to veterans involved with the criminal justice system; enhance street outreach and provide additional contracts with community providers who will help get veterans off the streets and engage them with appropriate services to end their homelessness. Below are four of VA's initiatives to prevent homelessness:

- **Supportive Services for Low-Income Veteran Families**
  Under the 2011 proposed budget VA will enhance prevention by offering more than $50 million for Supportive Service Grants for Low-Income Veterans and Families at 50 percent or less of area median income. This initiative will establish and provide grants and technical assistance to community nonprofit organizations to provide case management and supportive services for eligible veterans and their families to maintain their current housing and in cases where the veteran lacks financial capability to secure deposits, get them into permanent housing. This will include financial assistance to prevent veterans falling into homelessness. We expect to award funding in 2011 that will provide services for 22,500 veterans and families.
- **HUD–VA Homeless Prevention Pilot**
  Housing and Urban Development (HUD) and VA are initiating a prevention initiative which is a multi-site 3-year pilot project designed to provide early intervention to recently discharged veterans and their families to prevent homelessness. This collaborative effort will provide comprehensive community services for veterans and families and intensive case management by VA to provide needed health care and benefit assistance to eligible veterans. VA expects to spend $5 million to provide services to 200–300 veterans and families in 2011.

- **Programs for Justice-Involved Veterans**
  The prevention of homelessness requires a wide variety of efforts, including working with veterans who are being seen in the criminal justice system. The Health Care to Re-Entry (HCR) program aims to prevent homelessness by engaging veterans discharging from prisons and by providing linkage to VA services. VA also has a Veterans Justice Outreach program that provides direct linkage to veterans in drug, mental health, and veterans courts to offer appropriate health care services designed to get the veteran needed treatment that will prevent them from becoming homeless. VA expects to spend $12.6 million to provide direct services to more than 7,500 veterans in 2011.
- **Health Care for Homeless Veterans Contract Residential Care**
  VA's Health Care for Homeless Veterans (HCHV) program provides outreach services to more than 40,000 homeless veterans each year. HCHV is increasing resources and capacity at each VA medical center to realize the commitment to "no wrong door" by contracting with community partners who will provide comprehensive residential care for veterans who seek safe places to stay where immediate admission to a VA operated program is not available. VA expects to spend nearly $116 million and provide services to 12,000 veterans in 2011.

Question 8: VA informs that investments in homeless initiatives in fiscal year 2011 will emphasize education, jobs, prevention and treatment programs. Please explain the details of the education and jobs investments.

Response: Education and employment is another of VA's six strategic pillars in the continuum of interventions and services to end homelessness among veterans. VA is constantly striving to provide more supportive services through partnerships to prevent homelessness, improve employability, and increase independent living for veterans. We will do this by enhancing Compensated Work Therapy/Supported Employment (CWT/SE), Homeless Veterans Reintegration (HVRP) and the Vocational Rehabilitation and Employment (VR&E) Vet Success programs. Below are descriptions of these programs:

- **Compensated Work Therapy/Supported Employment (CWT/SE) Program**
  One of the key needs for many veterans is to return to gainful employment. Many veterans who have been homeless have years without productive employment. Many suffer with physical and mental issues that require them to participate in a therapeutic rehabilitative effort in order to once again be able to return to a position where they can become employment ready. The CWT/SE program is a therapeutic employment program targeted at veterans with significant health problems.
  VA currently offers CWT services at VA Medical Centers. Under our 2011 budget VA plans to expand CWT/SE services into the community by offering community-based staff that will target supportive employment opportunities for veterans with significant health problems. The availability of these services in community settings will increase employment opportunities available for veterans. VA plans to spend more than $29 million and provide community based CWT/SE services for 8,150 veterans in 2011.
- **Homeless Veteran Reintegration Program (HVRP)**
  The Department of Labor's (DoL) HVRP program is a key partnership with VA at the Federal level. DoL's Veterans Employment and Training Service (VETS) offers funding to community groups to get veterans back into gainful employment. VA aids this effort and works closely with DoL and its grantees to coordinate that needed health care and benefits assistance is provided. This close working relationship is beneficial to the veterans we mutually serve since employment opportunities, without addressing underlying health care and benefits, may produce gains that are not maintained over time.
  VA continues to partner with DoL and looks forward to working with them as they fund women-only HVRP programs and offer funding for Incarcerated Veteran Transition programs.

VBA Benefits

- **The Vocational Rehabilitation and Employment (VR&E) VetSuccess Program**
  This program is authorized by Congress under Title 38, Code of Federal Regulations, Chapter 31. The VetSuccess program assists veterans with service connected disabilities: to prepare for, find, and keep suitable jobs. For veterans with disabilities so severe that they cannot immediately consider work; VetSuccess offers services to improve their ability to live as independently as possible. Homeless veteran and those at risk of becoming homeless apply for benefits through VBA's Vocational Rehabilitation and Employment program.

Question 9: The fiscal year 2011 budget includes several legislative proposals to help caregivers of veterans. This includes health coverage through CHAMPVA, travel expenses, and education and training. As you know, both the House and Senate passed caregiver bills. What specific population of eligible veterans and caregivers do the fiscal year 2011 legislative proposals intend to target?

Response: With the passage of P.L. 111–163 "Caregivers and Veterans Omnibus Health Services Act of 2010" on May 5, 2010, VA is currently analyzing the legislation and determining the population of eligible veterans.

Those proposals include:

One proposal provides the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) benefits to caregivers without entitlement to other health insurance or coverage. This benefit would apply to one caregiver for each eligible veteran, provided that the caregiver meets all other CHAMPVA criteria.

The second proposal would provide travel benefits to the caregivers of veterans in a manner similar to that currently available to family caregivers of active duty servicemembers when the servicemember or veteran is receiving care for service related conditions. This proposal would only apply to the caregivers of eligible veterans with service after September 11, 2001.

- The third proposal would provide caregiver education materials for caregivers and individuals who support caregivers. The proposal assumes one caregiver per veteran would qualify.

The final proposal would provide that VA conduct a caregiver survey every 3 years to determine the number of caregivers, the types of services they provide and information about the caregiver.

Question 10: With the funds requested in the fiscal year 2011 budget, VA expects to spend about $218 million for women veterans. This includes a new peer call center and social networking site. Please expand on the details of the call center and social networking site proposals.

Response: The $218 million listed in the budget on page 1K–32, Volume 2 of 4, is for Gender Specific Health Care Services for approximately 186,000 unique patients. These services would include mammography and breast care, reproductive health care, including maternity services, and treatment for all female-specific diagnostic conditions and disorders. However, it does not include a proposal for a specific women veteran call center or social networking site. This will be addressed through a VA transformation initiative. Every VA medical center has a women veterans program manager designated to assist women veterans. In addition, VA currently uses *Facebook*, *Twitter*, *Flicker*, and *YouTube* to improve communication with all veterans, including women veterans, to help them access health care and benefits.

Question 11: What is VA's long-term strategy to improve the care provided to women veterans and how does the fiscal year 2011 budget request for women veterans fit into this long-term strategy?

Response: VA has continued long term strategic plans to enhance the provision of health care services to women veterans. The following elements from the plan are outlined as they relate to the FY 2011 budget request:

- **Fully Implement Comprehensive Primary Care for Women Veterans**
  - Staffing: Providers proficient in women's health.
  - Staffing: Support staff for care coordination within medical home care in women's health.
  - Facility Resources: Construction enhancements focusing on dignity, privacy and safety.
  - Equipment and Supplies: Necessary clinical enhancements to deliver primary care.
  - Training: Retrain providers to care for women veterans.
  - Communication: Effective internal and external communication about the care needs of women veterans.
  - Beginning with FY 2010, the VHA's New Model of Care Initiative supports the addition of primary care support staff, training, and some space configuration for women's health. In the FY 2011 budget request, general medical services dollars will continue to support the overall medical care provision for women veterans. In addition, the FY 2011 budget line item request for women veterans specifically increases the amount needed for gender-specific care, such as cervical and breast cancer screenings.

- **Develop a High-Quality Continuum of Health Care for Women Veterans**
  The strategic goal is to fully integrate specialty care services for women veterans at the facility level. In FY 2011, the requested budget will support Comprehensive Care Services for women veterans that includes:
  - Mental Health
  - Specialty Care
  - Emergency Care
  - Diagnostic Services
  - Tele-Health
  - Geriatric and extended care services
  - Women's health and wellness screening and prevention programs
  - Rehabilitation health (catastrophically injured women)

Question 12: During the past year, the Committee has become concerned over reports that there are problems in the implementation of the NDAA fiscal year 2008 and NDAA fiscal year 2009 sections regarding the joint establishment of the Defense and VA Centers of Excellence for Vision, Hearing, and Limb Extremity 'orthopedic injury.' We would like to know what VA staff has been appointed to these three centers, the budget for this year as well as fiscal year 2011–2012, and locations of these joint centers.

Response: National Defense Authorization Act (NDAA) of 2008 and 2009 establishes each of these as Department of Defense (DoD) Centers of Excellence. The legislation mandates collaboration from DoD "to the maximum extent practicable with the Secretary of Veterans Affairs" for the Hearing Loss and Auditory Injuries Center, and Vision Center. The legislation mandates that DoD and VA "jointly" establish the Center for Extremity Injuries and Amputation. VA has been steadily involved and working with DoD representatives to develop plans for these centers, and the registries associated with them.

The Vision Center of Excellence currently occupies temporary DoD space within the Washington, DC area. A congressional supplemental appropriation for DoD ($4.052 million) was approved for a permanent location at the Walter Reed National Military Medical Center in Bethesda, Maryland, with expected occupancy in fourth quarter FY 2011. VA has committed a total of six staff members for the Vision Center. The positions are currently supported for Deputy Director (detailed effective April 12, 2010), Chief of Staff (position filled), and a Blind Rehabilitation Specialist (detailed). A permanently hired Deputy Director and a Blind Rehabilitation Specialist have been selected, and are expected to begin third quarter FY 2010. VA is recruiting for the low vision research specialist (optometrist), administrative assistant, and biostatistician. Originally, the biostatistician position was going to be filled via DoD under a contract; however, VA just recently agreed to take responsibility for this recruitment and is in the process of developing a position description. Of the funding provided by Congress in FY 2009, VA allocated $6.9 million in the Medical Services appropriation for FY 2010 through 2014 and the funding for FY 2010 through 2012 is presented below. Cost for support of the Registry for FY 2010 is $1.7 million.

Budget	FY10	FY11	FY12
O&M	$1.1M	$1.1M	$1.5M
IT (Registry)	$1.7M		

Plans for the Hearing Loss and Auditory Injuries Center, and the Center for Extremity Injuries and Amputation, are still under development by DoD and have not yet been submitted to VA for review. Consequently, the level of support from VA will be determined when the plans are finalized.

Question 13: The Committee has been told that strong concerns over the organizational structure of these three Centers of Excellence have resulted in numerous meetings and delays in implementation. Where do the Directors and Deputy Directors report to, in both DoD and within VHA?

Response: For the Vision Center, VA staff report organizationally to the VHA Chief Patient Care Services Officer, through the VA National Program Directors for their respective disciplines; i.e., the VA National Program Directors for Ophthalmology, for Optometry, and for Blind Rehabilitation Service. VA staff functionally report to the DoD Executive Director for the Center. The DoD Executive Director currently reports to the Director of the TRICARE Management Activity, Under Assistant Secretary of Defense for Health Affairs.

Plans for the Hearing Loss and Auditory Injuries Center and the Center for Extremity Injuries and Amputation are still under development by DoD. VA continues to be involved in working groups with DoD representatives to assist in developing concepts of operations and plans for these centers and the level of support from VA with regard to budget and staff will be determined when the plans are finalized.

Question 14: The 2011 budget provided $590 million for medical and prosthetic research, which is $9 million above the 2010 enacted level. This increase does not keep pace with the estimated inflation for biomedical research and development. Does this mean that VA will have to decrease staff and/or award fewer grants?

Response: The increase in appropriations from FY 2009 ($510 million) to FY 2011 ($590 million) is 16 percent. The Office of Research and Development will be able to execute their mission without any adverse impacts.

Question 15: The 2011 budget includes a legislative proposal to create a central nonprofit corporation for VA research. It is my understanding that the VA already has more than 80 research and education nonprofit corporations, or NPCs. What could a central VA nonprofit do that the existing NPCs cannot? Please be specific in your response.

Response: This legislative proposal remedies several deficiencies associated with the use of local nonprofit corporations (NPC) in support of national research initiatives. It does so by minor modifications of the current law that strengthen accountability for national program operation by making the Chief Research and Development Officer and Chief Academic Affiliations Officer statutory members of the Board of the National Nonprofit, and assures that other members of the board serve under the same ethical and financial restrictions that govern board members for local NPCs. The Central NPC will not "compete" with local NPC's, nor operate in a manner similar to that of the Henry M. Jackson Foundation. Had that been the intent of the legislative initiative, a plan for disestablishing the local NPCs would have been proposed. It is expected that the Central NPC will often work cooperatively with the local NPCs, administering national research while each of them administers the particular part of the national study that is accomplished at its VAMC.

The nature of research has changed since 1988, with an increasing emphasis on interdisciplinary, large multi-site research. The VA is uniquely able to conduct this type of research because clinical care and research are under the same roof. Current NPCs work well with its current authority to manage studies in its specific jurisdictions, but the decentralized system does not allow VA to efficiently and effectively coordinate non-VA funded large multi-site research at a systemwide level, or to compete for non-VA funding at a national level.

A central NPC will be integral to the future of VA's Genomic Medicine initiative to develop a genomic database that links patient genetic information with longitudinal health outcomes using VA's electronic health record. Few areas hold as much promise for changing everyday practice of health care delivery. This initiative includes the Million Veteran Program to collect samples and health information, with longitudinal followup, on a million veterans—an effort that will be unparalleled anywhere in the world. It also includes nationwide studies to examine the genetic bases of mental health issues such as schizophrenia and bipolar disease. This initiative requires partnerships with other Federal and non-Federal research entities, for which a central NPC will be an essential enabler. VA's Genomic Medicine initiative is a national program whose activities will not be managed in a specific VAMC, so a central NPC without ties to a specific VAMC, as is required by current statutory authority, is crucial to the future of this program. Likewise, when VA Cooperative Studies leverage funding by partnering with industry partners, a central NPC would facilitate the dissemination of funding to the multiple coordinating centers and sites. While it is true that the Cooperative Studies Program has been able to operate within the current framework of local NPCs, its concern has been overwhelmingly with only intramural research funded fully through VA's research appropriation. Such funds are wholly managed within VA without assistance from the NPCs. When outside funds are needed or appropriated for national or multi-site research, the Central NPC will provide VA with a mechanism for obtaining, administering and overseeing such funds. Indeed, since the Chief Research and Development Officer and Chief Academic Affiliations Officer of VA will serve on the Board of the proposed Central NPC, the new arrangement will give VA, at the national level, the same level of oversight and accountability for NPC operations in support of national programs that local facility Directors now have for local NPCs.

The purpose of the Central NPC will be to: (1) act as a flexible funding mechanism for the conduct of national medical research and education projects under cooperative arrangements with VA, (2) serve as a focus for interdisciplinary interchange and dialogue between VA medical research personnel and researchers from other Federal and non-Federal entities and (3) encourage the participation of the medical, dental, nursing, veterinary and other biomedical scientists at VA in research at the national level that will be facilitated by the Central NPC for the mutual benefit of VA and non-VA medicine, veterans and the public.

The establishment of a central NPC also creates synergies with other efforts currently underway in VA to improve the health and well-being of veterans. This includes VA's development of a central Institutional Review Board (IRB) to streamline the IRB review process for large multi-site studies. This type of study, especially when supported by outside funding, is the type that a central NPC will better enable VA to conduct. The existence and authorities of the local NPCs would be unaffected.

Question 16: In an effort to better understand the need for the legislative proposal to create a central nonprofit corporation, I would like to know if there are opportunities for non-VA support for research that VA is unable to accommodate through its own authorities, through the NPCs or through VA-affiliated universities. If yes, please give specific examples.

Response: A central NPC can leverage VA funding by negotiating with non-VA funding agencies, such as National Institutes of Health (NIH), to support studies associated with large VA projects such as the Genomic Medicine initiative. It would be neither feasible, nor appropriate for a local NPC to take on this role on behalf of the entire VA research enterprise. A central NPC will increase VA's ability to compete nationally for funding from other Federal, industry and nonprofit research sponsors, by making VA's research program a more attractive collaborator. The central NPC will provide VA a more straightforward mechanism to work with other Federal and non-Federal research sponsors. It will further give VA more flexibility and leverage to execute interagency agreements with other Federal research sponsors, and to assure that VA's responsibilities under these agreements are appropriately executed with high-level program accountability. A central NPC will also provide VA with more flexibility and weight for collaborations with industry and nonprofit research sponsors. This is particularly relevant for large multi-site clinical trials where industry and nonprofit research sponsors must currently negotiate with several separate local VA-affiliated NPCs, which may result in the sponsors turning to other organizations to conduct the research.

The Central NPC should be in a more robust financial position than smaller local NPCs and would be able to enter into research agreements under the Federal Acquisition Regulation (FAR). Currently, smaller local NPCs are unable to afford to meet some of the requirements for subcontractors under the FAR, making research with the DoD through the Henry M. Jackson Foundation that now requires use of FAR contracts instead of grants, problematic for the smaller NPCs. Through economies of scale the Central NPC, after meeting the FAR requirements, would enter into one larger agreement on behalf of the affected VA sites and would fully administer the funds for any site where the local NPC was not able to meet the FAR requirements.

Additionally, the Central NPC will be VA's facilitator for collaborative research between VA and outside public and/or private entities which contain centers for excellence or leaders in various fields. Through the Central NPC, needed funds can be sought and raised for projects such as this which are of national scope and importance, in which VA might otherwise be unable to participate.

Question 17: Also related to the legislative proposal to create a central nonprofit corporation, I would like to know whether under the current law, regulations, or policies, there are specific impediments to VA research that central nonprofit is intended to overcome.

Response: By statute, local VA-affiliated NPCs cannot administer funds for large studies involving a number of VA sites and multiple VAMCs. They are limited to facilitating research and education at the one VA medical center (VAMC) at which they were created. The proposal will, first and foremost, permit the establishment of an NPC that is not affiliated with a particular VAMC, but which may operate in any or all VAMCs, including those in which there is a local NPC. This is the major change accomplished by the proposed legislation. It will allow VA research that is of national scale to be conceived of, facilitated, funded and administered on that scale and could usher in a new age for VA research. The proposed legislation will, in addition, grant VA limited new authorities not available under the current NPC statute and clarify others, by allowing: (1) VA to enter into Intergovernmental

Personnel Act agreements with the proposed central NPC; (2) VA and the Central NPC to enter into Cooperative Agreements with one another to conduct cooperative enterprises with non-appropriated funds; and (3) VA to provide appropriated funds and resources to establish the NPC. Although the Board of Directors of the Central NPC will include VA Central Office staff, the majority of Directors will not be government employees. Finally, the Central NPC will be explicitly defined as not an entity of the U.S. Government.

A central NPC will increase VA's flexibility in using non-VA funding. It will allow VA to adapt more quickly to changes in science by shifting the focus on non-VA funding and changing the scope of agreements with non-VA sponsors more easily. It will also increase VA's ability to carry over non-VA funds between fiscal years.

A central NPC will increase ability and flexibility to hire personnel. A central NPC will provide VA a quick and flexible hiring mechanism for professional, technical and/or clerical personnel as part of the cooperative agreements with the Central NPC. This will allow VA to quickly fill gaps in personnel that may be necessary to address rapidly emerging needs.

Question 18: Of the $48.2 billion requested in fiscal year 2011 for the medical care accounts, about 80 percent of the funds are distributed to the 21 VISNs using the VERA General Purpose Fund and 20 percent is distributed to select VISNs for special programs and initiative using the VERA Specific Purpose Fund. In the fiscal year 2012 budget request, the projected funding distribution using the VERA Specific Purpose Fund decreases to about $290 million compared to the fiscal year 2011 request. It is my understanding that the VERA Specific Purpose Fund provides resources for special programs such as mental health and homeless grants. As these are priority initiatives, what is the rationale for decreasing the funding set-aside for the VERA Specific Purpose Fund?

Response: When comparing FY 2009 and FY 2010 Specific Purpose funding one needs to consider the one-time congressional funding of nearly $1.5 billion. Specific Purpose funds actually increased over $1 billion when accounting for the one-time congressional add-ons in FY 2009 (see table below). From FY 2011 to FY 2012, Specific Purpose funding increases nearly $288 million.

Description	**2009**	**2010**	**Inc./Dec.**
VERA Specific Purpose Allocation to VISNs & Prgs	$9,380,011	$9,092,279	($287,732)
Less: Congressional Add-Ons (Non-Recurring)	($1,497,400)	($186,000)	$1,311,400
Total	$7,884,620	$8,908,289	$1,023,669
	2011	**2012**	**Inc./Dec.**
VERA Specific Purpose Allocation to VISNs & Prgs	$9,592,354	$9,880,125	$287,771

Question 19: After years of no major hospital construction, there are now a few projects in the pipeline scheduled for completion. I believe the first one is scheduled to open in 2012. At what point are budgetary arrangements going to be made to ensure activation or to bring them online? For example, if a facility is opening in 2012, would activation funds be included in the fiscal year 2011 budget?

Response: Funds for estimated activation requirements are included in each year's budget request. VA budgets an amount estimated to be sufficient to meet the needs of the VISNs that will be activating facilities and will have funding requirements in that year. This amount is based on projected major construction and major leases with occupancy dates for the current and following years.

Question 20: Of the budget request for medical facilities, how much is for facility activation? How does VA develop the budget request for facility activation and how do you disseminate the facility activation funding? In other words, must localities apply for this funding or are the funds set aside for a defined list of facilities?

Response: The budget request estimates $268 million for activations. The activation request is based on anticipated facility activations. While the funds are set aside for a defined list of activations, VISNs request these funds to ensure budget execution is synchronized with actual beneficial occupancy dates of the specific facilities.

Question 21: In 2010, resident engineers were funded from the GOE account. The 2011 budget requests $24 million to fund 140 resident engineers in the major constructions account, but these funds would be used to reimburse the GOE account. What is the rationale for requesting funding for resident engineers under the major construction account only to reimburse the GOE account? Why not keep the funding for the resident engineers in the GOE account? Also, how many resident engineers were funded in 2010 and please justify whether 140 resident engineers in 2011 is sufficient to oversee the major construction projects of VA.

What is the rationale for requesting funding for resident engineers under the major construction account? Why not keep the funding for the resident engineers in the GOE account?

Response: In 2011, resident engineer costs will be moved from the General Administration (GOE) appropriation to the Major Construction appropriation in order to directly link the funding for staffing requirements for major construction to the funding for the projects themselves.

The Major Construction appropriation will provide funding for on-site supervision, including resident engineers and other project administrative staff for VHA and National Cemetery Administration (NCA) major construction projects located throughout the country.

The Office of Acquisition, Logistics, and Construction (OALC) will use its GOE appropriation to transform itself into a 21st century enterprise facilities management system. Under this transformation initiative, OALC will provide increased local and regional on-site supervision and support for construction and leasing projects. Because the costs of resident engineers will be reimbursed from the Major Construction and Medical Facilities appropriations, OALC will use GOE funding to hire additional planning staff, project managers, contracting officers, real property officers and sustainment personnel.

This transformation effort will allow OALC to:

- Integrate facilities management functions to maximize life-cycle performance.
- Implement corporate-level management with a decentralized system of project execution.
- Assess and meet facility needs while reducing overall costs.
- Leverage core mission expertise for minor design, construction and leasing.
- Increase technical support for local facilities engineers.
- Increase return on facility investment.

How many resident engineers were funded in 2010?

The GOE appropriation provides funding for 129 full-time equivalents (FTE) in 2010, including on-site supervision and support. The Medical Facilities appropriation provides funding for 36 FTE in 2010.

In 2011, funding from the Major Construction appropriation is requested for 140 FTE, including on-site supervision and support. Funding from the Medical Facilities appropriation is requested for 62 FTE, an increase of 26 from the 2010 level.

Justify whether 140 resident engineers in 2011 is sufficient to oversee the major construction projects of VA.

The 2011 Major Construction budget request identifies 5 major construction projects with funding for construction. There will also be 39 projects under construction in 2011 using prior year funding. An analysis of the size and scope of the major projects requested and ongoing major projects indicate that 140 FTE are required to provide sufficient oversight. This is an average of only 3 to 4 people per site and includes administrative support necessary to effectively manage these projects. The number of staff required to adequately provide oversight varies based on the complexity and scope of the project. More staff are needed with increased complexity of the work, multiple shifts and multiple contractors. VA currently has several projects costing over $100 million, which require at least 5 resident engineers to oversee various aspects of construction—foundations, electrical, mechanical, plumbing, dry wall, etc. Insufficient staff can lead to poor quality work, untimely responses to requests for information from the contractor, which cause delays in completion and beneficial occupancy for veterans and increased claims. Inadequate staff can also slow the close out of contracts since staff must move to a new job before being able to fully finish the prior job.

Question 22: The budget proposes $468 million for minor construction programs in 2011, of which $387 million is for VHA. This represents a decrease of $235 mil-

lion from 2010. Please explain the proposed decrease in funding when VA facilities are aging and minor construction demands continue to grow.

Response: The 2011 minor construction request is the second largest amount the Department has requested for the minor construction program. (The largest minor construction budget requested was the President's 2010 budget at $600 million.) Historically, VA has requested $390 million for minor construction (2008–2010). This request is approximately 20 percent above this historical request level. In addition, the 2011 request includes $1.1 billion in the medical facilities account for nonrecurring maintenance (NRM). This is the largest request VA has ever made for the VHA NRM account. A significant portion of the VHA NRM account is used to address the repair and maintenance needs at VA medical facilities.

Question 23: VA requests about $1.3 billion for medical IT investments to develop the next generation health care system known as Health*e*Vet to enhance and supplement the current legacy system, VistA. This is a decrease of about $150 million from the 2010 level. In light of this focus on Health*e*Vet, what is the rationale for the decrease in funding in 2011?

Response: The $1.3 billion for medical IT investments includes not only development of Health*e*Vet; it also includes the sustainment of VistA Legacy and operational sustainment of medical center IT systems. The 2011 budget request provides development funding that is comparable to 2010; the estimated $150 million decrease is represented in the Operations and Maintenance portion of the budget request and should not affect the development efforts underway.

Question 24: Please provide an update on VA's collaboration with DoD to create Virtual Lifetime Electronic Records (VLER). How much is requested in the fiscal year 2011 budget for the VLER initiative and what is the full project cost in the out-years in fiscal year 2012 and beyond to fully develop and implement VLER?

Response: VA is collaborating daily with DoD on various aspects of the Virtual Lifetime Electronic Record (VLER). A number of lessons learned from the go-live January 31st date for the VLER Health Communities exchange of health information between DoD, VA, and Kaiser Permanente in San Diego, CA are being applied toward the planning of the next pilot deployment site in the Tidewater, Virginia, area. VA is working with DoD to determine the next several sites yet to be announced. Determining the next health data sets, collaborating on similar functionalities, and establishing a joint integrated master schedule through the Interagency Program Office are all activities underway.

There is $52 million in the FY 2011 President's Budget for VLER. This money will continue deployment and productization of the software solution created for the VLER Health Communities throughout the VA. It will also begin to address the overall enterprise architecture and systems integration required for the long-term strategy for VLER. Work is commencing in the VLER Enterprise Program Management Office (EPMO) to develop a multi-year funding profile for VLER that will identify and incorporate the initiatives required to meet the President's vision of VLER. It should be noted that the two Departments are not creating a new system, but leveraging existing initiatives that create the seamless integration of the information required for all service providers.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
March 9, 2010

Mr. Blake C. Ortner
Senior Associate Legislative Director
Paralyzed Veterans of America
801 18th Street, NW
Washington, D.C. 20006

Dear Mr. Ortner:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "The Veterans Health Administration's Fiscal Year 2011 Budget" that took place on February 23, 2010.

Please provide answers to the following questions by April 20, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. *The Independent Budget* estimates that it will cost about $252 million to care for an additional 75,000 new OEF/OIF veterans in fiscal year 2011. However, VA's 2011 budget submission projects spending about $600 million to care for an additional 57,000 OEF/OIF veterans. This means that the IB projects a faster growth in OEF/OIF veterans but estimates that it will cost less to treat these additional individuals. Please provide an explanation of the basis for *The Independent Budget's* projections.
2. *The Independent Budget* highlights two key policy initiatives for long-term care and prosthetics. There appears to be a disconnect between the critical issues that *The Independent Budget* identified for fiscal year 2011 in that neither long-term care nor prosthetics were mentioned in *The Independent Budget's* critical issues document. Please explain this disconnect.
3. *The Independent Budget* recommends $700 million for medical and prosthetic research in 2011. This is $119 million above the fiscal year 2010 enacted level and $100 million above the Administration's request. We recognize the importance of research and would like to better understand the basis for *The Independent Budget's* funding recommendation for medical and prosthetic research. In addition, are there particular research areas that you believe VA should target with your recommended increase in funding?
4. You recommend $300 million to address the research infrastructure deficiencies in fiscal year 2011. To clarify, is this request reflected in the $52 billion that *The Independent Budget* requests for the medical care accounts in 2011? Do you have alternate recommendations for addressing the research infrastructure deficiencies without creating a new appropriations account?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by April 20, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Paralyzed Veterans of America
Washington, DC.
April 1, 2010

Honorable Michael Michaud
Chairman
House Committee on Veterans' Affairs
Subcommittee on Health
338 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Michaud:

On behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to present our views on the FY 2011 budget for the Veterans Health Administration (VHA). 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 ensure that the Government Accountability Office (GAO) follows through on its responsibility as a part of the advance appropriations process. Only through cooperation between the veterans' service organizations and the Members of the Committee can we hope to attain a sufficient, timely, and predictable budget for the VA.

We have included with our letter a response to each of the questions that you presented following the hearing on February 23, 2010. Thank you very much.

Sincerely,

Blake C. Ortner
Senior Associate Legislative Director

Question 1: *The Independent Budget* estimates that it will cost about $252 million to care for an additional 75,000 new OEF/OIF veterans in fiscal year 2011. However, VA's 2011 budget submission projects spending about $600 million to care for an additional 57,000 OEF/OIF veterans. This means that the IB projects a faster growth in OEF/OIF veterans but estimates that it will cost less to treat these additional individuals. Please provide an explanation of the basis for *The Independent Budget's* projections.

Answer: Before providing an explanation of *The Independent Budget's* projections, we believe that it is first necessary to analyze the Administration's proposal. While the Administration recommends approximately $600 million to provide for 56,784 new OEF/OIF uniques, we do not fully understand how they came up with this recommendation.

Examining the Administration budget submission in more detail, we note that the Administration projects $2.575 billion in total expenditures for FY 2011 to address the needs of 439,271 total cumulative OEF/OIF unique users. This computes to approximately $5,862 per individual unique OEF/OIF user. However, taking the Administration's $600 million estimation and applying it to the 56,784 new OEF/OIF uniques suggests a cost per individual unique OEF/OIF user of $10,566. This seems to suggest a real discrepancy in their budget recommendations. Calculating a cost for new OEF/OIF unique users based on the actual cost per unique ($5,862) yields a real cost of approximately $333 million.

However, it is fair to conclude that they may have additional factors built into the budget recommendation. For instance, the cost per unique OEF/OIF user may also factor in things like prosthetics utilization, access to new mental health programs, or similar programs. Unfortunately, the Administration budget submission does not really provide detailed justification for its budget recommendations, and it certainly does not explain the difference between the apparent cost per unique ($5,862) and the cost for new unique users in FY 2011 ($10,566).

As for *The Independent Budget*, part of the reason our budget estimate is less than the Administration's recommendation is because we project an even lower cost per unique OEF/OIF user. That value is approximately $3,360. Our projection of 75,000 new uniques is based on the historical trend that year-to-year increases in new users have gone up over time, not leveled out or declined. In recent years, we believe the Administration has actually underestimated the year-to-year increases in new users. Our cost estimate of $252 million is based on this projection of new OEF/OIF unique users multiplied by our projected cost per user. Were we to use the apparent actual cost of unique OEF/OIF users ($5,862) according to the VA, the recommendation would actually be approximately $440 million.

Question 2: *The Independent Budget* highlights two key policy initiatives for long-term care and prosthetics. There appears to be a disconnect between the critical issues that *The Independent Budget* identified for fiscal year 2011 in that neither long-term care nor prosthetics were mentioned in *The Independent Budget's* critical issues document. Please explain this disconnect.

Answer: First, we believe there is no particular disconnect between the Critical Issues Report published last fall and the recently released *Independent Budget*. It is important to realize that the Critical Issues Report is meant to address broad, sweeping policy issues facing the VA. While overall funding for the VA, and the VA health care system in particular, is of critical importance, the individual components of the funding recommendations do not generally receive that level of attention in the Critical Issues Report.

Additionally, as explained in the introduction of the Critical Issues Report, that document is designed to alert the Administration, Members of Congress, VA, and the public to the issues concerning VA health care, benefits, and benefit delivery that we believe deserve special scrutiny and attention. The Report does not offer specific funding recommendations, but instead serves as a guide to policymakers so they can prepare for the coming budget debate in February and beyond. Through these efforts we believe VA is better positioned to successfully meet the challenges of the future. The Critical Issues Report also provides direction and guidance for the Administration and Members of Congress.

Question 3: *The Independent Budget* recommends $700 million for medical and prosthetic research in 2011. This is $119 million above the fiscal year 2010 enacted level and $100 million above the Administration's request. We recognize the importance of research and would like to better understand the basis for *The Independent Budget's* funding recommendation for medical and prosthetic research. In addition,

are there particular research areas that you believe VA should target with your recommended increase in funding?

Answer: For over 60 years, the VA research 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, and radioimmunoassay. The first liver transplant in the world was performed by a VA surgeon-researcher. VA clinical trials established the effectiveness of new treatments for 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. The "DEKA Arm," a collaborative invention involving VA and Department of Defense (DoD) scientists and private entrepreneurs, holds major promise for upper extremity amputees to regain normative activity.

To keep VA research funding at current-services levels, the program needs at least $20 million (a 3.3-percent increase over FY 2010) to account for inflation. Beyond anticipated inflation, additional VA 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 Freedom and Iraqi Freedom (OEF/OIF) veterans and others who were deployed to combat zones in the past; and (3) maximize use of VA's expertise in research conducted to evaluate the clinical effectiveness, risks and benefits of medical treatments. Thus, the IBVSOs believe an additional $100 million in FY 2011, beyond inflationary coverage, is necessary for sustained support of new VA research initiatives.

In fiscal year (FY) 2009, VA awarded more than 2,200 new grants to VA-based investigators designed to enhance the health care VA provides to veterans. Among other initiatives, VA researchers are currently:

- Developing new assistive devices for the visually impaired, including an artificial retina to restore vision.
- Working on ways to ease the physical and psychological pain of veterans now returning from two current overseas wars.
- Gaining new knowledge of the biological and behavioral roots of post traumatic stress disorder (PTSD) and developing and evaluating effective PTSD treatments.
- Developing powerful new approaches to assess, manage, and treat chronic pain to help veterans with burns and other injuries.
- Learning how to deliver low-level, computer-controlled electrical currents to weakened or paralyzed muscles to allow people with incomplete spinal cord injury to once again walk and perform other everyday activities.
- 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.
- 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 routine daily tasks such as using e-mail.
- Exploring organization of care, delivery methods, patient outcomes, and treatment effectiveness to further improve access to health care for veterans.

As for specific areas to direct funding, the IBVSOs would like to see added focus in two research areas. First, additional funding is needed to expand research on strategies for overcoming the devastating injuries suffered by veterans of OEF/OIF. Urgent needs are apparent for improvements in prosthetics technologies and rehabilitation methods, as well as more effective treatments for polytrauma, traumatic brain injury, injury to the eye (highly significant in this population, with thousands of potential injuries), significant body burns, PTSD and other mental health consequences of war, including depression and suicide risk.

Second, through genomic medicine VA is uniquely positioned to revamp modern health care and to provide progressive and cutting-edge care for veterans. 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 of millions of veterans to sustain important research. Innovations in genomic medicine will allow the 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.

In 2006, VA launched the Genomic Medicine Program to examine the potential of emerging genomic technologies, optimize medical care for veterans, and enhance the development of tests and treatments for relevant diseases. One of the main objectives of the Genomic Medicine Program is to create an expanded DNA sample biobank of veteran donors, which will be made available for carefully designed research that leads to improved treatment while protecting veteran privacy and safety. *The Independent Budget* believes that at least $25 million should be directed toward this initiative in FY 2011 to move this program forward.

Question 4: You recommend $300 million to address the research infrastructure deficiencies in fiscal year 2011. To clarify, is this request reflected in the $52 billion that *The Independent Budget* requests for the medical care accounts in 2011? Do you have alternate recommendations for addressing the research infrastructure deficiencies without creating a new appropriations account?

Answer: The research infrastructure recommendation is not included in the funding recommendations for the medical care accounts for FY 2011. The Major Construction account includes a $100 million recommendation to address the backlog of research infrastructure needs. Additionally, the Minor Construction account includes $200 million for research infrastructure needs. As explained in *The Independent Budget* for FY 2011, in recent years, funding for the VA maintenance and construction appropriations has failed to provide the resources needed by VA to maintain, upgrade, and replace its aging research facilities. Consequently many VA facilities have run out of adequate research space.

In the 2003 *Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan*, VA listed $468.6 million designated for new laboratory construction, renovation of existing research space, and build-out costs for leased research facilities. However, these capital improvement projects were omitted from the Secretary's final report on capital planning consequential to the CARES effort.

In FY 2008, the VA Office of Research and Development (ORD) began an as yet incomplete examination of all VA research infrastructure, for physical condition, capacity for current research, as well as needed program growth and sustainability of VA space to conduct research. According to an October 26, 2009, VA ORD report to the VA National Research Advisory Committee, surveys to date support the pilot findings: "There is a clear need for research infrastructure improvements throughout the system, including many that impact on life safety."

By the end of FY 2009, a total of 53 sites within 47 research programs will have been surveyed. Approximately 20 sites remain to be assessed in FY 2010. To date, the combined total estimated cost for improvements exceeds $570 million. About 44 percent of the estimated correction costs constitute "priority 1" deficiencies—those with an immediate need for correction to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and correct life-safety hazards. Furthermore, only six buildings (of 38 buildings surveyed) at five sites were rated above the "poor" range. Three of the seven buildings rated above "poor" were structures housing the main hospital. Five buildings that rated "poor" were main hospitals housing laboratories. It is time that dedicated resources are provided for research infrastructure upgrades to overcome these challenges.

A significant cause of the VA research infrastructure's neglect is that there is no direct funding line, nor any budgetary request made, for VA research facilities. The VA Medical and Prosthetic Research appropriation also does not contain funding for construction, renovation, or maintenance of VA research facilities. If the VA and Congress are unwilling to provide dedicated funding in a separate account for VA research infrastructure needs, then the Congress must ensure that adequate funding is appropriated through the current account structure, with particular emphasis on directing that funding to research needs.