DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2004

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

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DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2004

TUESDAY, FEBRUARY 11, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The committee met, pursuant to call, at 10:05 a.m., in room 334, Cannon House Office Building, Hon. Christopher H. Smith (chairman of the committee) presiding.

Present: Representatives Smith, Buyer, Stearns, Simmons, Brown of South Carolina, Miller, Boozman, Bradley, Beauprez, Brown-Waite of Florida, Renzi, Evans, Filner, Snyder, Rodriquez, and Michaud.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. I would like to welcome all of you to today's hearing, and I say thank you for coming out to members of the panel—we have three panels today—and to the members of the committee on both sides of the aisle.

Today, our Nation is poised to engage in another war to secure our freedoms, freedoms won and protected for over 200 years by millions of soldiers, sailors, airmen, and Marines. We examine the fiscal year 2004 budget for the Department of Veterans Affairs. As the second largest agency in the Federal Government, the VA employs over 220,000 people, most of them outside of Washington, DC, with an operating budget that will top $60 billion in 2004. VA programs touch millions of lives each year with benefits and services designed to rehabilitate those veterans injured from their service, and to help all veterans transition into healthy and productive post-service careers.

This year, about 2.7 million veterans will receive disability compensation or pension payments from the VA through the Veterans Benefit Administration. In addition, over 500,000 surviving spouses, children, or parents of veterans will receive benefits. Today, more than 3 million GI Bill home loan programs, home loans, are guaranteed by the VA, and 250,000 more are added each and every year, helping to make home ownership more affordable for former servicemembers and for their families. VA operates six life insurance programs with more than 2.1 million policies, and administers the servicemembers group life insurance and veterans group life insurance programs, which provide coverage to 3 million veterans, active duty military reservists, guardsmen, and their families.

Since 1944, the GI Bill College Educational Program has provided assistance to almost 21 million veterans. Legislation in the 107th Congress substantially increased the basic benefit by about 46 percent. VA has seen an increase in GI Bill utilization. More than 200,000 veterans will receive education and training under the GI Bill this year.

VA also contains the National Cemetery Administration, which operates 124 national cemeteries. About 100,000 veterans and family members are interred each year, and VA also provides headstones and markers for another 300,000 deceased veterans. Under the auspices of the Veterans Health Administration, VA runs the largest integrated health care network in the world. This year, VA will provide comprehensive medical services to more than 4.5 million veterans. VA health care is among the safest and most innovative in the world, having won numerous awards in recent years. At the same time, VA manages the largest medical education program in the country and will train more than 80,000 health care professionals this year. In fact, more than half of all physicians practicing in the United States today received at least part of their medical training through the VA.

Finally, the VA's medical research programs are world class, with with a $1 billion budget. Their cutting-edge research in prosthetics, post-traumatic stress disorder, Hepatitis C organ transplant, and hundreds of other crucial areas are world renowned.

I say all this because people in Washington are often in the habit of talking only about what is wrong, and rarely point out what is being done right. VA has much to be proud of, particularly under the leadership of Secretary Anthony Principi. In fact, the highly respected *Weekly National Journal* recently looked at the entire Bush cabinet and gave all of them grades. Secretary Principi was one of only four in the cabinet to receive an A. And I would point out that many, many fine things were said about him in that article, but the headline, I think, said it all, "A Standout." And Mr. Secretary, you indeed have been a standout. A true veteran's advocate and a combat decorated veteran himself, Secretary Principi has been the most effective Secretary ever to run this department. And I have been in here on this committee for 23 years, and I do believe that with all of my heart.

President Bush made an inspired choice when he chose Secretary Principi, whose reputation for personal integrity, intellectual honesty and professional persuasiveness are well earned. I am proud to have the honor of working with him on behalf of our Nation's veterans.

Although there is much to be proud of, we do have some challenges as we look ahead at this budget. The VA budget submitted for fiscal year 2004 begins another budget debate, in many ways, similar to ones that have occurred for many years. For those of us on the committee, I would like to put this budget in historical perspective. The Department of Veterans Affairs budget is primarily divided into two components, Veterans Health Administration, and the Veterans Benefits Administration, and one small component, the National Cemetery Administration.

The Veterans Benefit Administration is expected to provide more than $33 billion in entitlement programs to more than 3 million

veterans and spouses next year. Although the budget proposes almost no increase in funding for VBA, it projects that the Secretary's ambitious performance objectives related to the quality and timeliness of benefit decisions will be met in most categories. If these projections hold up, the Secretary, Admiral Cooper, and all those who have worked so hard to make it happen, deserve a great deal of praise.

The budget proposed by the National Cemetery Administration looks a little bit less promising. The NCA operates 124 national cemeteries, only 61 of which are fully operational. NCA has opened eight new cemeteries in the last 15 years, with five more expected to be opened in the next three. The budget projects good progress in opening these five new cemeteries, which Congress directed the VA to open in the Millennium Act. Unfortunately, the budget provides almost no additional funds to address the nearly $300 million maintenance backlog at VA's aging and closed secretaries. Last year we received a comprehensive and authoritative study of all the VA's national cemeteries, and the results were less than satisfying. Capacity remains uneven across the country, and many national cemeteries need significant repairs. And hopefully, working with the Secretary, we can do better.

Finally, the budget for Veterans Health Administration has been and remains the most vexing and contentious part of the VA's budget year in and year out. Looking back over the last 5 years, only one administration budget projected a match between health care funding and the expected need, and it turned out that that funding for that year was short by at least a half a billion dollars.

For the past 23 years that I have been in Congress and a member of this committee, the administration's proposed budgets, Republicans and Democrats alike, have all been starting points, not ending points, in determining funding to meet the health needs of our veterans around in this country. This year, I would respectfully submit, is no exception.

I would like to now turn to my good friend and colleague, Mr. Evans, for any opening comments he might have.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. Three months ago today, our Nation paid respect to all veterans. Three months ago today, the President spoke at Arlington National Cemetery on Veterans Day. He joined with all of us in celebrating the contributions of our veterans throughout the country. America must and will keep its word to those men and women who have given us so much. Veterans have been promised good health care when they are sick and disabled. They must be treated with fairness and respect.

Today, Mr. Secretary you will propose that the sacrifices of 50 percent service-connected veterans are no longer enough to receive the VA inpatient, long-term health care. I disagree. The VA has a funding shortfall of nearly $2 billion this year. There is no request for more funds. We are told access to VA care has improved because there are more community-based clinics. How many veterans are awaiting more than 30 days for a clinic appointment? We are

told of unprecedented efforts to improve VA/DOD cooperation. Tell us instead about the results and improved delivery of benefits and services to our veterans.

Congress is asked to provide $225 million in funding for CARES-related construction that is not yet identified. No funding is requested, however, for already identified CARES construction needs at the Chicago Westside. Plans have been made to close inpatient care at Lakeside, but no funding requested for Westside inpatient care construction. Costs of higher education continues to skyrocket, but there is no proposed improvement in GI education benefits for our men and women serving in uniform. VA has reported $280 million is needed to restore national cemeteries to national memorials. These funds have not yet been requested. The budget fails to adequately honor to fully value veterans' health care, for our Nation's veterans. This budget does not keep faith with our Nation's veterans. It does not adequately fund the benefits and services this Congress has authorized on behalf half of a grateful nation.

Mr. Secretary, my admiration for you is not lessened. I cannot, however, support your request.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

If members do have statements, we can submit them for the record. During the course of the hearing, since we do have three very long panels, we will operate under the 5-minute rule, and that goes for the Chairman as well.

I would like to welcome our first witness today, our good friend, the Honorable Anthony Principi, Secretary of Veterans Affairs. I am sure most people in this room know the Secretary's background. However, for those who don't, especially for our new members, here are some of the highlights of this career:

Prior to his nomination, Mr. Principi, Secretary Principi was president of QTC Medical Services, Inc., a group of professional service companies providing independent medical administration services and examinations.

Before this, he was senior vice president at Lockheed-Martin, and partner in the San Diego law firm of Luce, Forward, Hamilton & Scripps. Secretary Principi has worked on national policy issues and has held several executive level positions in Federal government. He chaired the Federal Quality Institute in 1991, and was chairman of the Commission on Service Members and Veterans Transition Assistance established by Congress in 1996. He also has no trouble getting around Capitol Hill, having served as chief counsel and staff director of both the Senate Armed Services and Veterans' Affairs Committees.

A graduate of the U.S. Naval Academy in Annapolis, and a combat-decorated Vietnam veteran, Secretary Principi first saw active duty above the destroyer USS Joseph B. Kennedy. He also commanded a river patrol unit in Vietnam's Mekong Delta.

Secretary Principi, you have served our Nation proudly and well, and we welcome you and look forward to your testimony.

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY HON. ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, HON. VICE ADMIRAL DANIEL L. COOPER, USN (RET.), UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS, ERIC BENSON, ACTING UNDER SECRETARY FOR MEMORIAL AFFAIRS, DEPARTMENT OF VETERANS AFFAIRS, HON. TIM S. McCLAIN, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS, AND HON. WILLIAM H. CAMPBELL, ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS

Secretary PRINCIPI. Thank you, Mr. Chairman. Thank you, Mr. Evans, members of the committee. It is a pleasure and a privilege to be here this morning. I thank you for the opportunity to present and discuss the Department's proposed budget for fiscal year 2004 with the members of the House Veterans' Affairs Committee.

I believe you can be proud of your unbroken record of advocacy for veterans and your oversight over VA stewardship of our Nation's programs for the men and women who defended our freedom. As you indicated, Mr. Chairman, we have so much to be proud of. We have many challenges ahead of us, but I think all of the progress that had been made over the years long before I came to the VA is because of the support and the advocacy that this committee has given to the VA and the veterans we have the privilege to serve. And when I say "your" in the last sentence, I refer to you both collectively and individually on both sides of the aisle.

The budget that we are submitting sets forth clear priorities. However, priorities necessarily call for choices. And where difficult choices are necessary, I have made them, and our budget identifies and acknowledges them. Comparing the proposed 2004 budget to 2003 is difficult, because in the fifth month of this fiscal year, we do not have an appropriation; we are on a continuing resolution. When I make comparisons to 2003, I will use the amounts proposed by the House and Senate Appropriations Committees because those are the amounts we hope to get. And again, I thank the members of this committee for their advocacy in getting us this increased appropriation. We hope that that will be resolved very soon in conference and to the President for signature.

If the Congress ultimately provides less funding, the increases I discuss this morning will be greater because they will be compared to a smaller base. But just as we would then have greater increases in 2004, so would we have greater challenges in 2003. This is a good budget in absolute terms, in percentage terms and in comparative terms. First the numbers.

In absolute terms, the President requests a total of 63.6 billion, 33.4 billion for entitlement program, and 30.2 billion for discretionary spending. It will fund treatment for more higher priority veterans than ever before. In 2004, we will be treating 2 million more veterans than we did when we went to open enrollment in 1996.

In comparative terms, the President is asking for a greater percentage increase for VA than he is asking for any other department of our government. For our dominant discretionary programs, VA

will commit an additional $2 billion to veterans' health care. In percentage terms, this represents an increase of 7.7 percent above what we hope to receive this year, and a 21.4 percent increase over the past 2 years. Approximately 500 million will come from increased insurance collections and co-payments, and 1.5 billion will come from increased appropriation of taxpayer dollars.

In addition, the budget shows approximately $950 million through management efficiencies. This committee frequently reminds me that VA leaves hundreds of millions of dollars on the table through procurement and not collecting insurance collections, and has encouraged and supported efforts to improve VA's business practices. I wholeheartedly agree with you. I believe that just in pharmaceuticals alone, by greater sharing and cooperation between DOD and VA, my procurement experts estimate that we can save $460 million over a period of time. That is a lot of money that we are leaving on the table, money that is not available to increase the reach of health care for our Nation's veterans.

Through better business practices, through better procurement reform, we can save dollars that can be used to provide more health care to veterans, and that is what we intend to do. That is why I established our business oversight board, directed construction of an information technology enterprise architecture, chartered a procurement reform task force to identify areas where we can standardize our procurement practices and do more national contracting, and placed a high priority on improving our collection of co-payments and insurance payments. We only collect 40 percent of the bills we send to insurance companies. We have submitted a proposal to direct HMOs to pay bills that we submit to them. To date, HM Os have refused to pay for the cost of care for those who are enrolled in HMOs. That is why I am comfortable with an aggressive, ambitious, but achievable goal for management efficiencies.

I will not hide from the fact that this budget assumes that VA will continue to sharpen the focus of our care on those veterans identified by Congress as having the highest priority, the service-connected disabled, the reason the VA was established. That is our primary mission, to care for him who shall have borne the battle. The lower income people left few options for health care and have to turn to the VA because they may not have insurance. They may be unemployed. And those who need our specialized programs, spinal cord injury, blind rehabilitation, and mental health. We project that we will treat 167,000 more of these veterans in 2004 than we expect to treat in 2003.

These veterans are my highest priority and have the highest priorities and stature. If someone took a bullet in Vietnam or in the Persian Gulf, or is somehow disabled by virtue of their military service, then I believe we must—we must give them the highest priority for care. They certainly have earned it and they certainly deserve it. There is no higher moral obligation in this country than to care for those who indeed have borne the battle.

With these increases, as I indicated, VA will care for 2 million more patients than we treated in 1996, when Congress made the decision to make every veteran eligible for, but not entitled to, comprehensive health care, including ambulatory care and prescription

drugs. I acknowledge that my recent decision to suspend additional enrollment of veterans in the lowest statutory priority group, priority group 8, set VA on a course through unchartered waters. I will monitor our outcomes very carefully to ensure that we don't overshoot the mark in bringing demand for care and resources into line so that we meets the expectation of veterans who enroll the 6.8 million and give them timely high quality care.

My enrollment decision does not mean that VA believes that higher income, nondisabled veterans are unimportant. They are very important. We have worked very closely with H H S to break down the barriers between Medicare and VA. Secretary Thompson and I have agreed in concept to a new program called VA Plus Choice so that any priority 8 veterans who cannot enroll in the VA can get their care from VA by enrolling in a VA+Choice program. And for the first time in history, Medicare will reimburse the VA for the cost of their care. I think that is a landmark decision. It came about by the pressure from Members of Congress and the veterans service organizations who believe that we were being shortchanged. I think this is a good program. I am hopeful that Dr. Roswell and his team will be able to work out the details of VA+Choice over the next several months and put the program into place at the beginning of the new fiscal year.

In addition to maintaining VA's high standard for medical care, the budget the President submitted to Congress will fund the Veterans Benefits Administration's continued progress toward achieving my goal of benefit decisions in 100 days, with no more than 250,000 cases in our working inventory. We are making progress, but we still have a long way to go. I am hopeful that we will achieve that goal later this year.

The budget also funds the activation of four new national cemeteries, the most aggressive schedule since the Civil War. And we will—a fifth cemetery we have requested activation funds—I am sorry—advanced planning funds so that we can open that cemetery in 2005.

Mr. Chairman, Mr. Evans, members of this committee, I appreciate your advocacy and I look forward to working with you in the challenging months ahead, and thank you very much for this opportunity.

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

Secretary PRINCIPI. Excuse me, Mr. Chairman. I didn't introduce the members of my team. May I do that, please? I am sorry.

Admiral Cooper to my far left is our Under Secretary of Benefits; Dr. Roswell, our Under Secretary of Health; Bill Campbell to my immediate right is our Assistant Secretary of Management; Eric Benson is our acting Under Secretary of Memorial Affairs; and Tim McClain is our general counsel.

The CHAIRMAN. Thank you, Mr. Secretary. And thank you for your presentation.

[The prepared statement of Secretary Principi appears on p. 106.]

The CHAIRMAN. Mr. Evans asked to speak out of order for a moment.

Mr. EVANS. Thank you, Mr. Chairman. I was remiss in my remarks not to mention the AFGE union folks today. They are as much stakeholders in this battle, Mr. Secretary. If they could all

raise their hands so we can see how many are here, that would be helpful. Thank you.

The CHAIRMAN. Let me just make a couple of observations. I noticed, and I mentioned this to some of my colleagues earlier today, that in addition to reading the VA's budget, which is a very detailed analysis of not only programs but also costs and estimates, also read the Independent Budget, which I think has been provided almost 2 decades, the 17th year, as they point out, by the VSOs, including the four, AMVETS, paralyzed veterans, disabled American veterans, and VFW. It provides I think an additional very fine blueprint of services or the lack of them within the VA.

A couple of good points are made about access to clinics. It points out that the VHA conducted a survey in July of 2002, which revealed 310,000 veterans waiting for medical appointments, half of whom must wait 6 months, and that the number dropped 235,869. The National Journal article points out that the benefits and the waiting time, as well as the backlog, which we all spoke about repeatedly, have dropped precipitously, although it is not cleaned up or cleared up, at least we are making progress. So I think the management of the VA is improved markedly, and we thank you for that.

I am concerned about a number of things. The mental health issue, for example. The Independent Budget makes the point, and I frankly concur with it, about the capacity issue which we envisioned in legislation we passed last year so there is uniformity and even-handedness of mental health being provided to our veterans. I think there are almost 500 million service-connected veterans who have a mental impairment—500,000. Sorry. 500,000. More exactly 454,000, for mental disability. And yet, from VISN to VISN, medical care center to medical care center, there are gaps. And I wonder if you might address that. And Dr. Roswell, I see you might want to take that one. And also the issue of homelessness, which is a very high priority to this committee on both sides of the aisle.

You know, we want to end homelessness within 10 years. That was the thrust of our bill. We want to know what resources are needed to do it. We laid out a plan, a blueprint, if you will, in our Homeless Veterans Assistance Act. Touch on that, please, and use the timer, if you would, for all of us just to get through, and then we will do a second round if we can.

If you could do those two first, Dr. Roswell and Secretary Principi.

Dr. ROSWELL. Well, thank you, Mr. Chairman. It is a pleasure to be here before the committee again.

With regard to mental health, we take that very seriously. That is a major condition highly prevalent in the veteran population. We do have a plan this year to significantly expand the way we do case management of the more seriously mentally ill patients. We have recently implemented a model of care called the Mental Health Intensive Case Management Program that is a community-based, interdisciplinary program that addresses the most seriously mentally ill patients, but allows them to live independent of an institutional care setting. That, coupled with the newer atypical antipsychotic drugs has really allowed us to achieve a much higher functional level and quality of life for veterans with serious mental

illness. I am pleased to report that over the next 24 months we will be opening an additional 24 new mental health intensive case management programs to greatly expand our capacity to provide serious mental illness care. We are also working with our Serious Mental Illness Advisory Committee to look at other ways we can expand care in a noninstitutional setting.

I would say, as a matter of note, that the CARES process that looks at our capacity and projects its needs in 2012 and 2022 projected a much lower than anticipated level of outpatient mental health services. Because we had strong reservations about the serious need for outpatient mental health, we actually pulled those data and are currently reanalyzing them in concert with an actuary, an external consultant, and our serious mental illness committee to better determine that. So I think you will be very pleased with the progress with mental health across the VA.

With regard to the homeless program, a lot has been done. One of the problems has been looking at people's ability to submit grants timely and of sufficient merit that we can make an award. This year, we are providing $750,000 in technical assistance to people who wish to submit a grant for a per diem program or a homeless program. We are also adding 2½ million dollars to improve life safety concerns in existing facilities. In addition to that, this year we have extended and will continue into 2004 dental care benefits for homeless veterans at an estimated annual cost of between 12 and $13 million. We have also made $5 million available through a cooperative venture with the Department of Health and Human Services and HUD. So, a great deal is going on with our outreach to homeless veterans.

Secretary PRINCIPI. I would just add that the two components, the treatment component which I think is very important to address the underlying medical behavioral concerns that veterans have, and every year for the past couple of years, we have added about $100 million to the base. So we are about 1.3, $1.4 billion in treatment for those with chronic mental illness and other types of problems. I hope that by the end of this fiscal year, we will add 1,500 to 2,000 new beds through the grant and per diem program. And that will address the special populations of those with mental illness as well as women veterans, because we see a sizeable number of women veterans who are homeless, and we have to address their concerns as well.

The CHAIRMAN. I notice in the long-term health care issue, especially the number of beds; last year the indication was we needed about 17,000 over the next decade to accommodate a growing need. If my understanding is correct, we will see a cutoff of about 5,000. What could be done on that, Mr. Secretary?

Secretary PRINCIPI. Mr. Chairman, I very much appreciate your concerns about long-term care, and of course we are trying to balance the needs in the long-term care area with the acute care needs and the outpatient care needs, the homeless care needs, and with a constrained resources we are really trying to pursue expanding the noninstitutional care programs. We have found that many veterans, elderly veterans would like to stay in their own home rather than be institutionalized in a nursing home, and we have lacked comprehensive noninstitutional care programs to allow that.

So our budget proposes to increase the non-institutional care programs so that we can reach many, many more veterans, increase our funding to the State homes, nursing homes as well. But it is an issue that we need to work with you to ensure that we are addressing the long-term care needs of our veterans.

The CHAIRMAN. Ranking Member Evans.

Mr. EVANS. Mr. Secretary, you indicated that about 40 percent of the insurance, only 40 percent of the insurance is coming back to pay for the VA clinics and so forth. What can we do to improve that?

Secretary PRINCIPI. I think it is a multifaceted approach. First, I would say, Mr. Evans, and I know you are very concerned about this as I am. I think we have made some good progress over the past 2 years. In 2002, we achieved 112 percent of our goal in collections from insurance companies. In 2003, at this point in time, we are slightly over $400 million, 96 percent of our goal, with a third of the year gone. I believe we can hopefully achieve our goal in 2003.

For 2004, we have got a lot of work ahead of us. We have got to—first of all, we have to identify veterans who have insurance. Sometimes we are not very good at getting that insurance information from veterans. We need to do better. We need to do a better job of installing software that enables us to better process, more accurately do coding and billing, which we are doing, and more training. There are so many different areas of this program that we need to improve. But we have a new revenue office, and their responsibility is to maximize our collections. We have the legislation proposed to require HMOs to pay the VA for the cost of care. So I think it is a combination of things.

Dr. Roswell, do you want to add anything to that?

Dr. ROSWELL. Well, I certainly agree with the Secretary.

Let me point out, Mr. Evans, that in addition to the inability to collect from HMOs, for which we have proposed a legislative remedy, we also are required to bill Medicare for the full cost of care in order to be able to collect from a Medigap insurer for veterans who have Medicare. And that artificially lowers our collection ratio. So while 40 percent collections on billed services sounds like an abysmal collection record, in fact, it is not comparable to the industry standard, because we are forced to bill Medicare and HMOs knowing full well that we can't collect. I think the legislative initiatives will greatly rectify those problems.

I would also point out that the 2003 collection goal has been increased this year by a full 34 percent. So, being just at 96 percent of that goal represents a remarkable increase over last year's collection effort of over $1.1 billion.

Mr. EVANS. I understand your son is here, Mr. Secretary.

Secretary PRINCIPI. I am sorry, sir?

Mr. EVANS. I understand your son is here today, and I am sure you would like to recognize him.

Secretary PRINCIPI. That is my son, John. He is my youngest of three sons. The other two are in the military overseas, and John is probably going to join them shortly. So I appreciate his being here and I appreciate your recognizing him. Thank you, Mr. Evans.

The CHAIRMAN. Chairman Buyer.

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Before I begin, Captain Benson, we are well aware of your son having experienced combat in Enduring Freedom and his loss in an aircraft accident. And having a son myself, I can't sympathize, I can only empathize. And we have you in our thoughts when you lose a son.

Mr. Secretary, I am in deep struggle over this whole issue on eligibility reform. And I feel as though I am almost exhausting my breath, so I will talk to anybody who will listen. So when I tried to share with the new colleagues of what Congress intended to do back in 1996 and where we are today, you know, I just said enough is enough. Facts are stubborn things. You can shade it, you can color it, you can spin it, you can use rhetoric. But facts are very stubborn things. I want to welcome all the members and whoever in the community wants to go back to the record. Look on the July 18, 1996, the report, the committee report when we did eligibility reform. It is fascinating. You see, the GAO and the CBO were warning Congress about the eligibility reform, but Congress wouldn't listen, as if this committee itself had its own ideas. Even PVA, interesting, when you read and hear PVA's testimony, it stated that there wouldn't be a run on the system. Shocking!

They kept using quotes back then called the new demand. The new demand. Let me read something out of this. I am curious about your comment. You see, back then I guess Congress said, well, we don't like what CBO and the GAO are testifying to, so maybe just in case if we are wrong, let us make sure that we give some tools to the Secretary.

So, what was the intent of Congress? We said that with respect to the, quote, new demand, which nobody could really estimate what this new demand was going to be when we did eligibility reform, said, therefore, the reported bill gives VA, you, new tools, both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by private health plans.

Boy, that is pretty clear. This committee wrote that as legislative intent. Yet, you know, members will attack you; yet, we opened the door, veterans rush in, GAO warned us. GAO warned us and gave us their testimony—gave us their testimony and said this is going to happen. And as a matter of fact, Congress, when you open that door and if you don't fund it, you are going to force the Secretary to make tough choices, who may even then have to, quote, ration care, and everybody opens with their criticism, even the critic that lurks in the shadow and has no courage.

So, let me ask this question, Mr. Secretary. How many of those veterans out there, seven out of ten, six out of ten, nine out of ten, have a private health plan, who then are also category 7 or category 8, making a run on the system and placing in jeopardy the priority of care to a disabled veteran?

Secretary PRINCIPI. Certainly almost 50 percent of the veterans in categories 7 and 8 who come to us for care have Medicare coverage as well as—okay. So, 53 percent of us are coming to us for drugs only, and roughly 50 percent are enrolled in Medicare. And the number who are enrolled in insurance companies—do you have that figure?

Dr. ROSWELL. It is a substantial number. Over 80 percent of the total number of veterans have other insurance. When we have actually done reliance data to look at how many veterans rely in total on the VA health care system for the entirety of their health care needs, it is a very small percentage. It is limited primarily to category 1, those veterans with a service connection disability 50 percent or greater.

Mr. BUYER. Many are making the runs for the medication. Is that correct, Mr. Secretary?

Secretary PRINCIPI. That is correct.

Mr. BUYER. It is also, we note in here—this is reading right from the record: "it is critical to note that H.R. 3118, like existing law, would not permit the VA simply to serve as a veterans' drug store, providing medications, prosthetic devices, and other medical care prescribed by a private physician who has no affiliation or contractual relationship with the VA."

That was Congress's intent, for you not to be the drug store. So, Mr. Secretary, when you get a chance—and I know you have got a lot on your plate—go back and read this. This is very interesting reading about Congress's intent when we passed this law and where we are today and how the VSOs are trying to turn this into something that was not envisioned by Congress. I yield back.

The CHAIRMAN. Dr. Snyder.

Mr. SNYDER. Mr. Filner?

[The prepared statement of Congressman Filner appears on p. 98.]

The CHAIRMAN. I would just observe to the committee that unless you wanted to yield to Mr. Filner, when the gavel goes down, whoever is here, we go in order. That is standard operating procedure on every committee of the House.

Mr. SNYDER. Thank you, Mr. Chairman. I didn't want to offend—Bob doesn't have anything to do now that his cell phone can't operate during committee hearings. So. Thank you.

Thank you, Mr. Secretary, for being here.

And Mr. Chairman, I want to say I sometimes get discouraged by what happens on committees when the committee reports come out from the staff because both sides seem to be—put out a rapidly parsed document. But this seems to be a really good document, and I appreciate the staff's effort.

Mr. Secretary, I don't know if you have seen this, but it was put out by the committee staff. But on page 3 of this committee report, which you probably haven't seen, it says—and it was talking about the budget: In response to questions from staff of the committee, VA has conceded that it will be hard pressed to deliver timely care to all enrolled veterans with the funds requested in the 2004 budget.

Do you agree with that, hard pressed to deliver timely health care to all enrolled veterans with the funds requested in the 2004 budget?

Secretary PRINCIPI. No, I don't think so. I think with the—if we get the appropriation that we expect for 2003, with the plus up of $1.1 billion, and our request for 2004 with the policies that are in them, I believe that we can eliminate the backlog by the end of this fiscal year, the waiting time, so that every veteran who comes to

VA will be seen by a primary care doctor within 30 days, a specialist within a reasonable time thereafter, 45 days or whatever is appropriate within the community. And I believe that the combination of the increase, we achieve our goals in medical care cost recovery, our efficiencies, that the combination, we would be able to do it. Tough, but I think we can get there.

Mr. SNYDER. There are a fair number of ifs there. One of the challenges we have is that we all have our own sources, obviously the committee staff does. And, you know, when you talk about management efficiencies, it is just hard to believe that there hasn't been a determined effort in the last decade to do a lot of these management efficiencies and somehow it is going to be achieved this fiscal year when it wasn't in others. And that is part of the challenge. But I appreciate your efforts.

Secretary PRINCIPI. But I just don't think we have made a bonafide effort. I mean, I think we have tried, but there is so much more that can be done.

Mr. SNYDER. I understand. The issue of requiring payment from HMOs. And, you know, HMO, it is like we have created a new three-letter curse word in the last few years in this country. But to—and I am not a member of an HMO. But if I as a veteran sign up for an HMO, I do it with the understanding that I have probably a limited group of private doctors for me to go and seek health care, and probably the same with regard to a list of hospitals.

And if we pass legislation that says that the VA can go after HMOs, essentially, you know, this contractual agreement between the HMO and the veteran, isn't that going to distort the pricing that HMOs are basing their—whether or not—I mean, I would think it would have to be an increase in HMO insurance rates if it turns out the Federal government can say, yeah, all your veteran members, we are going to go—we are going to give you additional costs if they choose to come to us rather than go to their primary care network of the H MO.

Secretary PRINCIPI. Let me ask Dr. Roswell.

Dr. ROSWELL. The point is well taken. I think that we would not seek full reimbursement for a network provider rate. We would seek a discounted rate for out-of-network care. But many times a veteran of necessity because of limited abilities is forced to leave the HMO coverage and seek care from the VA. And——

Mr. SNYDER. All HMOs—and I don't mean to beat a dead horse here. I am just concerned about pricing of H MOs. We can try to do one thing to help your financial problem, and insurance affordability is a tremendous problem in this country. But I mean, HMOs and primary care places, they do have clauses in terms of emergency and that kind of thing. But that is not what you are talking about, I don't think. I think you are talking about somebody decides that, by choice, I am not going to go to Dr. X down the way because there is a co-pay, and I can get my drugs cheaper. I am going to come to the VA. And you end up hospitalizing them, and then you go into the HMO when it was not an emergent situation. I think that is a different situation. Is it not?

Secretary PRINCIPI. I would hope if our rates are comparable to other providers in the PPO, as Dr. Roswell said, a discounted rate,

then there shouldn't be any—I would think there should be no increase in insurance premiums. That is my hope.

Mr. SNYDER. See, I guess my family practice background is coming out here. My dealings with insurance companies is they don't just magnanimously step forward and say, you are right, we are going to send you a whole lot of money when we are under no legal obligation to do so.

Secretary PRINCIPI. Well, that is what has happened. And they have said—they have collected the premiums from veterans and they have sent the veterans to get care from the VA, including their prescriptions. And then we bill them, and they deny payment.

Mr. SNYDER. I understand. The issue on the long-term care beds—and I understand, I applaud your efforts to try to come up with what is best for the veteran and the veteran's family needs, whether it is home health care or supportive services or whatever it is, not just an institutional bed. But part of your—the part that—Mr. Chairman asked about the 5,000 beds, though. It is also a 70 percent—I mean, you are just establishing a cutoff, are you not, from those who would be eligible? What is current law versus what you would like to do with regard to eligibility? It is not just graciously we are stepping forward to find the best kind of care. We are going to cut some people clearly off. Are we not?

Secretary PRINCIPI. Well, first of all, anybody who is currently in a nursing home bed, that bed is not going to be taken away.

Dr. ROSWELL. Just to briefly capsulize it. The eligibility reform legislation that Mr. Buyer referred to creates the uniform health care benefits that is available to all enrolled veterans. Long-term care is not a part of that uniform health care benefit. It is offered by the Secretary on a discretionary basis as resources permit. Currently, law also requires and actually mandates that 70 percent service-connected veterans or greater who require long-term care have that provided by the VA.

We propose with the policy changes in the 2004 budget to honor that requirement to provide any and all long-term care for 70 percent service-connected veterans, but to begin to look at a full continuum of care for veterans with less eligibility.

Mr. SNYDER. My time is up. So the 70 percent is, in terms of eligibility, there is no change? You are not proposing a change?

Dr. ROSWELL. No.

Mr. SNYDER. Okay. That is helpful. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Would the gentleman yield? It is my understanding that the law also prescribed 13,500 beds. So there is a loss there.

Secretary PRINCIPI. That is correct.

Dr. ROSWELL. That provision of the law would not be met.

The CHAIRMAN. So that is a challenge we face going forward. Thank you, Dr. Snyder. Chairman Brown.

Mr. BROWN. Thank you, Mr. Secretary, for coming today and to enlighten us on some of the needs around the Nation and some of the ways you are going to be addressing those needs.

My question is, and I know you made real progress in implementing short-term recommendations of the 2001 Claims Processing Task Force, but I am concerned about the medium and long-

term recommendations. How much more money would VBA need in 2004, for example, to hire nurses and other medically-trained individuals to work on compensation claims, to establish a more permanent claims training cadre and to outbased rating specialists at 70 of the largest VA medical centers?

Secretary PRINCIPI. Mr. Chairman, we would need an additional $30 million, approximately $30 million to bring on the additional staff, the RNs, and to have outplacement at our medical centers.

Mr. BROWN. Thank you, sir.

The CHAIRMAN. The gentleman has concluded?

Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. And let me, first of all, thank you, Mr. Secretary, because I know—and I really believe that you have been out there doing and working hard for our veterans, and I do want to thank you for the hard work that you do. And I guess I am just going to appeal to you and to appeal to the administration and to—on the Republican side, is that we really need to—because, once again, The Washington Post talked about an 11 percent increase. And, once again, I felt, my God, you know, it is about time. And then I looked at the numbers, and I know that almost, what, 3.2 billion come from the veterans themselves in terms of co-payments and that kind of thing.

Somehow we need to—and once again, I am going to ask, you know, because I am not the one voting for the tax cut. So I am going to ask you, as a priority item, you know, when you look at voting out there, we need to see, maybe the Republicans can meet with the administration here, see if we can get some additional resources for our veterans. We know that the numbers are going to just increase because they are reaching that age. So I don't know what else—because I know the Democratic side didn't do it, and you guys are presenting a good, you know, presentation in terms of the numbers being there. But you know that they are not there. So we have got to see how we can work together to make this happen.

You know, you are saying that it was never meant to provide prescriptions, the VA. Well, Mexico was never there to provide our prescriptions, but people are going there because there is a need and they can't afford it. And I have got buses going from San Antonio to buy prescriptions in Mexico. And so wherever they are going to get it, they are going to try to get that access to health care. And so I wanted to touch base with you briefly and just appeal to you in that area, see what you can do. Because, and once again, I am not going to vote for that tax cut because I don't think that that is a priority when we have got too many other items on the agenda.

And I hope you think seriously about that when you do that, and just ask to maybe put the squeeze on the administration, whatever. I know we tried to do it when we had our secretary there. And I have to admit, he wasn't half of what you have turned out to be, and you have been a great person and so I want to thank you.

[The prepared statement of Congressman Rodriguez appears on p. 92.]

Mr. RODRIGUEZ. In the area of mental health, you mentioned 24 new programs. How many hospitals do we have out there? Three hundred something total hospitals?

Secretary PRINCIPI. 163 hospital, 664 outpatient clinics.

Mr. RODRIGUEZ. How widespread is case management for the mentally ill? You mentioned 24. I don't have any idea what that means.

Dr. ROSWELL. Case management is a widely used technique in our——

Mr. RODRIGUEZ. I know about the technique. I am a social worker; I am a case worker by profession, and I was a mental health care worker. So I need to know the numbers and how widespread that actually is when you say 24.

Dr. ROSWELL. 24 is in addition to the current one. This particular model of care, the mental health intensive case management, has currently been used primarily in larger metropolitan areas where there is a greater density of veterans who need that care. We believe it has great applicability and are expanding it. I don't know the exact number.

Mr. RODRIGUEZ. You don't know the exact number of actual case workers or how many they are going to be serving?

Dr. ROSWELL. The typical MHICM program serves approximately 30 clients. So, 24 times 30 would be the additional capacity through this new program.

Mr. RODRIGUEZ. So we are looking at a very minimal expansion in comparison to what the need is.

Dr. ROSWELL. That is correct. The expansion is incremental. We don't anticipate that that is going to be sufficient. That is why we are looking at another case management model that is not as resource intensive as the MHICM model, and our serious mental illness problem.

Mr. RODRIGUEZ. But I want to stress the fact that those case models are still more cost effective than actual 24-hour placements. So that, in the long term, we are saving money. And we are also—it is a quality-of-life issue. So I really believe in the case work model concept.

Dr. ROSWELL. You are absolutely correct. I totally agree with you. I have been told that we have 71. So the 24 would bring the total to 95 programs. And again, that won't meet the entire need. But we also need to recognize that this particular model of care may not be applicable in certain settings where the prevalence of serious mental illness is not concentrated, which is why we are working with the serious mental illness committee as well as an external consultant to begin to look at how we can expand case management beyond these intensive management programs to other settings.

The Secretary mentioned we have over 600 outpatient clinics. Mental health is a significant component of most of those, and we are working to expand that in all of those locations as well.

Mr. RODRIGUEZ. Mr. Secretary, I know we haven't talked about this, but that 112/Project, those projects that we denied that had occurred in the 1960s and 1970s, where we have identified about 40 something projects that had impacted veterans that we used a combination of chemicals and other stuff on our own troops. We

had identified about 5,000 veterans that had been impacted. Where are we at on that?

Secretary PRINCIPI. That is exactly right, Mr. Rodriguez. We have identified 3,100 letters to veterans identified by DOD. We know that there were 134 tests, 48 confirmed as conducted. And to date we, VA—DOD has provided the VA with over 5,000. And of the 5,000 names we have, we have correct addresses for about 3,000. We have sent them letters. We are continuing to try to track down the other veterans so that we can advise them to come on in for an examination.

Mr. RODRIGUEZ. And I want to ask just maybe, Mr. Chairman, that maybe we can follow up, because it is a very critical issue. It is an issue that for 2 decades we kept—we were not aware of it. It was not exposed until last year.

The CHAIRMAN. I am glad the gentleman raised the issue. We plan on a series of follow-ups. You may recall at the hearing that we did have, many of us were disappointed that letters went out, but there was no comprehensive and aggressive follow-up. And those who were doing the presenting obviously weren't even around in most cases. They were in grammar school or elementary school at the time. We have also thought of inviting Secretary McNamara, who approved the program, and we may still try that. He has been on television, so he is certainly visible, to give an accounting. What was going on in the thinking at the time that would put our men and women in harm's way with real live chemical agents. Some were not; there are substitutes, but many of them were. And I mean, looking back, it seems unconscionable, but maybe there was a thought process there.

So the gentleman raised a good question, and we will follow up.

Mr. RODRIGUEZ. Thank you, Mr. Chairman. And Mr. Secretary, thank you very much, and thank you for what you are doing for our veterans. Thank you.

The CHAIRMAN. The gentleman from Arkansas, Mr. Boozman.

Mr. BOOZMAN. You alluded to the fact that the VA is not—certainly doesn't want to get into the prescription-only business, and yet the reality is, is that we have. You mentioned the 50 percent, 50 percent plus, basically, access the VA for prescription drugs. So we have got a situation where, you know, individuals are pretty smart. They have figured out a way to beat the system, and really, you know, are very pleased with their primary care physicians and Medicare or whatever, and then again have gone around the system.

So I really feel like—and I don't—I don't know how we address this, but I do feel like that is an underlying cost that we do have to address. What it is doing is making it such that we have—Medicare in itself is—actuarially has more problems than Social Security, by about three times. So it is forcing us to basically have dual systems for several million people.

Secretary PRINCIPI. Well, I will let Dr. Roswell expand. But I can say it is an internal struggle. Obviously, we want to meet the veterans needs for prescription drugs, you know, something that they cannot receive by just being an American, but by virtue of being a veteran, we can get them those prescription drugs at a very, very low co-payment. We are concerned that where that would lead. Ob-

viously, we would like to maintain, we need to maintain a comprehensive health care system that is balanced between primary care and acute care, and we are concerned that if we just become, quote, a drug store, the cost associated with that, where it will take the VA away from its primary mission of comprehensive care.

And see, there are lots of issues that we need to address with regard to this, but I appreciate your concerns, and the fact that many veterans are pleased with their primary care docs, and we are making them get on a waiting list to see another doc before they can get their prescriptions. It is one of those issues we are working with.

Dr. ROSWELL. I would just add that I think the Secretary and I share your fundamental concern that we can't become a prescription provider for all Americans. I think Mr. Buyer made that point when he referenced the 1996 committee intent. I would point out that the Secretary has made a concerted effort over time to refocus the system on exactly what you are talking about, and that is meeting the comprehensive total health care needs of our core veteran constituency. He did that with the enrollment decision he announced on January 17th of this year.

That enrollment decision said we can't continue to accept all veterans, particularly those who are only seeking primarily prescription drugs. He reinforced that with the introduction of this budget, which has significant policy changes that further discourage casual users from simply seeking prescription drugs.

Secretary Principi also did that with the work he has done with Secretary Thompson to introduce the VA+Choice product, which actually allows the system to be accessed by veterans who have Medicare benefits and otherwise wouldn't get it. But it is a capitated program or an HMO-like product, which requires the veterans who enroll in that product to receive their entire comprehensive Medicare health benefit from the VA, not just prescription drugs. So Secretary Principi has addressed your concerns and has consistently shown policy direction to move the system back to meeting the comprehensive needs of veterans and not simply being a supplemental policy for Medicare eligible veterans.

Mr. BOOZMAN. Right. I would like for us maybe to consider maybe a study where you did—maybe both, where perhaps they came and had—you know, they are on a medicine, they get a good physical. If the medicine hasn't changed, you know, they don't need additional medicines or whatever, then at that point then—and again, I am just thinking out loud. Maybe have a hybrid of the system now. So I am not saying that we need to cut off the prescription benefit. It does seem like at times it is a little bit—I know it makes it harder for the veteran, and maybe that cuts down use.

On the other hand it is an expense also.

The other thing I would like for you to comment on real quickly is we have had some illusions as to that perhaps we are not doing enough. Under your watch, under President Bush, can you kind of compare the increase in the budget that we have had compared to the previous Secretary?

Secretary PRINCIPI. Well, I think we are doing very, very well. I don't know all of the figures. I do know when we went to open enrollment in 1998 when the law became effective, the VA's budget

was zero, increased to—there was no proposed increase; and then the following year I think was nine-tenths of 1 percent. So, I recognize that we struggle to keep up with the demand, but that we are doing very well. I am told that the Bush average for 3 years is 7 percent, and President Clinton's average was 4.5 percent. So I guess we are a little higher.

Mr. RODRIGUEZ. Can I follow up on that question?

The CHAIRMAN. Time is expired. Just make it 30 seconds, if you would.

Mr. RODRIGUEZ. Real quickly. Like the 11 percent that is there, it is out of VA copayments, and so sometimes it is misleading. So I would just ask that you look at it real closely.

Secretary PRINCIPI. Well, I hope it is not misleading, and I know the 11 percent is compared—because we don't have an appropriation in 2003, the 11 percent increase is the 2004 request compared to the President's request in 2003. Clearly we include copayments, and that started with the previous administration. When the Congress said that the insurance premiums and the copayments can stay with the VA, it then became part of the appropriation, and it has always been that way since I think 1998 or 1997 when Congress made that change.

The CHAIRMAN. Recognize the gentleman from Maine, Mr. Michaud.

OPENING STATEMENT OF HON. MICHAEL MICHAUD

Mr. MICHAUD. Thank you very much, Mr. Chair, and I can relate to, Congressman, your discussion about the—going to Mexico and buses for prescription. In Maine we do the same thing, but we have busloads going to Canada to buy a prescription, because it is much cheaper than here in the United States.

Thank you, Mr. Secretary, for being here. I have several questions I would like to ask, and I will submit some in writing, because I know I will not have the time to get them all out, and primarily, most of them deal with the so-called management efficiencies.

Before I got elected to Congress, I spent 22 years in the Maine legislature. The bulk of my time in the Senate has been on the Appropriations Committee, and I also was able to serve on Governor King's so-called Productivity Realization Task Force, which was looked at to save State dollars, which is made up of both legislators and people from—individuals from the private sector.

And that is where I have a lot of concerns when I hear about management efficiencies, because we found out that they are not there, and that is what some of my questions now will be relating to.

I know the VA has renewed the focus on A–76 competitive outsourcing for specific functions in areas, and it is estimated that in fiscal year 2004, VA will realize a potential saving of $138 million.

My questions, Mr. Secretary, are, do the saving estimates include the cost of study, analysis, for each targeted position? Do the savings estimates include the cost of training and integrating the contract winners into the VA positions?

My third question is, the Inspector General reviews are critical of VA contracting practices regarding effectiveness, accountability, and accuracy, and how much larger will we need to grow the VA contracting force to accommodate the increased responsibility of analyzing functions for possible outsourcing?

And my last question at this time is what studies have been done on the long-term effect of outsourcing to the human resource investment on an organization culture? As I stated, we have found a lot of flaws in Maine, and I have that same skepticism when I hear you are looking at management efficiency, particularly to the tune that you are talking about.

Secretary PRINCIPI. I appreciate your question. I have often said and will continue to say that I believe the VA has one of the finest workforces in government, and I think our mission sets us apart, especially in the health care and benefits area. People see their grandfather, father, uncle, mother, in the VA medical beds, and that is not to say we shouldn't look at competitive outsourcing. We should, thoughtfully, in areas where we can be more efficient. That is not to say by looking that we will automatically outsource it, but it has identified efficiencies that we can make internally in government, and we have that responsibility. We are the stewards of the public trust, and we owe that to the taxpayers, but to do it thoughtfully and not to destroy morale in the process, because I believe sincerely in the VA workforce.

And I know what you are saying about management efficiency. What we have proposed is a little bit more than 3 percent of the VA discretionary budget, and I think any business needs to look at how they can be more efficient. This committee, on both sides of the aisle members have said, Mr. Secretary, you need to reform your procurement initiatives, and I agree with them. Some of the products we buy from hundreds of different of manufacturers, and if we had national contracting, we could drive the price down. I mean, you can leverage your sheer size and purchasing power, and be mindful of small business and disadvantaged businesses. So I think there is more we can do. But we will proceed on the competitive outsourcing very thoughtfully.

Mr. MICHAUD. And I appreciate that, but you haven't answered my specific question.

Secretary PRINCIPI. I am sorry.

Mr. MICHAUD. Which I will submit in writing, plus additional questions as well, because to talk about it in general terms—that is what we did in Maine, and when we went down to looking for specifics as far as will they save taxpayers' dollars, the answer was no. In a lot of cases they actually would have cost additional dollars. And in some of the areas when we looked, in the particular areas where they are looking at outsourcing where they said they are able to outsource, they never even provided the service. So that is why I am really——

Secretary PRINCIPI. I understand.

Mr. MICHAUD (continuing). Skeptical of the whole outsourcing initiative.

Secretary PRINCIPI. I would certainly agree with you that the A–76 process is a very burdensome, burdensome process and needs to be reformed.

Dr. Roswell, do you want to——

Dr. ROSWELL. I just want to point out that the competitive sourcing requirement is to evaluate the potential gains from outsourcing, not necessarily to outsource.

Currently we are looking at our laundries, and one of the things that has impressed me is that critically looking at our laundry operations with an eye to outsource—that has actually allowed us to achieve internal efficiencies to make those laundries more efficient.

So the process is looking and doing an evaluation, not necessarily inevitably does it lead to outsourcing, and in fact I think the gains that come through the competitive sourcing process—we are trying to understand the best in industry and how we can replicate that. And if we can't achieve that industry benchmark, then we have to make a determination about outsourcing.

The CHAIRMAN. Mr. Bradley.

Mr. BRADLEY. Thank you very much, Mr. Chairman, and thank you, Secretary Principi, not only for your service to your country but your very forthright testimony today.

My question: You made a tough decision on priority 8 veterans. Had you not made that decision, what were your projections for enrollment going ahead into the future?

Secretary PRINCIPI. Clearly, with the uncontrolled growth, we would have been over 9 million enrolled veterans by 2012. More than half of the growth in our enrollment is in the priority 8. So it shows a very, very dramatic increase in that category of veterans.

I am reminded that we project that almost 42 percent by 2012 would be category 8 veterans.

Mr. BRADLEY. Thank you. I have nothing further at this time.

The CHAIRMAN. Thank you. Mr. Filner.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman. Welcome, Mr. Secretary. Mr. Chairman, I ask for unanimous consent that I may put my opening remarks in the record——

The CHAIRMAN. Without objection, so ordered.

[The prepared statement of Congressman Filner appears on p. 98.]

Mr. FILNER. As always, it is good to have you here. You are not in an enviable position, in that you have a commitment to our veterans, and yet you have to work within certain budget realities, some of which you have been given whether you like them or not. And so you have your job, we have our job. I don't have to accept those figures that you have to accept, although I will never say that your commitment is less than anybody else's. You are working under certain rules.

By the way, in all the tough decisions that you have made, I don't think you have ever referred to veterans as "making a run on the system" as one of the members of our committee did today. I find that extremely offensive. We have veterans who may be in different categories but who have served our Nation, and many of them are poor, many of them do not have access to other medical care, and to refer to them as making a run on the system is an insult to them and an insult to this Nation.

I am sorry that Dr. Roswell felt he had to play to that and talk about "casual users." These are real people who have real needs, and they are going to try to get them met. And they are our veterans, and if we can meet them, we should; to call them casual users or making a run on the system is an insult.

As I said, Mr. Secretary, you have your job, and I have my job. You called yours a good budget. I would have preferred that you say you made the best budget within the constraints that you have. Let me tell you what I am going to be fighting for. I am going to be fighting for the Independent Budget that we are going to hear testimony about later. I think it is a professionally arrived-at set of numbers. It doesn't just say, give us more. It tells us specifically the amount of funding we are going to need for each part of the budget, how much is going to decrease the waiting time, et cetera. I am going to use that as my Bible as we try to go through this budget process.

I am upset that new priority 8s are excluded. I understand the realities, but I don't think we should exclude anyone who is a veteran from our system. We are a rich Nation that can find those resources, and I am going to be fighting for them. I am not going to call them making a run on the system.

We are about to send young men and women into the Gulf again—as I was saying before. I believe a member of this committee made an insulting remark but I praise that same member for his service in the Gulf, and we are about to send young men and women into that area.

We have had several hundred thousand of our veterans who have Persian Gulf War illness. We don't know the cause, and we don't know the cure, and yet we are sending our young men and women right back, maybe for the same fate. We should have been in the last decade devoting far more resources to figuring that out, and I think we have to keep working on that and not shy away from that area.

Contracting out is something I am going to fight, because in the workforce that you have, that you complimented, contracting out would, disproportionately affect certain groups, including disabled veterans, including women, including ethnic minorities, and we have got to be very conscious of what we do there. I think that contracting out the whole thing is a fraud on the Nation. And although, as you said, the system allows you to find efficiencies, there are far more things that you cannot quantify that our public employees give us. Contracting out dismisses certain of their great benefits that just can't be quantified.

Lastly, and I say this especially for the freshmen in the room today, we have a group of people in the audience who are national heroes. They were veterans of World War II who happen to have been born and raised in the Philippines. Would the Filipino World War II veterans please stand for a minute?

Thank you.

More than 50 years ago, my colleagues, the Congress saw fit to take away benefits that these veterans had as American soldiers, and many of us have been fighting for a long time to try to restore those benefits. This committee and this House passed last year a bill to restore VA health benefits. The Chairman supported that.

The Secretary supported that. The administration supported that. We passed it. Unfortunately, the Senate didn't have time at the end of their session to deal with it.

I am going to introduce that bill today, with Chairman Simmons' support and the bipartisan support of members on this committee in this Congress. I hope we can pass that bill very quickly, as we did it last time.

Unfortunately, your budget didn't have any provision for $12 million for this year for those health care benefits. If you would let me know if we pass that bill, how are you going to deal with that $12 million?

Secretary PRINCIPI. It will be absorbed within our medical care budget. So I supported it last year. I intend to support it again this year, and if it becomes law, we will—the Filipino American veterans will get their care.

Mr. FILNER. Thank you, Mr. Secretary, and we are going to fight for that. Thank you.

The CHAIRMAN. Mr. Beauprez.

OPENING STATEMENT OF HON. BOB BEAUPREZ

Mr. BEAUPREZ. Thank you, Mr. Chairman. Secretary Principi, thank you for coming today. And I want to acknowledge, once again, the commitment, the contribution you personally have made to this country, but especially the contribution you have made in providing this country with three of its young soldiers, two of them already overseas, as you acknowledge, your third headed there.

Mr. Benson, you have my sympathy and my gratitude as well.

I am going to assume that for gentlemen such as yourselves that this goes way beyond a job, certainly way beyond admiration for our veterans. It is indeed, I am sure, very, very personal for you, and I acknowledge and appreciate that.

I want to get to two questions, and I will set the stage a little bit by acknowledging also that health care seems to me to be an industry that evolves perhaps as rapidly as any industry that we have out there, and I am going to assume that that goes for whether or not we are providing health care to veterans or to the private sector. And I have a little bit of experience of what has gone on in the private sector, having served on the board of a hospital as it tries to keep up.

I appreciate some of the efforts that it appears to me that you are making: improved outpatient therapy; making very, very difficult decisions such as your enrollment fee; addressing the copay question as it relates to prescription drugs; the efficiencies in management and procurement efforts that I see evidence of in your report and in your budget.

My question would be—or my questions would be in this regard: I appreciate knowing where we are at and the difficulties that you have in meeting the very immediate objectives, but thinking of where do we go from here, would you address, if you would, please, because I know at my hospital at least—and I think relative to the VA—you are looking for other partnerships, strategic alliances, ways that you can become ever more efficient in providing quality service, improved quality service, but doing so with less resources, dollars—especially if you can do that.

Are there alliances, and specifically with the DOD, that perhaps you might want to address? And secondly, I know that in the world I come from, capital construction for both maintenance and new construction is an ever-present issue. I would like you to address the numbers in this budget and the adequacy or inadequacy of those numbers.

Secretary PRINCIPI. The construction budget. Clearly, I think it is critically important that the VA stay on the leading edge of the changes, the profound changes that are taking place in health care in this Nation. You know, medical advances, new technologies, telemetry, telemedicine, drug therapy, are just redefining health care from the medical center to the ambulatory center to the home. It is just extraordinary to me what has begun. And the VA has been on the leading edge, and I don't take credit for it. My predecessors deserve a lot of the credit as well for moving VA to become a more patient-focused health care system instead of a hospital-centric system.

We need the hospital, of course, but we also recognize that we can keep a lot of patients out of the hospital and treat them with drugs and treat them—have their surgeries in ambulatory centers. So I think it is very, very important that we stay—manage our health care system to treat patients and not just infrastructure.

I think our strategic alliances with medical schools are very, very important. I sometimes get concerned that they get out of balance and that they need to be in balance and that the medical schools and the VA derive equally from that partnership. I think that partnership has been good for American medicine, medical research, and for the VA, but times have changed and we need to work on that.

And clearly with DOD, we have barely begun to break down the barriers separating the two Departments. So much more can be done. We talked about the Gulf War, just making sure we have access to medical records in a timely matter, seamlessly, electronically, so we have a good database from the time a servicemember enters the military, so that we can provide care. We know their health at any given point in time. Sharing of VA-DOD medical centers, you know, more mergers like we see in Albuquerque and Elmendorf and Tripler and Nellis Air Force Base where we work closely together.

And in procurement, I just think these two systems are so large, if we combine our procurement activities, I mean combine them, both procurement and distribution, we can save hundreds of millions of dollars that stays with the VA, stays with DOD, and we can provide better health care.

Please address the——

Dr. ROSWELL. I think the Secretary has really been very effective in moving the Department towards better collaboration with DOD. We now have a Joint Executive Council and a Health Executive Council. Already those councils have established a uniform rate schedule for shared services at any location between DOD and VA anywhere in the Nation. We have a program now that actually takes DOD physicians who may not be needed during peacetime and assigns them to VA facilities.

This year we have had four cardiovascular surgeons on active duty in the United States Army working on veterans in VA hospitals. It has been a wonderful agreement. It has enhanced readiness, but it has also has served veterans.

We have a governance structure we are looking at for integrated facilities. We actually have three representatives from the Department of Defense on our CARES program, the Capital Asset Realignment that is looking at restructuring our system to make sure that we don't miss any opportunity to work more collaboratively with DOD. And we have done a tremendous amount with information technology, moving both the VA information system and the DOD information system to a common platform so that very soon we will be able to share medical records from active duty personnel directly with VA at any point in care in either system.

The CHAIRMAN. Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman. In my opinion, we just endured a little bit of a tirade from one of our members who classified the entire contracting out system as a fraud on our Nation. Yes or no, would you classify the entire group of health care providers and caregivers as frauds who we contract out to? Just yes or no.

Secretary PRINCIPI. Absolutely not.

Mr. RENZI. They are an integral part of what we do as far as contracting out; isn't that right?

Secretary PRINCIPI. That is correct.

Mr. RENZI. So the entire system is not a fraud. It needs to be fixed. But when we jump on other members for some words and then we go to extremes, we just end up fighting one another.

Let me read you a letter that I received from Walter Dutton. He is a vet in Casa Grande, Arizona where many of our veterans go daily to Mexico for their prescription drugs. And he writes: In addition to traveling that far, when we were drafted for the Korean War we struck a deal to enter military service at lower wages than any other working poor. We endured whatever risks and hardships may come along, and we kept the enemy away from our gates. In return, a grateful Nation would remember our sacrifices and provide first-class veterans' benefits."

At the VA clinic in Casa Grande, Arizona where he goes for health care, the doctor quit a year ago, and there has been no doctor since. The essence of your workforce and of a good team and any championship football coach you meet will tell you they win the championship in the off season recruiting good players or good horses, so you don't beat a dead mule across the finish line.

I ask you, then, within the programs and the monies that are made available, what type of recruiting programs for nurses—even though we are facing a nursing shortage and even though you are competing against the hospitals to pull those nurses away from you—what kind of doctor recruitments are we looking at, tuition waivers, tax credits, scholarship programs, DOD doctor transfers to our veterans—to build the best workforce, you have got to have the best recruiting program, coach. Go ahead.

Secretary PRINCIPI. I think we do. We are continuing—I don't know about that situation in Casa Grande. We will certainly look into that. But we are continually on the front lines trying to recruit the best and the brightest to the VA health care system, either di-

rectly or through our affiliates with the medical schools. We have a new pay proposal that we are working on for our physicians to simplify and make our salaries, our compensation for physicians, much more competitive with the private sector. I hope to have that proposal—pay proposal to the Hill.

This committee and the Senate committee have worked hard on nurse recruitment initiatives, better compensation, scholarship programs. I think the whole—I think we are trying to attack it, Congressman, on several different fronts, because you are absolutely right; you need to recruit, but you also need to retain them at the back end.

Mr. RENZI. Thank you. As part of a small business plan, if you know you need a thousand doctors, you back into it. Any kind of accomplishment in life that we are going for, you begin at the end, right? You back into where you want to be. So any kind of a plan, a detailed recruiting plan, of how you are going to do this is an absolutely integral part to building this kind of workforce.

I am grateful. Thank you, sir.

The CHAIRMAN. Would the gentleman yield?

Mr. RENZI. Yes, sir.

The CHAIRMAN. Unless you have additional questions.

Mr. RENZI. No.

The CHAIRMAN. You bring out a very good point about recruitment. The Independent Budget points out, and we all know this, that the VA has the largest number of nursing staff, LPNs and registered nurses, probably in the world—55,000— but, very disturbingly, that 35 percent of the VA's registered nurses will be eligible to retire in 2005.

Last Congress we passed legislation which the President signed that had a number of very strong provisions dealing with nursing, including a commission.

What is the VA doing in that, because we are very concerned that all of a sudden those very crucial caregivers will no longer exist, or at least in the numbers we need?

Secretary PRINCIPI. The Nursing Commission has been established. You know, they are meeting. We are getting recommendations from them, and we certainly will look at all of those recommendations. We have increased the salary rates, the scholarship programs. You know, we have a crisis of nursing in the Nation. It is not just the VA, it is across the Nation. You know, folks are not going into the nursing profession like they did before, both male and female, and that is of concern to the VA. And that was one of the reasons for the VA Nursing Commission. So we certainly will be mindful of the fact that not only nurses, but many of our people, are approaching retirement age and that we need to have a workforce succession plan to ensure that we have that continuity and we can fill that vacuum when folks decide it is time to move on to the golf course and not the VA.

The CHAIRMAN. Thank you. Ms. Brown-Waite.

Ms. BROWN-WAITE of Florida. Thank you, Mr. Chairman. Mr. Secretary, you weren't here when I unloaded on Dr. Roswell. We have a very long waiting period in Florida for——

Mr. FILNER. Before Mr. Renzi leaves, if you thought that was a tirade, you haven't seen a tirade!

The CHAIRMAN. Regular order. The Chair will just note, I ask that the members—all of us have to live by the rules. Mr. Buyer did not put on his mike when references were made to him. I don't think you crossed the line, because you talked about a disagreement on policy. Obviously we never want to attack members personally. Hopefully both sides of the aisle will adhere to that; normally 99.9 percent of the time we do. And the same goes to the administration. I think this has been a very dignified hearing. Members who may have some disagreements with the administration—I know I have a few, we all do—we are discussing it, I think, with a great deal of comity, and that is the way it ought to be.

So I would hope that there would be no outbursts. Let us adhere to the rules. That is why they are there, so that debate can be facilitated.

Ms. Brown-Waite of Florida.

Ms. BROWN-WAITE of Florida. Thank you, Mr. Chairman. It also gave me the opportunity to clear my throat.

I told Dr. Roswell last week that we have 18-month waiting periods in my district for people to get into a clinic. If you are patterning the VA+Choice plan after the Medicare+Choice plan, it is going to not work in all areas. So I would ask, number one, are you patterning it after the Medicare+Choice plan?

Dr. ROSWELL. It follows the Medicare guidelines for +Choice programs. We recognize that many of the Medicare+Choice programs have been unsuccessful, particularly in certain areas, and that is why we are working very closely with Health and Human Services Secretary Thompson and Tom Scully, the Administrator of CMS, to try to craft a somewhat different approach that will address the needs.

In contrast to areas where +Choice programs have been unsuccessful, the +Choice program that VA will operate will use VA providers who are very interested in serving veterans, and I think that may be the key difference.

Ms. BROWN-WAITE of Florida. If I may continue, Mr. Chairman, the problem is that there are lots of areas where Medicare+Choice doesn't exist and you don't have contract providers. So we are going to have the same backup of the system that you have now. That is just totally unacceptable. So what are you going to do for those areas that are already underserved where there are no Medicare+Choice—where there is no Medicare+Choice availability right now and the chances of getting a VA +Choice aren't very good?

I can tell you that the doctors don't participate in Medicare+Choice, because in certain areas of various States, they are not reimbursed as much as in other areas, and yet their costs are the same.

Secretary PRINCIPI. Well, I think the—well, first, we will not implement the VA +Choice program until such time as the backlog—the waiting list is over. We cannot meet guidelines, HHS guidelines on access and timeliness until such time as we ensure those on the waiting list are done. And Florida clearly is an area where we have great demand.

Secondly, I think the difference is that we are going to be using VA physicians, and I believe that we are more cost-effective than

the private sector and I believe that the capitated rate that we will receive, risk adjusted, will allow us to take care of those veterans and be reimbursed from HHS. So I would hope that the fact that we are a closed system, we are using VA physicians, will allow us to meet the demand.

Now, we will phase this in over time to make sure that it is working, working well. We will go back to HHS if we have to make some refinements as we go along. That is my hope.

Dr. ROSWELL. Ms. Brown-Waite, if I can also add, please be assured that no veteran on a waiting list in your district will need to access a VA +Choice program. Every veteran currently enrolled will remain enrolled and be eligible for the full health care benefit. As soon as we receive a 2003 budget, we have plans in place to aggressively address the waiting list, including those in Florida, where the intervenor allocation will increase the funds available by approximately 12 percent to allow the network director to execute the plan to eliminate those waiting lists.

And with that full House-Senate mark, with the additional $1.1 million that we hope to receive in 2003, we are committed to eliminating those waits.

Ms. BROWN-WAITE of Florida. One last question. VA currently allows for aging in place, are veterans to go into an assisted living facility? Do you have any plans in the current budget that you have proposed here to allow reimbursement for other than ALFs; for example, adult care home? Many States—they are called by different names in different States. It is an individual residence that older people can go to to make sure that they—that they are receiving their medication, that they are supervised. And this may be also a way of saving money, because they are less expensive than the ALF. Certainly lots of people are depending on their ADLs and ALF is an appropriate placement for them, but also you have the availability of some care homes.

Dr. ROSWELL. You know, it is a fascinating area and it is an area we are very interested in. Currently we don't have statutory authority to place veterans in an ALF or a care home. What we have done, though, is create a new care coordination office that this year will actually add 15,000 veterans to a care coordination program using interactive technologies. Our goal is to help veterans work with other resources to get less costly housing where there is assistance with activities of daily living, and then to use the authority we have to put interactive technologies in care homes, in ALFs, to provide the medical component that is needed for those veterans, and we have made a commitment for 15,000 veterans to be enrolled in such programs this year.

The CHAIRMAN. Before I go on to Chairman Simmons, I would like to announce—a few members have some additional questions, as do I—but we would like to have a lightening round, if you will, perhaps 3 minutes or less, after Chairman Simmons gets his full 5.

OPENING STATEMENT OF HON. ROB SIMMONS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Mr. SIMMONS. Thank you, Mr. Chairman. Apologies for being late. My airplane got stuck in the snow this morning. That was the

bad news. The good news is it didn't get stuck in the snow on landing. It was before it took off, so we had a late departure.

Without objection, I would like to submit some questions for the record.

The CHAIRMAN. Without objection, so ordered.

(See p. 232.)

Mr. SIMMONS. As I reviewed the VA budget, I looked at it as actually having a lot of good news, although I came in late at this hearing. It sounds to me like I am hearing quite a bit about the bad news, but I think that there is good news, and I think there is good news from the standpoint of health care. We just have to simply focus on some of the positives, like a 7.7 increase in funding, elimination of some of the copays, which I think is good news, and then see how we can work with some of the aspects of this proposal that is not so good news. Increased collection rates are good for you. Maybe they are not so good for the veterans. So we will have to take a look at that and do the balancing act. And reducing waiting periods is good news in my view. Increasing certain copays is probably not so good.

So I think from the standpoint of veterans' health care, there are a lot of positives in here, and I think it is an opportunity for the Health Subcommittee to get into this budget in greater detail and really give our Members the opportunity to dig a little deeper and really get a sense of what is here and what we can do with it. I look forward to that.

I agree with my colleagues on prescription drugs. We have got to get some forward motion on prescription drugs, and I think that is going to be an agenda item for the subcommittee.

VA-DOD sharing, excellent progress on that, but there is a lot that we can do. I have heard stories already about CAT scanners that have been bought by the military and bought by VA within 5 miles of each other. These are very expensive pieces of equipment, and that should stop.

The CARES report—I look forward to seeing that. I think everybody probably does. So we will hold our breath on that.

I would like to make a comment on competitive sourcing or outsourcing. Some of my colleagues have said it already. People in my experience go to work for the VA because they love the job and they love veterans, and I guess I would be interested in looking at some of the proposals. But if it is a question of taking a whack at some of the people who work for VA, then I think we have to be very careful. These are dedicated people, and they are committed to what they are doing. I have seen in State government and elsewhere where attempts to create efficiencies by removing dedicated public servants has backfired, so I would be cautious about that.

My question goes to the issue that was brought out in a recent GAO report, the efforts to strengthen the link between resources and results within the Veterans Health Administration, VHA. They say here that the VHA's budget formulation planning processes are centrally managed but not closely linked, that the resources distribution to VHA health care networks is mostly formulaic, determined by the district of veterans being served, which we understand.

But then they go on to say in the detailed text that up to fiscal year 2003, VHA's budget was prepared centrally and reflected an incremental approach, primarily taking prior years' appropriations, making adjustments, and then adding on.

You know, this is kind of the traditional way of Federal budgeting, in my view, and I have seen it in many different venues. I don't look at last year's numbers. You make an educated guess on what next year's numbers are going to be, and you add on to them. And I think what the GAO is saying in this report is the linkage between projects and the linkage between planning are not as tight as they should be. Does VHA, or does VA have a plan to look at the GAO report and its recommendations to try to create efficiencies in this fashion?

Secretary PRINCIPI. Certainly will. I am not familiar with that GAO report, but I certainly will take a look at it. Perhaps Dr. Roswell can comment on some of the specifics in it.

Dr. ROSWELL. Well, certainly, our approach to budgeting uses a process called VERA, or Veterans Equitable Resource Allocation, that specifically looks at the patients treated in a particular region, as actually we are required to by law.

We have made some significant refinements to that VERA process, going from 2 capitation rates to a full 10 capitation payment rates. We also recognize that we have had to provide supplemental funding in certain regions of the care, because certain areas manage much more complex and costly patients, and we have implemented a high-cost 1 percent reinsurance provision that should eliminate the need for supplemental funding.

This year the increase in 2003 with the full House-Senate mark would vary from a low of a 5 percent increase, which barely reflects the pay raise, to a high of almost 13 percent, which reflects where we have had significant growth, such as in areas like Florida.

Mr. SIMMONS. Okay. I appreciate that response. And again, what the GAO report—and it was published in December of 2002—is suggesting that the VA, VHA, is using a traditional form of budget request which is built on last year's budget, and as we all know, it is typical, but it is not efficient. Mr. Beauprez and others have mentioned that they would like to see some more businesslike approaches to budgeting, and I think that is where efficiencies can be found. So I will be looking at that a little more closely.

My time is up. I am interested in the concept of mandatory funding. I am not sure that the Secretary is prepared to respond to that question at this point in time, but I believe that some Members of the committee are going to be pursuing that issue, and I look forward to working with Mr. Filner to come up with a bipartisan agenda for the Health Subcommittee and for hearings so that we can pursue some of these issues this spring and summer. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Chairman Simmons.

Just to go very briefly now with a quick round with all the members, I notice in the budget that for the homeless transitional housing program, the recommendation is that it go from a guarantee to discretionary. I would strongly urge that not be even be thought. We thank you for the good work you are doing on that. You have begun to, to make that program work, and we are very happy with

that. Please don't go to discretionary. We know what will happen then.

Earlier, Dr. Roswell, in response to Mr. Boozman, you were talking about providing for some priority 8 veterans a capitated payment, which in a way is a form of mandatory funding. In the last Congress, I introduced legislation along with Lane and many others, for a mandatory funding scheme, believing that VA health care isn't broken but the funding mechanism is broken. There isn't a sustainable means to provide that all-important funding to our veterans. As you yourself pointed out, Mr. Secretary, we are, what, 5 months into the fiscal year, and you are still operating on a shoestring in terms of not knowing what the budget is going to be. We just dodged a major bullet with the $700 million across-the-board Senate amendment, which I know you and I and the VSOs lobbied extremely hard to keep funding at $23.9 billion for fiscal year 2003. Seven hundred million, I don't know what you would have done. That would have been catastrophic.

But to take a snapshot and work out a formula that is real and transparent, and to figure out how to fund veterans going forward seems to me to be a prudent way of doing business.

Dr. Roswell, you indicated a philosophical commitment to it in our hearing 2 weeks ago. Of course, the details are all important. How might you respond today to that? Mr. Secretary, I know it is under consideration.

Secretary PRINCIPI. Well, certainly.

The CHAIRMAN. I know the Presidential task force is looking at it as well. The system of funding, not VA itself, the funding mechanism is broken. You are in competition with all these different groups for the appropriations.

Secretary PRINCIPI. Well, certainly, Mr. Chairman, no disagreement that it has been a struggle balancing resources with demand, and there are some fundamental policy issues that need to be decided upon.

My only—my major concern I think with the mandatory spending plan is tying a very dynamic health care system to a rigid formula and whether—and I am not smart enough to know all of the unintended consequences that could result from that, because health care changes so dramatically. For example, AIDS therapy, as we know, is very, very costly, and perhaps if you tie it to a rigid formula, the VA would be underfunded to care for the very, very expensive treatment that would go with certain kinds of illnesses. So we could possibly be underfunded.

On the other hand, some medication, some drugs, could come along that could dramatically cut the costs of health care, and therefore perhaps we might be overfunded.

So I think we need to take into consideration how we can apply a rigid formula to both the changes in health care as well as the demographics of the veteran population?

Also construction, as you know—and you have fought, everyone on this committee I believe has fought—the fact that our capital construction program has been deficient over the previous years. And so if you have a formula that says we are going to get 120 percent of a base year without taking into consideration the tremendous resources that might be needed in the future as we go

through this CARES process to make sure that we have the dollars for construction.

So I think there are some issues there, but the underlying thrust of ensuring that we are adequately funding for the people that Congress determines that they want us to care for is an issue.

The CHAIRMAN. With all due respect, there would be an immediate increase in the short-term, intermediate and long term. Maybe there would be less funding because on a capitated basis the numbers might go down. But it seems to me when you do this on an annual basis, we will get it right, even if the formula coming under the blocks the first year may not be absolutely perfect. Right now the discretionary scheme is shortchanging our veterans. At least that is my belief.

Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I would like to go back to the A–76 process, because it disturbs me in terms of which way this Administration seems to be going. This President's management agenda says that they are launching a new recruitment Web site which will assist the VA in addressing, quote, "identified human capital shortages." I think that means jobs and people.

And this plan to compete 52,000 jobs over the next 5 years, such as laundry, food, and sanitation services—with the estimated savings as much as $3 billion over 5 years—these are people, who are going to lose—many of the people perhaps standing here today, they are going to lose their homes, their jobs and their families, and their communities are going to be hurt as well. And I just find it disturbing that we aren't looking for how we create 52,000 new jobs. It seems like the emphasis is on getting rid of jobs and getting rid of the workers.

And I will give you one example. As you may know—I am sure you do, Mr. Secretary—janitorial uniforms are one of the most expensive things that you can buy, because you have to change them every 2 or 3 days. You can make those products in America, you can make them in Galesburg, IL, my own district.

Laundry service workers. These folks don't have the legal representation that high-powered lawyers can bring to them. And I just think that these are people who need to be involved within the process, and I know, Mr. Secretary, you will be open to that.

But I just want to emphasize that this is a lot of jobs that are going to be lost, and the janitorial uniforms could be made in Galesburg, IL for the same amount of money or less, I believe.

And it is not only the A–76 process. It is also the loss of good-paying manufacturing jobs, and particularly in the Northeast and Midwestern area.

So I appreciate your emphasis on trying to do what you can, but it just seems to me to be a misguided priority to let these jobs go and let these communities go as well. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Chairman Buyer.

Mr. BUYER. Thank you. I don't fear the process for government to look at thyself. Bringing business practices and principles to government should not be a radical concept. There are some times during the A–76 process if the government—I remember this in the mid-1990s. Actually, the government could manipulate the numbers so that the local bid fails, the government bid fails, and so we

asked for a good look into the A–76 process. And, Lane, you and I are on the Armed Services Committee and went at that in the 1990s. But for us to look inwardly, my gosh, you have got 63 laundry facilities, 60 government-owned, government-operated facilities, 3 owned and contract-operated facilities, 108 total VA laundry services. I mean, for us to look at things like that, we ought to look at it.

Secretary PRINCIPI. I agree.

Mr. BUYER. I don't fear that. I'm not afraid to ask questions like why does the VA have its own law enforcement training facility? We are going to look at that.

The other thing I just wanted to reiterate and make a point, again, the facts of the record don't frighten me. What maybe frightens some members of the committee is how wrong we got it. We have to acknowledge that Congress didn't get this right in the eligibility reform, that Congress and this committee did not listen to the forecasts of CBO and GAO, and we got it wrong. And we created an expectation in the veterans' community.

Now, when I tour the VA facilities in Florida, like I did a few weeks ago, and there is an outpatient clinic that you have created down there, and the expectation was that it would serve 3,000 and 12,000 are trying to get in, that is making a run.

So we have created this problem and we want to work with you. And I applaud you. This committee gave you the tools, and you are exercising the right to use them. And now what? We want to criticize you? That is crazy.

I am going to ask one question, though, of you, because the next panel that is testifying is going to testify on the Independent Budget. Have you had an opportunity to look at this document?

Secretary PRINCIPI. Briefly, yes.

Mr. BUYER. I love to look at mission statements and guiding principles. You see, there is a word game going on here, and I think it is more than just semantics. You give your testimony to us, and you are very careful. You used the word "eligibility" you see, that is not what the veteran's service organizations do. They use the word "entitlement." So in the guiding principles, they will say veterans must not have to wait for benefits for which they are entitled. Who is going to disagree with that? But they are very clever using the word "entitled." You use the word "eligible."

Will you explain to me what your sense is here? Why does somebody use the word "entitled" versus you use the word "eligible"?

Secretary PRINCIPI. Well, I used the word "eligible," because that is the statutory construct, if you will, for VA health care.

Mr. BUYER. Congratulations.

Secretary PRINCIPI. Congress did not create an entitlement and never has created an entitlement for VA health care.

Mr. BUYER. Mr. Secretary, that is the right answer. I yield back.

The CHAIRMAN. The gentleman yields.

Secretary PRINCIPI. I mean, I don't know how else to—I am stating what the law is. I am not taking—that is what——

The CHAIRMAN. Mr. Filner.

Mr. FILNER. Glad you got the right answer. No wonder you got an A from National Journal.

Let me just briefly in the second round, Mr. Chairman, say one word about the contracting out situation, which several of us have discussed. And in absentia, I would like to say to Mr. Renzi—what I said in my earlier statement—I think a fraud has been perpetrated, in the notion that the benefits of privatization can be strictly measured on a quantitative basis and a bottom-line kind of situation. As Mr. Simmons pointed out, what do you say about morale? What do you say about commitment? What do you say about energy that you want to give to veterans?

In addition, many of the private contractors that we are comparing with don't provide health insurance or pensions or any of the other benefits. So sure, they are going to be cheaper. We have something in this country that no other country has ever tried in our various—well, I was about to say "entitlements," but I guess I shouldn't say that.

Our postal service, our Veterans Administration, try to reach every single person that is eligible, if I can use that phrase. That is, we don't just take off the ones that can be treated with little cost or ones you make a profit off of. We try to do everybody. And that is the greatest thing about America, whether it is the postal service or the VA or anything; we have eliminated class distinctions and economic distinctions. We don't say if you live in a rural area, you don't get postal service. We try to serve all.

Of course, you can't compete with somebody whose goal is to make a profit, because they are going to do the ones that you make money off of. And we try to do everybody, and I think that is a great benefit of the United States, and we ought to keep to that principle.

I do want to just underline what the Chairman said about the mandatory proposal. It seems, Mr. Secretary, you leave some leverage now. You are an "A" Cabinet member. You know, you were straining a little with that problem of what is wrong with a rigid formula. You can change the formula every year to take into account what your costs are in treating the average person. Actuarially, you can determine that. That is what insurance companies do. That is what you do in your estimates, you figure out what it costs. So each year you figure that cost out and that is all you have to do. It seems to me you should be fighting for mandatory health care funding. You are committed to our veterans. This would get you out of this incredible problem.

Let us get to a mandatory system based on a formula that is relevant to the costs that you have, and if AIDS has gone up or drugs have gone down, the formula reflects that.

I hope you would be a fighter for that and not try to oppose it. And I hope we get an official position on that proposal. I think the Chairman deserves that. This is an important item, and we believe in it passionately. It is not just something that we are doing for political purposes, and so I hope we have a legitimate discussion on it.

The CHAIRMAN. Ms. Brown-Waite.

Ms. BROWN-WAITE of Florida. Thank you very much.

Mr. Secretary, have you computed the impact to the VA if we do pass a prescription drug plan for seniors? How many fewer veterans will use the VA as—because, admittedly, so many of them are

for prescription drugs. Have you computed the impact that it will have on the VA?

Secretary PRINCIPI. I don't know if we have any. I will defer to Dr. Roswell. But it is hard to predict without knowing precisely what the prescription drug benefit would look like. As you know, currently—although the co-pays could rise. Currently, $7 per month per prescription is a very generous benefit; and I doubt that we will see a Medicare prescription plan that approaches that. Therefore, I would think that the suppression—the demand would be very low. I don't think we would see much change unless it is a very generous benefit.

Dr. Roswell?

Dr. ROSWELL. I agree with the Secretary. The likelihood that a Medicare prescription drug benefit would be anywhere near as comprehensive or as robust as VAs is a remote possibility, which means there would still be demand. We have costed out what a prescription drug benefit would cost if applied to veterans currently not using the VA.

Let me remind you, there are 25 million veterans in this Nation. Six million are currently enrolled, leaving 19 million unenrolled. For every million veterans who would use the VA for prescription drugs, our appropriation requirement would increase by approximately $1 billion a year, which is why we have significant reservations about providing a prescription-drug-only benefit. But certainly, as other members of the committee have expressed, it is something that we are willing to further explore.

Secretary PRINCIPI. We have one of the finest pharmacy benefit management programs in the country; and I think it is a model, if you will, for the rest of the country in developing a prescription plan. We have been able, with the national formulary, with our consolidated mailout program, to dramatically keep our costs in check. Over the past 4 years our costs per prescription have remained flat, about $12 per prescription. I think that is remarkable. We use a lot of generic drugs; and all of that has helped us to be good stewards and watch our dollars, how we spend them.

Ms. BROWN-WAITE of Florida. One other quick question. Have there been any studies on the real impact of the fact that, as I see it in my district, there is a duplication of services? People go to their primary care and they go to the VA. That is a cost. That is a cost that drives up the cost of health care for both Medicare, for private pay, and for the VA. Have any studies ever been done on that issue?

Secretary PRINCIPI. Not to my knowledge. But I fully agree with you, there is a cost that concerns me. Everywhere I go in our system, when I ask that question, there is a great deal of redundancy and overlap in the delivery of care; and it is something that we really need to work on.

Ms. BROWN-WAITE of Florida. Thank you.

The CHAIRMAN. Thank you. Chairman Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman.

Very quickly, reference was made earlier to issues relative to rural health care and the delivery of service in those rural areas. I can't speak for other areas of the country, but the community clinics have been extraordinarily useful in my State in dealing with

issues of rural health care. I represent, believe it or not, a rural district in Connecticut, the most rural district in the State. I share the concerns of my colleague that Medicare+Choice has failed us at a county level in parts of New England because we don't have county government, and so the rules that apply for the delivery of those services elsewhere in the country don't necessarily apply in some regions of the country. So I think that whatever approach we take to that is going to have to take into account the different political and geographic aspects of the country. Is this in track with what you folks have in mind with your exploration of delivery of care to veterans in the rural area?

Dr. ROSWELL. Let me reassure you that the VA+Choice program the Secretary spoke about, I believe it won't be as precarious as Medicare+Choice providers. The key to a Medicare+Choice program operating successfully is local providers being willing to accept payments from the capitated HMO provider. The VA+Choice program specifically uses VA physicians who have chosen to dedicate their professional careers to caring for veterans and are salaried employees of the Department of Veterans Affairs. And the receipts that come from the capitated payments from Medicare don't go to the physicians, they go to reimburse the Department for the cost of their salaries. So the idea that practitioners won't participate in a VA+Choice product is erroneous, because they are VA physicians who want to get involved with and want to provide care to veterans.

Now, going back to rural health care, I would also point out that the Secretary has expressed his desire to reexamine the community-based outpatient clinics. We have a new directive that has been designed to look at their effectiveness, and we are considering where we may have additional need for expanded capacity in the CBOCs.

Mr. SIMMONS. I thank you for that answer. To me, those clinics have been hugely successful, and I think we need to see that go forward.

Secretary PRINCIPI. I think as soon as the appropriation bill is signed into law we will begin to take a look at some of those that have already been approved and are on the hold list and begin to systematically begin to open up new CBOCs across the country where they are truly needed in a way that we can manage the growth as well.

Mr. SIMMONS. Thank you, Mr. Chairman.

Thank you, too, Mr. Secretary. I look forward to working with you and your staff this session.

The CHAIRMAN. Thank you, Chairman Simmons.

Secretary PRINCIPI. The same here, Mr. Simmons.

The CHAIRMAN. I want to thank the distinguished Secretary and his very, very able and committed staff for being here. You have been here in excess of 2 hours. We thank you for that. I would just say as you part, in answer to Ms. Brown-Waite, we are working on a concept which we hope to turn into legislation on prescription drugs so that the VA gets some of that money. If we pass such a provision for senior citizens, it seems to me that the money ought to follow the veteran so that you get additional resources in order

to do your job. So we would like to consult with you on that and get your input about what it ought to look like.

Chairman Bilirakis, who is vice chair of this committee but chairman of the Health Committee on Energy and Commerce, has made it clear that he wants to work with us on that as well. So, hopefully, we can craft something.

Again, extraordinarily good job, and thank you.

I would like to welcome our second panel to the witness table. Our next panel is the authors of the Independent Budget, which consists of four veteran service organizations: DAV, PVA, AMVETs, and the VFW.

Joseph Violante, a disabled Vietnam veteran, who will be the lead off witnesses, was appointed National Legislative Director of the million member Disabled American Veterans in July of 1997. A New Jersey native, Mr. Violante joined the Marine Corps in 1969. He served with the 2nd Battalion 4th Marines in Vietnam and was discharged in 1972 with the rank of sergeant. He attended the University of New Mexico and received a bachelor's degree in history and political science and earned his law degree from the University of San Fernando Valley College of Law in California. Mr. Violante was a practicing attorney in Thousand Oaks, California, before moving to Washington, DC, where he then worked as a staff attorney for the Department of Veterans Affairs' Board of Veterans' Appeals in 1985.

Mr. Violante's involvement with veterans' issues reaches beyond the DAV. He chairs the Legislative Committee of the Federal Circuit Bar Association and previously chaired the Veterans' Appeals Committee of the Federal Circuit Bar Association from 1992 to 1996. He is also a member of the VFW and the 3rd Marine Division Association.

John Bollinger became deputy directive for the Paralyzed Veterans of America in January of 1992. Previously, he served as the organization's national advocacy director and was responsible for all civil rights disability issues affecting PVA members. Prior to his employment at PVA, he worked for the VA from 1972 to 1987. While at VA, he held a number of positions in the Veterans' Benefits Department, including veterans' benefits counselor and management analyst. Mr. Bollinger grew up in Pittsburgh, PA, and is a veteran of the United States Navy. He was retired in 1970 due to a service-connected disability.

Richard "Rick" Jones has been the National Legislative Director of the AMVETS since January of 2001. He is the primary individual responsible for promoting AMVETS legislative agenda, national security, and foreign affairs goals before the Department of State, Defense, and Veterans' Affairs and the Congress. Rick is an Army veteran who served as a medical specialist during the Vietnam War era. His assignments included duty at Brooke General Hospital in San Antonio, Texas; Fitzsimmons General Hospital in Denver, Colorado; and Moncrief Community Hospital in Columbia, South Carolina. Rick completed undergraduate work at Brown University prior to his Army service and earned a master's degree in public administration from East Carolina University in Greenville, North Carolina, following his military service.

And, finally, Dennis Cullinan is the National Director of the veterans' National Legislative Service for the VFW. Prior to being honorably discharged from the U.S. Navy in 1970, Dennis served as an electronics technician aboard the USS Intrepid and completed three tours of duty in Vietnamese waters. After his discharge, Dennis studied abroad with 2 years at Catholic University in the Netherlands. He later completed his undergraduate education at State University of New York in Buffalo, where he also received his M.A. degree in English. After several years of teaching freshman composition and creative writing, Dennis became a member of the VFW Washington office in its National Veterans Service department. He later advanced to positions in the VFW Legislative Service department, and became its Director in August of 1997.

STATEMENTS OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; JOHN BOLLINGER, DEPUTY EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; AND DENNIS M. CULLINAN, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS

The CHAIRMAN. Mr. Violante, if you could begin.

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Thank you, Mr. Chairman, members of the committee. On behalf of the Disabled American Veterans, thank you for providing us this opportunity to address the administration's fiscal year 2004 budget for the Department of Veterans Affairs.

Ironically, as we sit here today discussing the fiscal year 2004 proposed budget and its potential impact on VA programs, VA still does not have a budget for the current fiscal year. Thousands of veterans, including service-connected disabled veterans, are being turned away for needed health care services. More than 200,000 sick and disabled veterans wait 6 months or more for a primary care appointment. The budget process for VA health care is broken. But I am not telling you anything you don't already know.

Last year, Mr. Chairman, you and Ranking Member Lane Evans introduced legislation to remove the uncertainty from the current budget process and provide a formula to ensure that VA receives a sufficient level of funding to enable it to provide timely quality health care to our Nation's sick and disabled veterans. Mr. Chairman, the introduction of the Veterans Health Care Funding Guarantee Act of 2002 gave veterans new-found hope that their health care system will be put on a stable financial footing, allowing them to receive timely, quality health care from VA.

Veterans cannot wait much longer for their government to acknowledge the deficiencies in the current budget process. Perennially inadequate budgets and currently no budget have forced veterans to wait too long for needed health care.

Based on testimony from last month's hearing on the State of VA health care, it is clear that the bipartisan leadership of this committee has the solution to this problem. Now is the time for decisive action. Now is the time for the leadership of this committee

to move forward with legislation to guarantee funding for the VA health care system.

Some in Congress have said that we cannot continue to throw money at the system. Maybe we should be asking ourselves whether we should be sending more young men and women into harm's way when we cannot care for those sick and disabled veterans from our prior war and conflicts.

VA health care is a binding commitment of a generous and grateful Nation. The committee is charged with ensuring that commitment is kept and there are sufficient resources are meet the needs of our sick and disabled veterans. DAV is disappointed that a guaranteed funding bill has not yet been introduced in this chamber. However, we remain optimistic, especially with the comments this morning, that it will soon be introduced. Sick and disabled veterans as well as the VA caregivers who rely on an adequate budget to do their jobs effectively count on its introduction.

Mr. Chairman, I apologize for focusing my remarks on health care. However, my written comments contain our assessment of the benefit programs, administrative expenses, and judicial review in veterans' benefits. Obviously, much of what this committee will seek to accomplish on behalf of veterans this year will be subject to what Congress appropriates for veterans' programs. We urge the committee to press for a budget that is adequate for existing programs and allows for some improvement in benefits and service for veterans.

We hope that our independent analysis of the resources necessary for veterans' programs and our administrative and policy recommendations are helpful to you, and we sincerely appreciate the opportunity to present our views and recommendations to the committee.

Mr. Chairman, I want to thank you and Mr. Evans for introducing H.R. 241 to repeal the 2-year limitation on payments of accrued benefits. It is one of the recommendations we have in the IB, and we appreciate that.

In response to Mr. Buyer's comments earlier, I think at last hearing we pointed out that, while we did lobby this Congress for eligibility reform, we also indicated at that time that guaranteed funding was a necessary and important part of that entire package; and we didn't get that. So, to that extent, Mr. Buyer is correct that Congress dropped the ball on that issue. We hope that we can get that corrected this time.

And I would disagree that there has been a run on the system. I think with 27 million veterans at the time when we were doing eligibility reform and 24 million veterans alive now, that hardly 4 million seeking or receiving care from the system and 6 million enrolled is a run on the system.

Again, I thank this committee for their advocacy on behalf of our Nation's veterans.

The CHAIRMAN. I thank you, Mr. Violante, for your testimony and for your great work.

[The prepared statement of Mr. Violante appears on p. 114.]

The CHAIRMAN. I would just note before going to Mr. Bollinger that utilization rates and an increase is a sign of success. And veterans are voting with their feet by walking through those doors

and utilizing those services. But I don't want to be out of order, and I want to go right to Mr. Bollinger.

STATEMENT OF JOHN C. BOLLINGER

Mr. BOLLINGER. Thank you, Mr. Chairman.

I am John Bollinger with PVA, and I am going to focus my remarks this morning on the health care portion of the Independent Budget for fiscal year 2004.

When VA's fiscal year 2004 budget first became public a couple of weeks ago, it was touted as being historic, a $1.9 billion increase to address veterans' health care needs. Now we have had the opportunity to dig into the detail of that proposed budget and have a good understanding of what makes up that historic increase, and we know the administration's budget will simply not be adequate to meet the needs of those who need the system.

Unfortunately, most veterans needing health care will gain their first understanding of this budget not from digging into the details of it but from digging into their pockets when they are forced to pay for their needed care. It is clear to us that the administration's budget relies far too heavily on management efficiencies and collections from others, including veterans, and not enough on appropriated dollars.

The Independent Budget has proposed $27.2 billion in real appropriated dollars for VA health care. These are funds needed to address a variety of matters, as stated in detail in the Independent Budget.

One good example is the shortage of nurses across the system. Although it is a national problem, VA must have the ability to attract and compete for this critical resource. The average VA nurse is somewhere between 45 and 50 years old, dedicated and caring, but we will need more than enrollment fees and more than co-pays to offset the cost of replacing an aging workforce as a generation of nurses approaches retirement and a generation of veterans approaches old age.

Long-term care for veterans will need more than enrollment fees and more than co-pays to address the needs of an aging veteran population. Care at home is an important thing, and we support that concept, but not at the expense of reducing VA nursing home beds. Extended care and VA facilities is critically important to maintain an increase as that population gets older.

The proposed enrollment fees and increases in co-payments may swell the proposed budget, but they will also chase away many veterans who very much need the system and in some cases rely very heavily on the system. For many who need VA specialized services, VA health care is not only the best game in town, it is the only game in town. Many older veterans retired and on fixed incomes have sought VA health care because of the rising costs and have public and private health care plans and insurance. The VA has become their safety net.

The members and endorsers of the Independent Budget strongly encourage you not to let the VA price itself out of their reach. The administration has proposed $408 million for research. This is good, but we are hopeful that your committee will accept the Independent Budget recommendation of $460 million. The continuity,

and the strength of VA research is a national resource and critical to the long-term care of veterans.

Mr. Chairman, Mr. Evans, we congratulate you for introducing legislation last year that would remove VA health care from the discretionary side of the budget process and making annual VA budgets mandatory. The lack of consistent funding for VA along with uncertainty attached to the process fuels efforts to deny more veterans health care and charge veterans more for the care they receive.

Mandatory funding legislation can be assigned to ensure that VA has sufficient resources to meet existing statutory obligations. By including veterans currently eligible to be enrolled for care, we will protect the specialized programs VA has developed so well over the years. We look forward to working with you and giving you every support to make VA health care a mandatory account as soon as possible.

Finally, Mr. Chairman, just speaking for—PVA, we don't want any new members. We are not looking for new veterans that have spinal cord injuries to join our organization. But as our Nation continues to prepare for war, let our Congress and our administration make certain that VA's health care system will be strong and well prepared.

And if I can respond further to Mr. Buyer's concerns. Let us all remember that eligibility reform was passed in 1996 for a variety of reasons. As a user of the system and one who went through his rehab in the VA and as a former VA employee, I can tell you that the prior system did not work. It was complex, it was complicated, and it was very difficult to administrate. So for that reason alone eligibility reform was an important thing for us to do in 1996, and I congratulate the Congress for doing it.

We support the Secretary's authority to make decisions on enrollment, but the reason we are here year after year and the reason we have been here for 17 years is to say, wouldn't it be nice if he didn't have to? Wouldn't it be nice if VA health care was such a priority that the Congress and the administration would fund it at the levels that we are suggesting?

Thank you, sir.

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

[The prepared statement of Mr. Bollinger, with attachment, appears on p. 122.]

The CHAIRMAN. Mr. Jones.

STATEMENT OF RICHARD JONES

Mr. JONES. Mr. Chairman, Ranking Member Evans, and members of the committee, AMVETS is honored to join fellow veteran service organizations at this hearing on the VA budget request for fiscal year 2004. We are pleased to provide you our best estimates on the resources necessary to carry out a responsible budget in the new year.

AMVETS would like to take a moment, before we begin, to state clearly that, with our IB partners, we, too, strongly support shifting VA health care funding from discretionary to mandatory. Mandatory funding would give some certainty to health care. VA facilities would not have to deal with the whimsy of discretionary fund-

ing, which has truly proven inconsistent and inadequate. We believe that mandatory funding would provide a comprehensive solution to the current funding problem. Once health care funding matches the actual average cost of care for veterans enrolled in the system, with an annual indexing for inflation, VA can fulfill its mission.

Before I address the budget recommendations for the National Cemetery Administration, which is AMVETS's primary responsibility in the development of the Independent Budget, I would like to thank the members for all of their strong leadership and their continued support for veterans. Through your work you represent the veterans' voice, and you have distinguished yourselves as willing to lead the country in addressing issues important to veterans and their families. We thank you.

Since its establishment, the National Cemetery Administration has provided the highest standards of service to veterans and eligible family members in the system's 120 national cemeteries. At the close of fiscal year 2004, we are hopeful that the system will have 124 national cemeteries, because progress is currently under way at several sites around the country to complete construction. These sites include Atlanta, Detroit, Miami, Pittsburgh, and Sacramento.Without the strong commitment of Congress and its authorizing committees and appropriations committees, VA will likely fall short of burial space for millions of veterans and their eligible dependents.

The members of the Independent Budget are encouraged by the administration's recommended increases in NCA resources for fiscal year 2004. However, it should be recognized that, while the proposal addresses employment increases and equipment needs, it does not serve to address problems and deficiencies identified in the Study on Improvements to Veterans Cemeteries, a comprehensive report submitted in 2002 by VA to Congress on the conditions of each cemetery.

Volume 2 of the Study identifies over 900 projects for gravesite renovation, repair, upgrade, and maintenance. The total estimated cost, according to the Study, of completing these projects is nearly $280 million.

As any public facility manager knows, failure to correct identified deficiencies in a timely fashion results in continued, often more rapid deterioration of facilities and, hence, increasing costs related to necessary repair. The Independent Budget veterans service organizations recommend that Congress and VA work together to establish a timeline for funding these projects based on the severity of the problems and commit additional funds for maintenance.

Volume 3 of the Study describes veterans cemeteries as national shrines, saying that one of the most important elements of veterans cemeteries is honoring the memory of America's brave men and women who served in the Armed Forces.

Indeed, Congress formally recognized veteran cemeteries as national shrines in 1973, stating that all national and other veterans cemeteries shall be considered national shrines as a tribute to our gallant dead. Many of the individual cemeteries within the system are truly steeped in history; and the monuments, the markers, the grounds, all the related memorial tributes represent the very foun-

dation of these United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Unfortunately, despite NCA's continued high standards of service and despite a true need to protect the nurture of this national treasure, the system has been and continues to be seriously challenged. The current and future needs of the National Cemetery Administration require continued adequate funding to ensure NCA remains world class.

The members of the Independent Budget recommend that Congress provide $162 million in fiscal year 2004 for the operation requirements of NCA, the national Shrine initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed Forces. This is an increase of $17.8 million over the administration's request for next year.

For funding the State Cemetery Grants Program, the members of the Independent Budget recommend $37 million for the new fiscal year. This is an increase of $5 million over the administration's proposal. The State Cemetery Grants Program is an important complement to NCA. It helps States establish gravesites for veterans, and it has become a very attractive program.

At the start of fiscal year 2003, the State Cemetery Grants Program had 11 new cemeteries under design and 13 new cemeteries in planning. In addition, the program had on hand 37 pre-applications, for a total of $165 million.

The IBVSOs estimate that a budget of $37 million would respond to demand and help honor veterans.

We also support several new increases in veterans' benefits regarding burial that have gone untouched for a number of years. These benefits have eroded over the years, and we list these in our statement and also in the Independent Budget. We are hopeful that Congress can take time to take a look at these and enact legislation that would augment these benefits for veterans.

In addition, we would like these benefits indexed for inflation so that we could avoid future erosion.

This concludes my statement. Thank you, Mr. Chairman.

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

[The prepared statement of Mr. Jones appears on p. 131.]

The CHAIRMAN. Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Mr. Chairman, distinguished members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States and our Ladies Auxiliary, I wish to convey our appreciation for inclusion in today's important hearing.

As an organization and as a proud co-author of the Independent Budget, we are strong advocates for an adequate budget for the Department of Veterans Affairs. While the primary focus of that attention is on actual delivery of health care and benefits for our Nation's veterans, we cannot afford to forget the importance that con-

struction and maintenance plays in the process. If VA does not invest proper amounts of money in its infrastructure, it will have immense repercussions in coming years when patient comfort, safety, and VA's ability to modernize equipment and facilities are compromised. Supporting additional funding now will lessen future burdens on patients and staffs, improve patient and worker safety, make health care delivery simpler, and even reduce costs in the long term.

Despite the importance of those factors, we are once again left with a budget request that falls short of these important goals. Using the old budgetary methodology, the request calls for $272.7 million and $252.1 million for major and minor construction projects respectively. That is far short of the $436 million and the $425 million the IB recommends for those same major and minor construction projects.

Further, VA's request for major and minor construction includes funding for the Capital Assets Realignment for Enhanced Services, also known as CARES, process, something we believe should be kept separate. Besides the $183 million earmarked for CARES, VA requested a paltry $89.3 million for major construction projects. Our request of $436 million does not include the CARES project. When we consider the CARES numbers separately, the construction accounts are even more strikingly deficient.

We recognize the difficulty of VA's position with regard to the construction budget. VA must often carry out these backlog maintenances and improvements within the context of the larger CARES process. Despite this, just as we strongly urge VA to exercise great care in divesting itself of properties until the process is complete, we also point out that it is essential that construction and repair continue on existing facilities. The pending status of CARES has led to the deferral of many basic projects vital to the sustenance of the VA's physical plant. VA has identified a number of high-risk buildings in desperate need of repairs, and the CARES process should not distract VA's obligation to protect its assets, whether they are to be used for current capacity or for future realignment.

We are greatly concerned with the way that the VA has delayed major construction projects because of the CARES process. As expressed just now, VA absolutely must continue maintenance and upgrades to existing facilities for the health of the infrastructure and for the proper care of our veteran patients.

With respect to the CARES process as a whole, we generally remain supportive. We acknowledge that there are some VA facilities that are unusable or unnecessary due to the aging infrastructure as well as the transformation of VA health care into a more outpatient-focused system. If the process truly does enhance services, then we are truly behind it. VA must ensure that the statistical model used reflects the particulars of VA's many specialized treatments to ensure that CARES really does serve the veteran population both now and into the future.

A concern that was particularly problematic in Phase I is the lack of clear communication. As Phase II begins and rapidly expands the process throughout the country, we must ensure that veterans—VA's patients and customers—have a voice in this proc-

ess. We simply must know what is going on and what the planning process is so we can make informed decisions and suggestions.

We urge Congress to enact legislation that would raise the limit on minor construction projects from $4 million to $10 million. The current cap inhibits many VA facilities from properly carrying out construction projects by forcing them to reduce the scope of the project or to group several small projects in an uneconomical, piecemeal approach. Raising this cap would allow VA to conduct more essential projects, and we thank you for your efforts in support of this endeavor in the last Congress.

I would just briefly join in with my colleagues here at the table in support of mandatory funding for the Department of Veterans Affairs. It seems to us, too, that it would be a far simpler and better thing to do to simply adjust the formula annually to take care of the dynamic situation with veterans' health care, instead of engaging in the annual discretionary battles where we just never seem to prevail.

I also agree with my colleagues at the table that eligibility reform addresses far more than simply funding issues. At that point in time before eligibility reform, the veteran was confronted with such a complex and labyrinthine eligibility system that many eligible veterans were denied the care that they needed and deserved, And we salute you for what you have done in that regard.

Mr. Chairman, that concludes my statement.

The CHAIRMAN. Mr. Cullinan, thank you very much for your testimony.

[The prepared statement of Mr. Cullinan appears on p. 137.]

The CHAIRMAN. I want to thank the four authors of this very incisive and remarkable document you have presented to us. Regrettably, I didn't get to read it until last night, but I read the entire thing, yellow-highlighted it, and pulled things out.

(A document entitled, "The Indepependent Budget For Fiscal Year 2004, A Comprehensive Budget and Policy Document Created by Veterans for Veterans" is retained in committee file.)

The CHAIRMAN. As you have noted in the past, and I think many of the ideas that you proffer in this very good recommendation or set of recommendations we did turn into law last Congress, and we plan on doing the same thing again. I mean, when you speak, we do listen; and the valuable time you spend giving us your best wisdom is greatly appreciated. I want you to know that.

This is a blueprint for action. It has been in the past. It will be this year.

I am grateful that you have had an entire section devoted to mandatory spending and the rationale for it. I think that debate was necessary. As I think you pointed out, Mr. Violante, when we did eligibility reform, that was a recommendation that fell off the charts again.

And if ever there was a year when the inadequacy of the process has been demonstrated, it is this year. Many months into the fiscal year, which began on October 1st, we still don't have a veterans' budget. And for the Secretary, that is an extremely difficult situation to be in and especially for the veteran beneficiary and user of health care.

I noted in your monologue, you point out what we know on this committee but more Members of Congress should know, that dollar for dollar we get the best bang for the buck using VA health care. And I appreciated your point, which I mentioned to the Secretary in the conversation earlier, that 67 percent of the enrolled veterans in fiscal year 2003 were Category sevens, but they accounted, according to your calculations, for about 13.38 percent of the total VHA medical care budget. We think it is around 12 percent. So the numbers are order of magnitude, right in the same ballpark.

So there is this sticker-shock mentality that so many Category sevens are using so much of the health care dollar when indeed they are not. The ones through sixs still, necessarily so, occupied the majority of the money.

Let me ask you then, because I appreciate predictability, adequacy and all those points which you have made so eloquently, do you believe that mandatory funding would positively impact on Categories one through six, and why?

Mr. VIOLANTE. Yes, I do. In fact, I think the equation would also positively impact on 7s and 8s. But what it does is it provides a formula for those veterans who are seeking care from the VA, are enrolled in the system, and provides a per capita base that is increased with the medical CPI. So it guarantees a source of funding at least 2 to 3 months, maybe 4 months prior to the fiscal year and requires the Secretary of the Treasury to provide VA with that funding at that time on October 1st, allows VA to plan in the meantime for their needs.

I would also like to point out that in the DOD budget there seems to be a provision in there to expand the mandatory funding stream for all military retirees similar to the one that was put in place for Tri-Care for life for Medicare eligible veterans. So I would certainly like to see that happen. But I hope we don't get forgotten in that equation.

Mr. CULLINAN. Mr. Chairman, we would certainly agree. It would benefit all veteran users. I mean, right now VA doesn't get enough money. They don't get it in a timely fashion. And mandatory funding would rectify that situation. It would allow the VA planners to plan, which is something they can't do very well right now. It would have systemic benefits.

The CHAIRMAN. I appreciate that. And the more information you could provide to us on that, because I seem to be hearing an argument that says if we just curtail enrollment, if we just do this or that, we inhibit utilization by sevens and eights, somehow we are out of the problem. And I don't think that is the case.

I think that we do have a systemic problem, and the mandatory funding scheme would ensure that the ones through sixs get an enhanced and certainly justified, and you would call it entitlement, frankly, because I think with service to our country, we can play semantic games and say, are you eligible, are you entitled. I believe that veterans are effectively entitled, and ones through sixs have an absolute entitlement that in terms of budget priorities, so they should be first among others.

I do have a question, Mr. Cullinan, on the CARES process. I have been through several BRACs myself. Several of my bases in my district were on the BRAC list. One of them, Lakehurst, was

actually going to be radically downgraded. It does all of the launch and recovery for our carrier fleet. As a matter of fact, my brother was a pilot on the Enterprise, was shot off with his A–7 many a time and every time was safely catapulted and returned. But that vital work went on at Lakehurst. That was going to be radically realigned.

It turned out that the basic information that was used to come to those conclusions was as flawed as it gets by a factor of 300 percent, three times. They said it would cost $97 million to radically realign, the base and this is the BRAC, the BSET, when they did their original work, only to find out that it was triple that amount.

My point is, I am concerned, and I assume absolutely goodwill on the part of the VA people who will be doing this. But mistakes can be made—big mistakes can be made. I know we will be doing vigorous oversight to make sure that CARES is done properly, but we have got to make sure that is not, you know, garbage in, garbage out. If you don't get the right data calls, you are going to get the wrong information coming out.

And I agree with you, we have passed bipartisan bills, such as H.R. 811, the construction budget which was another bite at the apple, only to go over to our friends on the Senate side who said, hold on, we are waiting for CARES. And that has happened year in and year out. So you are absolutely correct that you have many construction projects that have not been funded owing to waiting to see what CARES says. So you might want to respond to that even further.

But we have got to make sure of the information going in so that we do get an enhancement—we all remember the H word in this—and not just a loss of medical centers or outpatient clinics.

Mr. CULLINAN. Thank you very much, Mr. Chairman. We are very concerned that VA is using both adequate and appropriate statistics in assessing the process. And, to be quite frank, it is very hard for us to get a handle on what exactly is going into this process. We don't know. That also touches on our concern that our—the veteran user is not being adequately consulted as well.

I mentioned in my oral presentation or written presentation as well, VA has a very special mission, or missions, I should say, dealing with specialized services, you know, special care for traumatic injuries. They have a different patient caseload than is generally apparent in the private sector. All of these things have to be taken into consideration.

I would also like to say that the BRAC, the BRACs, those were devices to do away with. Those were systems designed to actually reduce facilities. And what they did is they circumvented the political process by doing it in that manner. We would not want to see CARES used in anything like that. We insist that CARES only be employed towards enhancement and improving veterans' health care and, in fact, making accessible to as many veterans as possible.

The CHAIRMAN. Thank you very much. Mr. Evans.

Mr. EVANS. No questions, except to say that I appreciate the work that you have done on The Independent Budget and for the mandatory funding legislation.

The CHAIRMAN. Thank you, Mr. Evans. Mr. Beauprez.

Mr. BEAUPREZ. No questions.

The CHAIRMAN. Mr. Filner?

Mr. FILNER. Thank you, Mr. Chairman.

Thank you, as always, for what you do for this Independent Budget. It is an incredible amount of work. It is professionally done. When are you going to have the final draft? Those of us who read this, like the chairman, need to know if you change anything—because whenever I have tirades around the country, I wave this and I have got to have good color copies of it because this is my Bible.

Mr. CULLINAN. Mr. Filner, I am pleased to tell you that it is at the printer, and the color is outstanding as well as the content.

Mr. VIOLANTE. It should be ready on the 25th.

Mr. FILNER. Fantastic. And, Joe, I appreciate your connecting what we do here on the Veterans Committee with the morale of our active duty personnel. When we are deploying our young men and women, it is important for them to know that they will be adequately treated when they become veterans. This is a really important part of their morale; and I appreciate your seeing that connection and understanding that. We have to see that what we are doing on this committee is absolutely connected to current events and not just past history.

The gentleman from Indiana was waving around this budget earlier. And I read it. I think it ought to be "entitlements" anyway, but what you say is not "entitlements," you say "benefits to which they are entitled." That is the very definition of eligibility. So, I don't know what he was talking about. But you recognize that very clearly.

This is, entitlement by law—which is eligibility. And Dennis, you talked about "eligibility reform." I don't know that in detail, and apparently a lot of other people don't. You might want to inform the gentleman from Indiana the full implications of that and what it would mean if we went back to the pre-reform days.

Maybe we as a committee ought to review that at some point so we all know the history and what was improved. I think you ought to at least take a little presentation to the gentleman from Indiana, because I learned from what you have said, and it is very important to know that.

You know, I am always giving you advice. You do a wonderful job here. But you know as well as I do this budget process is governed by politics and not by pure humanitarian or beneficial or even legal concerns. Unless your folks are making a lot of noise through the whole process, they are not going to get what they deserve. They shouldn't have to do it. But if they don't make the noise, they are not going to get what they do deserve.

Your folks are in every district, and you keep them well informed. I think you need to name names and take prisoners and let your Members off the leash. We need to hear them in Washington. I think there is a demonstration tomorrow, in fact, that is as much aimed at you guys as it is at us. That is, it is grassroots folks who are not convinced that they are being used by your organizations in a politically effective way.

So if you want to respond, that is fine. I have said this a lot of times to you both in public and in private. You have got a lot of power. It has got to be used. It has got to be used.

Anyway, thank you so much for what you do.

Were you going to say something, Mr. Bollinger? You are from Pittsburgh, and I am, too.

Mr. BOLLINGER. Right. I know that. We hear you, and we will be here in force week after next meeting with all of you, and our members will be here. So——

Mr. FILNER. You have got to bring them back when the conference committee meets, because nobody knows what goes on in that committee and no fingerprints are left. And that is where the pressure has got to be.

You know, when we had concurrent receipt—the House voted for it, the Senate voted for it. We had 400 co-sponsors in the House. Mr. Bilirakis has worked intensely for years on this. We instructed our conferees. Then a vote occurred when we were all on our way to Washington from our districts, when leadership insisted there would be no votes, but a voice vote occurred, and there was no concurrent receipt. I call that concurrent deceit, and the people who did that should be identified.

I don't know what happened, frankly. All of a sudden, it is gone; and nobody will talk about it. Nobody takes any responsibility.

I think that was an incredible slap at not only the veterans but the Congress. We said what we wanted, and the conferees just eliminated it. I thought that was a horrible thing, and we have got to watch that process intensely.

The CHAIRMAN. Thank you. Mr. Bradley.

Mr. BRADLEY. Thank you. But nothing at this time.

The CHAIRMAN. Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman.

Last week, our chairman was kind enough to have a group come in, Mr. Violante; and we learned that the disabled vets own over 800,000 small businesses in America. And I realize my question doesn't necessarily go towards care directly, but, as we all know, work is healing. And we felt the passion of one gentleman who came and testified and spoke of his inability to get Small Business Administration involved in contracting many of the types of contracts that the government lets, particularly DOD, to the disabled vets.

And one of the things that struck me and I didn't get a chance to ask what I would ask you is, is there a national database available where our disabled veterans plug in and give a short description or a bio on what it is that they are doing as far as the small business community goes, no matter where they be located anywhere in the world, including Pittsburgh?

Mr. VIOLANTE. Mr. Renzi, I am sorry, I don't know the answer to that question. I don't know of any database out there, but there may well be, and maybe someone else may know for a fact. But I don't.

Mr. RENZI. Sir, do you want to?

Mr. CULLINAN. Yeah. Mr. Renzi, I don't handle employment issues. We have a directorship that actually is specific to that area. But I do know from that gentleman that the Department of Labor

has an Internet-based database where information like that is stored and made available. If it does exactly what you are talking about, I don't know. But I know——

Mr. RENZI. It seems to me that so many of our veterans, as we spoke last week, are hiring veterans and that if we have disabled veterans coming out of the hospitals, coming out of the therapy sessions and looking to move into small businesses, they are naturally going to be able to move in with less stress to those businesses that are owned by disabled. We assimilate to our own types and kinds. And if we had that national database that could also help not only our small business community find those disabled veterans in order to let their contracts, it could also help provide our therapists and our health care people with where they could probably find more of an easier employment.

Mr. CULLINAN. Mr. Renzi, as nationally, we have encouraged our posts—we have about 10,000 nationwide—to help veterans secure employment. But something at the level of sophistication you are talking, we don't have as an organization. We do the best we can. We tell our local people, hey, give a veteran a hand getting a job or the training or whatever he needs. But that level of sophistication or organization we simply don't possess it.

Mr. BOLLINGER. Mr. Renzi, let me add something to that. For those with catastrophic disabilities, it is not just a matter of dealing with a potential employer. It is a matter of rehabilitation and health care. And as you think through that whole process, please don't forget people with severe catastrophic disabilities, because their problems begin in the hospital and in the rehab process, not just when they are trying to get into the employer's door.

Mr. RENZI. That is well said. Thank you, gentleman.

Mr. FILNER. Mr. Renzi, would you yield for one second?

I am behind you. What you bring up is a very important issue. We mandated SBA, Small Business Administration, to be doing exactly what you said.

The CHAIRMAN. It was a goal, though. That was the problem.

Mr. FILNER. And they haven't done it. We set it as a goal. We had hearings. We have to keep an eye on them. Because you raise a real important issue, and there are ways to do it, but they haven't done it. And the SBA was the key there. So if we can do some oversight on that, that would be great.

Thank you, Mr. Renzi, for bringing that up.

The CHAIRMAN. I would say for the record that Mr. Renzi and I and others, and it will be a bipartisan bill, are looking at language, and he is likely to take the lead on it, that would maybe even establish a mandatory goal. Because as we got from the folks from the GAO and others who testified, the trendline is in the opposite direction. Rather than reaching the goal, the contracts that are being let are going down. They are declining. It is a very negative trendline. So we need to infuse some kind of discipline to break out and to make sure.

But thank you for raising it; and thank you, Mr. Renzi, for raising it as well.

Ms. Brown-Waite, and then we go to our chairman.

Ms. BROWN-WAITE of Florida. Thank you.

I recently was approached by a person who is a retired official earning about $70,000 a year in pension plus Social Security; and he said to me, "you have got to do something to improve veterans' health care." I said to him, well, tell me a little bit about it; and he proceeded to tell me that he had to wait a long time to get into the Veterans Administration. And I said to him, well, I said, I know that you have the ability to take with you health care into your retirement. I am sure you did it, because it is a wonderful buy. Why are you utilizing the Veterans Administration? And the response was, well, it is the difference between $7 for a prescription and $35 which he would have to pay under his prescription drug program.

As long as we have this phenomena out there—I know the Federal government prints money, but as long as we have this phenomena out there of people who are going to the VA for the low-cost prescription drugs when truly they can afford the $35 under their other plan, tell me how we are ever going to care for those veterans who truly need it. Anyone care to venture a guess?

Mr. CULLINAN. Ms. Brown-Waite, I would have to say that that would be an exception. It has been our experience that there really aren't all that many veterans who are that financially that well off accessing the system. Are there those who are better off using it? Yes, there probably are. But still, to us, that doesn't mean that other veterans who really need it, need those drugs, those medications should be disenfranchised through the budget process.

Ms. BROWN-WAITE of Florida. But that is part of the problem. I mean, he is taking someone's slot who is having to wait. This is where the duplication of services come in. And is it fair to the person who is now at the 18-month waiting period because this person is there receiving prescription drugs? He was a veteran. If he needed the services, I would be the first one to say, you know, he should absolutely be receiving them. But this is a person who has other health care coverage. And for the difference between the $7 and the $35 he regularly—because he has to go back for the refills—is duplicating services. How do we set up a system where someone such as this person—and I know of others since then. How do we make sure that they are using the other system so the truly needy veterans can get in?

Mr. JONES. Well, one way you can't do it is the way it is currently done at VA, and that is simply to ask the veteran if he makes more than the threshold amount. You have to have a database. And for a $70,000 veteran on the VA ledger of data, this fellow is simply someone who is a Category 8 veteran who makes over $24,000 a year and above the HUD poverty factor now called a VA poverty factor.

Mr. JONES. VA doesn't have the data. You need to have that data if you want to return cash from individuals who can afford the payment. And if this individual, further, has medical care insurance, you have to Ensure that VA collects from that individual's insurance provider. VA has a very poor record in that regard, despite the testimony, given today by Dr. Roswell, of the superb advances being made in medical care cost recovery.

Mr. BOLLINGER. Ms. Brown-Waite, I am sure there are plenty of those individuals. I think one thing that we should not forget and

that we should by all means remember is a lot of those people go to the VA because the VA provides good health care. And I know in the case of those who need specialized services, like spinal cord injury, 80 percent of our members utilize the VA health care system. We go there because it is good health care, and for many of our members it is the only health care they can get for such a comprehensive disability that requires a multidisciplinary approach of care. So they use the system not just for their drugs, but they also use the system because they provide good health care.

The CHAIRMAN. Chairman Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman. Thank you, gentlemen, for your service to the country, and, I should say, for your continued service to the country by serving our veterans.

I was reading through the Independent Budget, and I noticed in the guiding principles that the first principle listed involving benefits and waiting for benefits to which they are entitled, was repeated. Is that because it is all about location, location, location? Are we repeating ourselves, or is that a printer's error?

Mr. BOLLINGER. I think someone mentioned it is at the printer now, and hopefully we can take that second one out.

Mr. SIMMONS. I used to be a proofreader for a newspaper so I did notice that, but you could probably explain it as being a literary flourish, repeating your most important principle.

Looking a little further at the Independent Budget and at the budget that was presented to us by VA, there is basically a focus on numbers and whether the numbers are going up, and that seems to be our standard. You probably heard my comments to the Secretary about the issue of simply building on last year's, without necessarily shaping next year's budget to meet next year's requirements, but also to provide efficiencies within the system.

We all know the horror stories about Federal officials and others who, in order to maintain their budget, essentially waste money the last month of the fiscal year, and that has to be a matter of concern. We all know the stories about medicines and blister packs, and when you break one of the blister packs you throw the rest away, even though they are perfectly good.

And so on and so on and so forth.

In reviewing the GAO report called "Managing for Results: Efforts to Strengthen the Link Between Resources and Results in the VHA", on page 16 they note that certain VHA officials directors, the network Directors, sign an annual performance agreement with the Under Secretary for Health, called the Network Performance Plan, and based on how they do in the course of the year, they may get a bonus.

The question to all of you: How is this working, in your view, and have you heard of anybody getting a nonbonus? In other words, being penalized for not meeting performance standards?

Mr. VIOLANTE. I would have to say it is not working very well. We have seen the same situation over on the benefits side, and I think as Mr. Evans pointed out, last year 85 percent of directors over there were receiving bonuses when we had backlogs, which just didn't demonstrate that they were doing their job properly. And the same does apply over on VHA. And certainly we would like to see accountability brought into the system, because it

doesn't do veterans any good to have money put into the system if it is not going to be used properly and if it is just going to be given out. And obviously, unfortunately, the Federal Government restricts what type of punishment you can meter out, or salary decreases to employees. It makes it difficult, I think, to do that, and maybe that can be looked at also as part of this.

Mr. SIMMONS. Well, I thank you for that. Eighty-five percent bonuses sounds pretty routine to me. I always thought a bonus was for exceptional performance, not routine performance, and if we are giving bonuses to 85 percent of the people, then that is just another aspect of their salary package, and I think that is worth a look.

I have a second question before my little green light goes yellow. If any of the others want to comment on that issue, I would be happy to hear it, but let me put my second question into the record. I have always felt that VA did an extraordinary job in research, and as a Vietnam veteran, I have had colleagues who were burned with napalm, burned with white phosphorous. I have had people who have had limbs blown off and, you know, overcoming the tragedy of the injury is one thing, but often a sense that they really got some pretty good care and that VA research is exceptional.

I notice that we have got about $400 million in this budget for VA research. The Independent Budget goes higher than that. I think you add an additional $52 for 460. I wonder if you would comment on that. Are we doing enough in research?

Mr. BOLLINGER. Mr. Simmons, John Bollinger with PVA. I thank you for raising that issue. It is one of vital importance to the members of the Independent Budget. VA truly is a national resource when it comes to research, and just the fact that they do so much research that focuses on the needs of those with specialized services, so we are very proud of what the VA has done over the years.

It is also a budget that is very fragile in the sense that when you tinker with it too much, and it doesn't have continuity and consistency, researchers themselves become—they can't anticipate. A lot of these projects are multiyear, and it is very important, we believe, that the administration, Congress, fund research at these appropriate levels.

NIH clearly does a lot as well, infinitely more than VA does. And a lot of those researchers use that money, but we believe it is critical that they stay and remain VA researchers for the very purpose that they are doing such good things for veterans specifically.

Mr. SIMMONS. Thank you very much.

And if I could take one more minute, Mr. Chairman, on the issue of research, where do the PVA and the other groups stand on the issue of stem cell research and cloning for purposes of spinal cord and other types of injuries? I have a friend who is in a wheelchair who had a spinal cord injury many years ago, a gunshot wound, and he feels that stem cell research and cloning could be the cure. He is otherwise in perfect health. Where do the organizations stand on that issue?

Mr. BOLLINGER. Well, PVA is working with the Christopher Reeve Foundation. Stem cell research has potential. Clearly, there are a lot of—people who have moral problems with cloning—with stem cell research, with a lot of things like that.

What we are trying to do is look at things that have potential, and hopefully foundations—VA, NIH, and others—will provide resources for those research projects. We believe very firmly in the government guidelines that control how those monies are spent.

I would also say things like umbilical cord research has a lot of potential, and we look forward to making strides there as well.

So my answer to your question would be it has potential, and I think it is important that our government provide the sources for researchers to look into it.

Mr. SIMMONS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. I want to thank our very distinguished witnesses, and just maybe to ask one additional question or make a comment that you might want to respond to.

I would hope that there would be a very significant wall made, a wall of separation between what many of us believe, but not everyone, to be ethical stem cell research and not broad-brush it as if all stem cell research is similar. There is no ethical baggage whatsoever with adult stem cell research which has, frankly, made all of the strides, and all of the advances have been made almost every day, maybe somewhat of an exaggeration, but certainly almost every week there is a major advance made in the area of adult stem cell research. We are literally walking repair kits, if you will, as human beings. We can coax our own stem cells and especially those coming from bone marrow to repair the body, so the promise is extraordinary.

And I think that the debate has been hampered by those who would use embryonic stem cells, where embryos are created and then destroyed, so human life is destroyed. And not everyone agrees with that, but I happen to believe very strongly and passionately that you don't create human life in order to destroy it.

And the same goes with therapeutic cloning, reproductive cloning. There is a clear consensus that it ought not happen, Cloning whereby we clone and kill, again, it I think crosses the line into an ethical morass that we don't want to go into.

And Mr. Bollinger, I am glad you mentioned the stem cells that can be derived from umbilical cords and cord blood, another remarkable breakthrough that gets underfocused upon by the media. There was just a good article about adult stem cells in the *U.S. News and World Report* pointing out that is where the strides are being made, that is where the clinical application is being made.

I chair the Autism Caucus, believing very strongly that there is a cure. We haven't found it yet. I am also chairman of the Alzheimer's Caucus, also believing in both of those instances that stem cells derived ethically hold enormous promise. But I think we get sidetracked and we create a diversion that hampers real medical research and a cure for many of the existing problems, especially spinal cord, that will come, I hope and pray, from adult stem cells.

So my hope is that our own budget and the President's budget, which clearly is putting more money into NIH and the like, will hasten the day when we make strides there. So I just say that for the sake of our distinguished friends here.

Any other comments? Mr. Bollinger?

Mr. BOLLINGER. No.

The CHAIRMAN. I want to thank all of you. Again, you have given us a blueprint, and it will greatly enlighten what we do going forward. Thank you.

I would like to welcome our third panel and ask them to be seated:

Richard Weidman. Rick serves as National Director of Government Relations on the National Staff of the Vietnam Veterans of America. He served as a medic with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969. He has served as a Consultant on Legislative Affairs to the National Coalition for Homeless Veterans and served at various times on the VA's Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans' Employment and Training, the President's Committee on Employment of Persons With Disabilities, and on numerous other advocacy posts in veterans' affairs.

Mr. Weidman was an instructor and an administrator at Johnson State College in Vermont in the 1970s, where he also was active in community and veterans' affairs. He attended Colgate University and did graduate study at the University of Vermont.

Mr. Peter Gaytan is the Principal Deputy Director of the Veterans' Affairs and Rehabilitation Commission for the American Legion. Peter attended Wesley College in Dover, Delaware where he earned a B.A. in political science. He is also a graduate of the Defense Information School, Fort Meade, MD, and earned an associate science degree in public affairs from the Community College of the Air Force.

In 1991 Mr. Gaytan entered the U.S. Air Force, and after completing initial training, served as Military Protocol liaison with the 435th Airlift Wing at Dover Air Force Base in Delaware. While serving there he worked with military, diplomatic, and congressional leaders. He is currently serving his sixth year with the 512th Airlift Wing of the U.S. Air Force Reserve as a Public Affairs Specialist.

Colonel Robert Norton, U.S. Army, retired. He was MOAA's Deputy Director of Government Relations and responsible for its legislative goals for veterans' health care and benefits. Today, however, he is appearing as the cochair of the Veterans' Committee for the Military Coalition. After earning his undergraduate degree, he enlisted in the U.S. Army as a private and was commissioned as a second lieutenant of infantry after completing officer candidate school.

After a tour of Vietnam as a civil affairs platoon leader with the 196th infantry brigade in I Corps, he transferred to the Army reserve and taught school at the secondary level.

Colonel Norton served in various staff positions with the 356th Civil Affairs Brigade, U.S. Army Reserve, until he volunteered to return to active duty in 1978. He served two tours in the Office of Secretary of Defense. He finished his career as a Special Assistant to the Principal Deputy Assistant Secretary of Defense, Special Operations, Low Intensity Conflict, and retired in 1995.

The CHAIRMAN. Rick, if you could begin.

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

Mr. WEIDMAN. Mr. Chairman, thank you very much for holding this hearing today and for your leadership, fighting for proper funding for the veterans' health care system. Thanks to you, thanks to Mr. Evans, and all of your distinguished colleagues on the committee.

We were talking about the core mission of VA earlier today. In regard to health care, it is to deal with those who have been harmed by virtue of military service, or he or she who hath borne the battle and their widows and orphans.

The Secretary of Veterans' Affairs made the correct judgment when he took a step towards the very difficult category 8 decision. People said, why are you all in favor of it? We were not in favor of it. It was a terrible decision, but it was the only responsible decision to take under the dire financial circumstances, and we applaud the Secretary for having the courage to do it and move forward.

The real problem is just not enough money, and we will talk about that here quickly.

In the December meeting with Secretary—Under Secretary for Health, people asked me, because I was unusually quiet, is this the Christmas spirit or what is it, Rick? And my reply was, I am very depressed, because we have failed you at providing adequate resources. This was near the end of a 2-hour meeting, and every single thing on the agenda we were talking about was a distortion in the medical system that was due to starving the system for resources. In other words, many of the management problems we can't get to because there is just flat not enough money. And that is the mission that we have to do so we can get on with utilizing it better.

Triage is hard. I did it as a medic, and that is essentially what the Secretary had to do. And we support him in that very responsible decision. I am going to comment on money in a second. But we need much greater accountability out of this system before we throw them too much more money and certainly before we move to mandatory funding.

In regard to whether or not they provide the proper level of specialized services, whether they are measuring capacity in a way that makes sense, instead of a "let us not and say we did," take a very close look at the bonuses and have clear guidelines as to why people get bonuses and what they actually did in order to achieve it.

We need a financial tracking system that works, because if you ask about how much is spent on X, Y, Z treatment, they can't tell you today, and therefore that financial tracking system does not exist.

The MIS system. The Secretary cannot tell you just by glancing at a report how many hepatologists he has in any place in the system. Think about that in comparison to the Commandant of the Marine Corps can't tell you how many artillery pieces he has at any location in the world, and he would not be Commandant at sundown.

What we have here is a situation where we have gone awry. We have had a discussion, argument, et cetera, for the last 3½ years between—first it was very inadequate versus grossly inadequate budget for the health care system. And this year we are arguing against inadequate versus very inadequate. While we very much appreciate the $1.5 billion increase recommended by the President, it is not enough; and it is good, in the sense that it is better than a sharp stick in the eye, but it is not enough to start to restore this system to where it needs to be, particularly as we have new veterans that—from my lips to God's ear that it doesn't happen, but we do rationally believe it is going to happen, and coming home into a system that is totally unprepared to take care of them.

So our recommendation is $28 billion, which is slightly higher than the IB budget. And that is straight cash. That does not count collections. That is straight taxpayer appropriated dollars of just in excess of $28 billion in order to stay where we are and start to reconstruct organizational capacity. Think of the many thousands of caregivers, and particularly physicians and allied health care people we have lost since 1996. The system has never bounced back from the flatline years, and we need to start doing that systematically and ramp up. We need the money ahead of time.

That leads me to the next thing in regard to funding, is VVA is strongly in favor of mandatory funding and mandatory funding that is on a capitalized basis based on 1996 figures per capita with—indexed and compounded for medical inflation for every year since, and then on into the future. It just has to be that, and then we can press them to become more businesslike in the future.

If you don't know how much money you are going to have, how are you going to ramp up to hire the physicians and allied health care people that you are going to need in the new fiscal year when the uncertainty in this case extends to the end of February, almost halfway through the fiscal year? We need to move to a stable funding phase and one that is based on per capita. We appreciate your leadership on that in the past, Mr. Chairman, and we certainly will back you in the future on that and do everything that we can.

One of the things—there is a projection on the per capita basis—is that for 2004, our understanding is that it is 4.8 versus 5.4. I would remind the Chair that in the 2002 budget when we ran out and had to get a supplemental and never did, that the official figure was 3.9 million projected users, when in fact it was 4.6 million people use the system. But the other 20 percent, since that is a 20 percent gross over the estimate, if you are going on a per capita basis, where was the other 20 percent of the dough? Where was the other $5 billion? And we need to move with that.

There are a number of other programs that we commented on in our written testimony, Mr. Chairman, that I don't have time for now but I do want to bring your attention to in preparing for this hearing, was looking back and researching and found an article in the New England Journal of Medicine from October 31, 1985 that talked about a Wall Street Journal article quoting John Cogan and a former associate OMB director who is quoted in that article, is if in fact whether taxpaying Americans should continue to pay for veterans' care regardless of their income, regardless of whether their disability was related to service and country; if so, then the

taxpayer should recognize that the cost of maintaining current VA medical care policy with no eligibility restraints will exceed $30 billion by the year 2000.

Now, this was an associate director of OMB under President Reagan in his first term. We are so far out of whack in what we are looking at and arguing back and forth, and it is no wonder that we have waiting lines. It is no wonder that we have physicians leaving the system and nurses leaving the system because they can't practice it properly.

Mr. Chairman, I am over my time. I thank you very much for your indulgence, sir, and for you holding this hearing today and for your leadership on so many subjects. Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Weidman appears on p. 139.]

The CHAIRMAN. Mr. Gaytan.

STATEMENT OF PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. GAYTAN. Mr. Chairman, thank you for the opportunity to express the views of the 2.8 million members of the American Legion regarding the Department of Veterans; Affairs fiscal year 2004 veterans' request. As veterans' advocates it is our job to ensure that VA is funded at a level that will not only ensure eligible veterans timely access to quality health care but also timely adjudication of benefit claims.

The American Legion believes the level of funding proposed in the fiscal year 2004 budget request may meet VA's stated goal of focusing on the health care needs of VA's core group of veterans, those with service-connected disabilities, the indigent and those with special needs, but it will also lead to over 1.2 million veterans leaving the system.

Squeezing veterans out of the system is not an effective response to VA's inability to treat eligible veterans in a timely manner. When Congress opened access to the VA health care system in 1996, which was discussed at some length this morning, many veterans believed VA was their best health care option, and many veterans chose to seek their health care from the VA system. Since CMS does not offer its beneficiaries a substantive prescription program, many Medicare-eligible veterans chose to enroll in VHA, specifically to receive quality health care and access to an affordable prescription program.

Since DOD, TRICARE and TRICARE for Life require military retirees to make copayments or pay premiums but does not provide for specialized care such as long-term care, many military retirees also chose to enroll in VHA.

Veterans continue today to suffer as a result of a system that has been routinely underfunded and is now ill-equipped to handle the large influx of veterans waiting to use their services. Veterans continue to endure interminable waiting times for medical appointments, as well as unacceptably long waiting times for claims adjudication.

The problems resulting from years of underfunding run even deeper within the VA health care system. In his first 5 months,

National Commander Ronald F. Conley of the American Legion has visited more than 25 Veterans Affairs' medical centers, and the information he is hearing directly from the facility staff is less than encouraging. VAMCs are expressing their concern over the significant increases in their MCCF goals for fiscal year 2003 and what impact the recent restrictions on enrolling any new priority group 8 veterans will have on their ability to meet these goals.

The American Legion shares their concerns, and we are also concerned about the impact of certain proposals included in the fiscal year 2004 budget request that seek to generate increased revenue for VA from the pockets of veterans instead of through the allocation of Federal funds.

The American Legion opposes the decision to deny enrollment to new priority group 8 veterans. We believe denying veterans access to VA health care, particularly while the Nation prepares for war, is the wrong message to send, not only to the members of the all-volunteer force but also to the young men and women who may be considering a life of service in the U.S. Armed Forces.

The American Legion also opposes the implementation of the $250 annual enrollment fee for nonservice-connected priority group 7 veterans and all priority group 8 veterans. The American Legion would urge Congress to reject this proposal, just as it did the administration's plan last year to charge priority group 7 veterans a $1,500 deductible.

While the Legion applauds the reduction of the pharmacy copayment for veterans in priority group 2 through 5, we do not support increasing the pharmacy copay from $7 to $15 for priority group 7 and 8 veterans.

Additionally, we do not support the increase of outpatient primary care copayments from $15 to $20 for all priority group 7 and 8 veterans. The American Legion would rather VA seek reimbursements from CMS for all enrolled Medicare-eligible veterans being treated for nonservice-connected medical conditions before they try to balance the budget on the backs of priority group 7 and 8 veterans.

While heartened by the administration's proposed funding levels, the American Legion continues to advocate for all MCCF collections to be added to the budget numbers and not be treated as an offset to the budget. Let me echo that the American Legion joins the IBVSOs in support of mandatory spending. We supported it last year, and, Chairman, we will be right behind any member of this committee in supporting mandatory spending for VHA again this year.

The American Legion is greatly concerned by the proposed straight-line staffing requests for VBA's Compensation and Pension Service and for the Board of Veterans' Appeals. There are long-term workload demands associated with the current backlog of pending claims that will extend well into fiscal year 2004. VBA acknowledges that there will also be a continued influx of new and reopened claims based on the enactment of expanded benefit entitlements by the 107th Congress, including the combat-related special compensation pay program, an expectation of additional presumptive diseases and recent precedent decisions of the courts.

Despite the fact that the present military buildup has been underway for a number of months, the budget request does not take into account the involvement of thousands of additional active duty personnel. VA must be able to provide these men and women timely quality service upon their return to civilian life as veterans, in addition to its ongoing responsibility to current veterans.

Despite assertions of improved quality decisionmaking, the number of appeals being filed continues to increase, as does a number of appeals requiring further development, either by the regional offices or by the Board of Veterans' Appeals. The American Legion believes these offices will require additional personnel if they are to achieve the ambitious service improvement goals promised the Nation's veterans and their families in this budget request. Discretionary funding for VBA's 9 business lines total $1.2 billion. While it provides for an additional 17 full-time employees for the education program, which is much needed, the American Legion is deeply disturbed by the lack of any increase in staffing for compensation programs.

We believe this will constrain VBA's ability to address the many internal and external challenges emerging in fiscal year 2003, which will have a profound budgetary and operational implication for the fiscal year 2004 budget. Given the many and varied issues that VBA is faced with, it is imperative that Congress critically evaluate the level of discretionary funding requested and whether this will enable the regional offices to operate efficiently and provide timely quality service that this Nation's veterans deserve. Individuals currently on active duty must also be assured that VA will not only be ready and willing to assist them but have the physical capacity to provide quality service without compromising current operations or benefits.

Finally, Mr. Chairman, let me note that some of the discussions today just raise some questions, and it seems to me that anyone who pays into Social Security in America is entitled to Social Security benefits, as anybody, veterans alike, same with citizens who pay into Medicare are entitled to Medicare. Yet what we have heard today is that veterans are not entitled to care at the VA, and the American Legion feels a little differently about that, and maybe we need to reassess our goals here and see which direction we are headed. Thank you.

The CHAIRMAN. We are just reiterating.

Mr. GAYTAN. Several times.

[The prepared statement of Mr. Gaytan appears on p. 148.]

The CHAIRMAN. Colonel Norton.

STATEMENT OF COLONEL ROBERT F. NORTON, USA (RET.), CO-CHAIR, VETERANS COMMITTEE, THE MILITARY COALITION

Colonel NORTON. Thank you, Mr. Chairman, and distinguished members of the committee for the opportunity to present testimony on behalf of the Military Coalition. This is the first opportunity that the Military Coalition has had to present its views before the full committee, and we really appreciate that.

With me today in the audience is my co-chair on the Veterans' Committee of the Military Coalition, Ms. Kim Vockel of the Noncommissioned Officers Association of America.

The Military Coalition offers a unique perspective on issues affecting the full spectrum of the uniformed services community: active duty, National Guard, Reserve servicemembers, family members, veterans, military retired veterans, survivors and dependents. We bring together the diverse perspective of 33 organizations with a collective membership of over 5½ million members, and we are proud of our record in representing their interests as we speak with one voice on issues affecting them.

I would like to briefly highlight a few of those key issues for the 2004 VA budget submission on the VA health care and benefit programs.

First, the Coalition strongly supports full funding for VA health care for all enrolled veterans. We support the principle that once the government has agreed to accept a veteran for enrollment in the VA health care system it has entered into an implicit contractual agreement to provide timely, high-quality care for that veteran. Under that contract the administration should identify and Congress should enact the necessary funding for timely delivery of high-quality health care.

The Coalition supports the VA's plan to essentially test Medicare+Choice in the VA system, but we caution that those plans have not fared well in the private sector.

Further, we believe that the committee should endorse the funding necessary to permit the entire VA system to meet Medicare access standards. We continue to support actual Medicare subvention in the VA: authorizing Medicare funds to be used directly in VA facilities for the nonservice-connected care of veterans who have paid into Medicare over a lifetime of work. Let the veteran have the choice to use his or her Medicare benefit in VA facilities, as has been the case in the Indian Health Service for many years. VA Medicare subvention would help alleviate VA's funding crunch and allow greater investment in specialty care, infrastructure upgrades, research and so forth.

On the issue of VA-DOD health care collaboration, the Military Coalition strongly recommends funding for continued investment in what has been called a seamless transferable medical record for young Americans when they enter the service and throughout their lives.

An example of the need can be seen in the experience of some 110,000 National Guard and Reserve servicemembers currently mobilized to support the war on terror at home and abroad. When they complete their active duty service, those who are not already veterans will earn veteran status, but if the Gulf War is any indication, many will not have entry or separation physicals to document their medical condition, and even those who do will need to establish a new, separate medical record in the VA for care and disability determinations.

A seamless transferable medical record is long overdue. Adequate support for this initiative has far-reaching implications for improved health care delivery in the VA and the DOD health care system for veterans and servicemembers. It has implications far into the future for improving the VA claims processing system and for enabling medical research in both DOD and the VA.

Turning now to veterans benefits, the Military Coalition recognizes the improvements made in processing disability claims, but we believe more needs to be done to ensure fair, accurate and consistent ratings. We urge the committee's support for adequate funds to ensure that recent improvements continue until the system is marked not only by improved production but a record of sustained, high-quality ratings.

I want to publicly acknowledge on behalf of the Military Coalition the steadfast leadership of Representative Mike Bilirakis who has led the charge for concurrent receipt equity for about 20 years now. Disabled military retired veterans should be allowed to keep all of their earned retired pay and their VA disability compensation.

The Military Coalition's statement indicates that immediate steps should be taken to fairly implement the new special pay for combat or operationally disabled retired veterans. But, make no mistake, the Military Coalition, with the active collaboration of our many partners in the veterans community, is determined to eliminate the dollar for dollar offset of military retired pay by VA disability compensation. With the help of the committee, we will succeed. We ask the committee's support for that ultimate goal and for the necessary funding for the VA to support implementation in the meantime of the new special pay for combat-disabled retirees.

The Coalition appreciates your leadership, Mr. Chairman, and that of Ranking Member Evans on upgrading the Montgomery GI bill. We ask the committee's support for funds to allow those career servicemembers who entered during the VEAP era, 1977 to 1985, but turned down that third-rate education benefits program to be allowed an opportunity to sign up for the Montgomery GI bill. As the backbone of today's deployed force, career servicemembers deserve the same chance to say yes or no to the Montgomery GI bill as all servicemembers who have entered service since July, 1985.

The Coalition continues its active affiliation with the Partnership for Veterans Education, and we urge that the committee support indexing or benchmarking the Montgomery GI bill to the average cost of a 4-year public college education. We also ask for support in proportionately upgrading the Reserve Montgomery GI bill so that it catches up to the basic program under Chapter 30.

Finally, Mr. Chairman, the Military Coalition strongly urges the committee's support for funds to allow retention of dependency and indemnity compensation for surviving spouses who remarry after age 55.

Thank you, Mr. Chairman, for the opportunity to present our views on funding priorities under VA's budget for 2004.

[The prepared statement of Coloner Norton appears on p. 162.]

The CHAIRMAN. Thank you very much, Colonel Norton, for all of your recommendations, but your final ones on the GI bill, we are looking very carefully at those. As you know, we tried and succeeded, to an extent, last year in upgrading the benefit provided by the GI bill. There are a lot of leftover items that we need to capture in a new bill which we are working on right now. So your very timely suggestions will be looked at very carefully.

Do you have any idea what the costs might be of recapturing those Vietnam-era veterans that you mentioned? Hundreds of millions? Any idea?

Colonel NORTON. No, not specifically, Mr. Chairman, but I would point out that when the last VEAP conversion program was conducted about 2 years ago, at that time there were about 116,000 active duty members who had active VEAP accounts and they were allowed to make an option to sign up for the GI bill but only approximately 2,800 took it. So we don't believe that the real cost is going to be that great; but I think the reality is this, that these are our Nation's servicemembers who are leading our efforts at home and abroad—the deployed force—in our war on terror. They should have the same opportunity as all other servicemembers to have a one-time opportunity just to say yes or no to the Montgomery GI bill.

The CHAIRMAN. Okay. Thank you.

You mentioned the Medicare+Choice and that it has some deficiencies. Would you elaborate on that a bit? Because just in general terms but not really relevant to the VA, Medicare+Choice is almost like an idea whose time has come and gone. I know that many of the providers in my own State have opted out because of inadequate funding from Medicare. They just—you know, when they realized that so many seniors signed up, they had catastrophic end-of-life experiences, and that goes for my own parents, whose final bill from cancer, both of them, was extraordinary, and they were in a Medicare+Choice that doesn't even exist anymore. So what are the pitfalls?

Colonel NORTON. As you indicated, Mr. Chairman, I am not sure of the specific pitfalls. What we are attracted to and what we find of interest is that, for the first time in history, the door would be open, if only slightly, for Medicare funding to be allowed in the VA—in a 'pass-through' situation. And we think that is a plus.

As you heard from earlier witnesses, VA physicians and VA facilities would be delivering the care, not HMOs on the outside, as we understand the broad concept.

But, in addition to that, Mr. Chairman, I think it is important to point out that while we endorse the Medicare+Choice plan in the VA, it seems to us that if this is good enough for Priority Group 8 veterans, those with the lowest priority for access to VA health care, then there ought to be a conscious investment in meeting Medicare access standards for all veterans enrolled in the VA health care system. They ought to be able to get primary care appointments within 30 days.

So if a Medicare+Choice plan is good enough for PG 8s, it ought to be food enough for all other enrolled veterans. So we see this as a small window, opening up Medicare. That is a positive thing. Having the benefit delivered in VA facilities is positive, and we see it primarily as a test, because our ultimate goal is to see subvention directly opened up into the VA health care system.

The CHAIRMAN. That, too, is one of my goals and shared by many members of this committee, and we will be doing a Medicare subvention bill. It has been Ways and Means Committee, and in the past it has been a nonstarter on that committee, which has prime jurisdiction over Medicare. But we have tried to make the case that

veterans are going to be getting their health care somewhere. Why not within the VA with those dollars following that?

We even did a Part B bill last year that we will try to—my sense of what we need to be doing on this committee, besides all the specific pieces of legislation, is to make the 108th Congress the year when we found a sustainable adequate funding source for the VA and stopped the nickel and diming, however well-intentioned. And I assume good intentions on the part of everyone, especially on the part of the appropriators, but they are in a competition for those discretionary dollars. We have got to find spigots.

Mandatory is, in my view, the most likely to achieve the goal, but the hurdles to get that enacted—because I have been engaged in nonstop discussions with our leadership, with the appropriators, and when you use the word—I am trying to find a word that is not mandatory, because it seems to frighten people, and they just recoil, but it seems to me that we—you probably have had those conversations as well. We need to get there.

I want to promote a piece of legislation with the right formula, and hopefully the Presidential Task Force will give us an additional push. Because to me that seems to be—and you might comment on this—an opportunity of a lifetime when you have got a Presidential Task Force putting its imprimatur on a prescribed course of action as to how we can fix this. Otherwise, we will be back next Congress saying there has been a gross underfunding of our veterans health care and other discretionary programs.

So, I mean, I am poised to go ahead and go all out, and there are chance—I appreciated that statement you—serious political capital is being expended here. Part of it I think is the lack of understanding of what the VA does and how it does it on a shoestring, so to speak, relatively speaking. So, you know, just a general statement, you might want to respond to it, but I do think that we have an opportunity with the Presidential Task Force, second to none, to finally give—to fire up this idea in whole or in part, and I hope it is in whole.

Mr. GAYTAN. Mr. Chairman, if you don't mind, the American Legion has been involved with the PTF since the beginning. Our national adjutant is the chair on that Task Force, and we have been focusing specifically on the mandatory funding issue and trying to convince the PTF of what you just said, educating them on exactly what the VA does. That is the first step is educating them on exactly what the VA does and how the discretionary funding mechanism right now does not allow VA to meet those requirements. That generates all the discussions in this room, all the bickering that maybe occurs between different members and even the VSO community.

We need to back up and reassess the entire package, and it starts with the funding mechanism. That is why we, the American Legion, have been promoting heavily the sense of mandatory funding and trying to anticipate the PTF's support.

I also wanted to add to the VA+Choice issue. The American Legion, while we applauded any sentence that has VA and Medicare reimbursement in it in a positive way, we backed up a little bit with the VA+Choice program. Our concern is that with the access standards that are mandatory with any Medicare reimbursement

program, be it through the VA or as it exists outside, there is a requirement for a 30-day window, and with the backlog, as you know, exists, be it 200,000 or 300,000, whatever the numbers are, you can't argue it if it is over 200,000. If somebody says it is 300,000, I don't think that difference is huge. When there are 200,000 veterans—they are not numbers, they are veterans waiting to receive health care nationwide and you are going to implement a program that has a 30-day window access standard, the success of any program like that is dependent upon the elimination of the backlog. Until we see the elimination of the backlog, I don't think the discussion of the VA+Choice program is feasible.

Now I understand it is going to be phased in and it is going to be regional. If that is the case, if you are going to phase it in and it is going to be regional, Category 8 in Florida, if it is implemented in Florida, it will be a +Choice program. A Category 8 in Florida could receive health care—has to receive health care in that 30-day window, whereas a Category 1, 2, 3, 4, 5 veteran in a State on the West Coast is not guaranteed that same access standard.

So we are running into priority problems there, too.

While we welcome, like I said, anything with VA and Medicare reimbursement in the same sentence, we want to explore that a little bit further, mention the fee-for-service option as it is outlined in the GI Bill of Health for the American Legion, and we hope to have some productive conversations with the VA on that program.

Mr. WEIDMAN. There are some problems, and Secretary Principi, from when he first discussed the program, noted that there were problems, predominantly with the backlog. But any Medicare reimbursement ought to come over to VA. It is not double-dipping, as some people have claimed; and, in good faith, I think they just don't understand the issue here.

Instead of calling it mandatory funding—and I think, frankly, as opposed to Medicare reimbursement, getting mandatory funding through this year should be everybody's top priority; and VVA, out of our national conference last summer, we came out with two top legislative priorities, essentially, 1A and 1B. Number one is mandatory funding for health care or funding that comes any way obligatory is the word I think that we are leaning towards starting to use now, and the second is vastly increased accountability on the part of the system beginning with the top managers all across the government, not just in VA, but VA is primarily what we are interested in.

The word obligatory comes from Vietnam Veterans of America. We have two founding principles. Number one is that never again shall one generation of American veterans abandon another generation of American veterans; and the second of those principles is that we hold that there is a covenant—and we use that word advisably—a covenant between the American people and those who take the step forward pledging life and limb in defense of the Constitution of the United States, not a particular government, not a particular policy, not a particular war or anything else, in defense of the Constitution, which begins with "we, the people."

And that covenant is, you take the step forward and be prepared to pay the price, and all too many have paid the price, some the ultimate price, but where you have been harmed, where you have

been lessened by virtue of military service, it is the obligation of the people of the United States to do everything humanly possible to make you as whole again as possible, whether you have been lessened physiologically, psychologically, neurologically, economically, emotionally or spiritually, I might add, although we generally don't talk about that, to help make folks whole again, both through government primarily but also through the community. And if we move into that, that—using the obligatory, in that sense, Mr. Chairman, I think maybe people will start to understand a bit more about why this is not just another mandatory program. It is an obligatory program between the people and those who have served and who are serving today.

The CHAIRMAN. Well put. Thank you. Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman.

Mr. Gaytan, I think you would agree that the record needs to show that you are wearing your American flag, your lapel pin, in distress. Is that what you would like to show?

Mr. GAYTAN. Unbeknownst to me, sir. I apologize for that.

Mr. RENZI. It was a message to me, and I want you to know that I am very privileged to be a son of an American Legionaire. I gained that privilege through the service of my father, Major General Gene Renzi. I left his care and security when he was a lieutenant colonel, but when I visit my veterans and when I see firsthand and listen to the testimony that you brought here today, I am reminded very much of my moral obligation to fight tooth and nail for you.

That said, I had the opportunity to visit with some of my veterans at a transitional home, veterans who are trying to move from the streets back into normal life; and I noticed that there are some veterans that will never leave transitional homes. They will be forced out possibly because of the policies, but they benefit from the camaraderie, from the team. And I would like to ask as we discuss homeless veterans where we go with that knowledge that we now have, that they are back with their unit, they are back with their comrades, that their quality of life is better, they are happier in that setting that they are in and how the system tends to move them out and where we can—could you expand more, Mr. Weidman?

Mr. WEIDMAN. Yes, I would be happy to, Mr. Renzi.

The obligation here for—towards VA, towards those veterans who are never going to make it on the outside, we strongly believe at VVA that it is to make a veteran as independent and fully function as possible. For those of working age, that is to get people to the point where they can take on and sustain meaningful employment; and we believe all veterans programs should be measured against that litmus test. Is it cost-efficient and effective, contributing to that final goal?

However, there are some folks who used to be on what they call back wards at VA hospitals and at particular places like Perry Point or Bath, New York, who even we knew were never going to hit the street. They weren't going to be able to make it without that supportive setting, not just of the institution but of those other individuals who shared that watershed life experience with them. And VA has not provided for that.

There is no place in this Nation—they keep saying there is. We keep saying, will you tell us so we can talk to them—where a veteran can be kept for longer than 105 days. No place. No place. And so what happens is we bounce them out and then they hit the revolving door, they hit the street, they get picked up and then they go back again. So that can be taken up much more efficiently and we believe more effectively with permanent housing.

We believe that the transitional housing in a setting of a 2-year limit now is an artificial one. It is not required by statute, number one; and, number two, OMB's proposal to move that from the mandatory funding side over to the discretionary side means that they are planning to go after it. Why people would go after a homeless veterans reintegration program—I mean, who the heck can be against homeless veterans getting jobs and earning their own way? And it is the most cost-efficient program at Labor.

But the key point here is that permanent housing is needed for some veterans, and it may be that permanent group housing is needed to help people sustain employment after they get it. And it is smarter for us to do that, because we will have fulfilled the goal of helping American veterans who have been injured by virtue of service become taxpayers again; and if we are not doing that, then something is wrong.

Mr. RENZI. Well said, sir. Thank you.

The CHAIRMAN. The gentleman yields?

Mr. RENZI. Yes, sir.

The CHAIRMAN. I thank my friend for yielding.

Earlier in the week or last week I met with Elaine Chao, the Secretary of Labor, and on the one hand thanked Labor, because they I think are committed to the Homeless Veterans Reintegration Program. They asked for a million and a half more, and that is in the budget. It will go up to 19.5 million from 18. But, let us not forget, we authorized in the Homeless Veterans Assistance Act $50 million; and I asked her to do everything humanly possible and I asked the Secretary of VA, Mr. Principi, to try and ratchet that number up as much as possible. We have to do our part, but it is hard when we get a budget figure that is at a certain level and the expectation among the appropriators is, well, that is all they need or spend or can absorb. So anything we can do to get that 19.5, even though it is a very modest increase, we ask your help on doing that as well.

Because I do think we have Secretary Chao's ear; and her heart, as she expressed in our meeting with Mr. Ryan and others on our staff, seems to be very real. She wants to work to eradicate homelessness; and your piece of it, more than anything else, is job training.

But thank you for bringing that up, because we have got to get more funding for it.

Mr. WEIDMAN. May I, Mr. Chairman?

The HVRP, it has always puzzled me why people don't go for it. It is strictly accountable, it is performance-based, and you have to deliver or you don't get the dough again. I mean, I think that is what some people at Labor and within the Employment and Training Administration and elsewhere don't like about it. There is accountability built into it, and we get more people into jobs at less

cost per head than any other Labor program. Otherwise, they don't renew the contract.

Our view is that that is the kind of accountability that needs to be built into all the Labor programs, number one; and, number two, to not ratchet that number up in terms of contractors. The excuse given is they don't have the organizational infrastructure within the Department of Labor. Our view at VVA is to contract with some service-connected disabled veteran-owned businesses and they will help you do their job.

Incidentally, Labor is one of them that in the first three-quarters of fiscal year 2002 had zero contracts with service-connected disabled veterans, zero, sir. So this would be a place where they could start.

The CHAIRMAN. Thank you, Mr. Weidman. Chairman Simmons.

Mr. SIMMONS. Thank you, Mr. Chairman.

As you know, I guess from sessions last year and 2 years ago, many homeless veterans suffer from post-traumatic stress syndrome, which research at Yale University and elsewhere has shown is a physical condition, not a mental condition. The brain actually changes in its chemistry and structure; and, consequently, you have to address that physical change before you can place the homeless vet in a home, because they won't stay. That is the challenge of it. And I think, again, when we talk about research and the research budget for the Veterans Administration, we have to have those dollars to do this kind of research, because it is developing all the time.

That being said, I was interested in Mr. Gaytan's comments or in his submitted testimony. On page 6, he refers to, again, research conducted by the VA. Towards the bottom he says, VHA's fourth mission is to support DOD during a national emergency. And the issue of bioterrorism is raised. We have spent all day today talking about the shortfalls that occur in the budget and the difficulties that we encounter in administering programs in VA, and yet especially now, especially following Secretary Powell's speech to the UN, especially following September 11, we have to also be aware that VHA has a responsibility for a bioterrorism attack on this country and on its people.

I wonder if any of the witnesses would like to comment on where they think the VA is on that topic.

Mr. WEIDMAN. Two comments, one if I may about the research. We did not mention that in our testimony for good reason, because we have still—they still are not requiring that a complete military history—it should be for every veteran that comes to the VA, but every veteran who is a participant in clinical trials under—funded under R&D, or the Myricks—there were over a thousand studies going at the VA facilities on schizophrenia of one sort or another, and none of them is scientifically valid in our view because they don't ask anybody whether or not they were ever exposed to combat and test whether there is post-traumatic stress disorder going on at the same time as the schizophrenia and whether there is an impact. So when they test treatment methodology and pharmacological problems, they have ignored a major variable, that they have not tested against the null factor, and that in our view doesn't pass anybody's litmus test for being proper science.

That said—first thing on that. The second thing has to do with the preparation for the fourth mission. As you no doubt have seen, Mr. Chairman, the latest issue of the VVA veteran which focuses on the fourth mission—and some things are good and some things are not so good. It is our view that taking a military history and exact locations and knowing what that means and training your physicians what that means is now more important than ever with the young people who are likely to come home from overseas. That is one thing.

The second thing is there simply is not the organizational capacity to deal with any kind of major terrorist attack in this country. The Secretary admitted that had, in fact, we had 5,000, 3,000, whatever it is, casualties as the backup system, that the New York Harbor VA system would have simply collapsed and the civilian system imploded had there been that many casualties all at once.

And the last thing is that—I would hope that the committee can ask questions as to why this is, is that there not only are not chemical warfare and biological warfare specialists on call and/or training the rest of the staff at each of the 168 medical centers around the country, there are no plans to do it. This makes no sense to us at all. You are going to have people coming in, and the doctors are not trained to recognize what they are seeing, because these are specialized treatments.

If this is going to be a veterans health care system, we have to start being a veterans health care system and dealing with the special things that veterans were exposed to; and, please, God, it never happen, our civilian population may be exposed to it. But we have got to be ready, and we are not taking the steps to get there, sir.

Mr. SIMMONS. I thank you for that response; and I just lifted my eyebrow to the Chairman, because it is a unique challenge that we have that has not really been brought to the table, I think, in a way that it should have been.

The CHAIRMAN. Can we yield very briefly?

Mr. SIMMONS. For all the time the Chairman wants.

The CHAIRMAN. We should have asked it earlier, but the Independent Budget did spend and devote some real quality time, beginning on page 1, with the fourth mission and pointed out that the Secretary himself had said $250 million is needed within the VA for that function, and he got zilch.

We passed last year the Medical Preparedness Act which would authorize up to four, hopefully more, medical preparedness centers to look at chemical, biological and radiological threats, at least one each; and the appropriators in their original VA-HUD appropriations bill had a specific line item that said no funds will be spent on implementing this bill, which I found absurd in the extreme at a time when biological and chemical and radiological, but certainly the first two, are an imminent threat.

We found—and I don't want to belabor the point, because the hearing has gone on long—but when anthrax hit Hamilton Township, New Jersey, as it hit Brentwood, I sat in on those meetings and heard experts from the CDC and others, very knowledgable people who didn't have a clue, to some extent, who certainly didn't know whether or not cross-contamination took place, didn't know how much Cipro to give for how long, on and on and on, suggesting

to me that there was no protocol off the table that could be taken and looked at to know what to do. And there are, what, 80 or so different toxins and combinations that could be used, nerve gas, sarin, smallpox and company, et al., whatever, that could be used against us militarily as well as against civilians, and we have not sweated the details in a Manhattan Project-like focus to come up with what to do if it happens. That is irresponsible.

So these preparedness centers, coupled with, as Mr. Weidman pointed out, experts who can be counted on—but the experts have to know what it is they have to do, and I don't think we have the answers to that yet. And, hopefully, Saddam Hussein and al Qaeda and Hezbollah and others don't know that we don't know, but I am sure they do.

That comes down to a money issue as well, and my hope is we have got to solve the adequate funding issue, but as to the fourth mission, it is not being done the way it could be or should be, and so I appreciate you raising that very important question.

Mr. SIMMONS. Would the Chairman yield?

I thank you for that, and I made the comment earlier that it would be my hope that the Health Subcommittee could put together an agenda where many of our talented colleagues on both sides of the aisle would have a chance to go after some of these issues in a little more detail, and I suspect that we will. But I think this has been an excellent hearing to illustrate some of the problems that we face, Mr. Chairman.

The CHAIRMAN. Any other questions or any other comments from our panel?

Mr. GAYTAN. Just briefly, I want to mention that the American Legion does think this is a very important issue. We included it in this testimony, and our National Commander included it in his full testimony in September. We have a team of VA&R employees who make quality review visits, and the Commander himself has been making facility visits. And this is one issue that he is focusing on, is the facility's ability to meet that fourth mission. The fourth mission is a reality. It is something the VA has to do. The funds not being there is another reality. How do you accomplish the goal without the funds being provided? This is one other obstacle that we need to overcome to improve the VA.

One other issue I want to bring up really briefly is the fact that VA hospitals have a lot of Guard and Reserve employees. And our commander is also asking at each one of these facilities, how many employees are in your facility who are Guard and Reserve members who could be activated? We have numbers on each one of those facilities, and we are going to bring that information to the Chair in the future, hopefully.

The CHAIRMAN. And I would just remind Mr. Gaytan that your previous National Commander was here and ready to testify at 10 a.m. on 9/11 when we had to vacate the building because of the possible threat to the Capitol. So, I mean, we appreciate that. I did have a question I was going to ask about his visits, because we could use the information.

Mr. GAYTAN. Yes, sir. My staff is working on this solely for the next 2 weeks, and it will be to you as soon as possible.

The CHAIRMAN. Thank you so much.

Mr. NORTON. Mr. Chairman, I would just offer a brief comment. We have been working very closely and participating with the Presidential Task Force on DOD/VA collaboration. As far as I know, in attending almost every one of these meetings from the outset, this has not been an interest area for DOD/VA collaboration. As you know, there are certainly some funding firewalls between VA and DOD on research of this kind, but certainly in terms of military medical readiness, the benefit of the civilian population, there has to be a way to find collaborative opportunities here between the VA and the Department of the Defense on this very critical national security issue and the security of individual American citizens.

The CHAIRMAN. Disappointing that it is not happening, but let us work together to try to ensure that it does. Thank you. Mr. Weidman.

Mr. WEIDMAN. Just two or three quick things, if I may, Mr. Chair.

First is, this committee—due to this committee's leadership, you passed legislation several Congresses ago that would have required VA to implement on their automated patient treatment record military history and move forward to do the kind of seamless transfer of military records into the VA system that we are discussing now. When they found out that the other body had weakened that in the final law, they stopped doing anything towards implementing that. If there is some way that we could revisit that either in appropriations language or in statute this year, that would be terrific.

The second think is in regard to—we talked about bonuses and lack of accountability. It doesn't mean it may not be happening elsewhere, but Admiral Cooper is the only one that we know working with the regional office directors around the country where he is demanding clear criteria and holding these people accountable, so that this year, if somebody gets a bonus who is an RO director, it is for the proper reasons and not just divvying up the spoils, if you will.

Last but not least, people talked about the nursing shortage and the need to replace the nursing force. We have suggested, V VA, over and over and over again that we set up consolidated Federal government recruiting centers, particularly with the VA, of OPM and Ms. Kay Coles James—the Honorable Kay Coles James and Secretary Principi and Secretary Chao and Assistant Secretary Sarbanes at every place we separate young people from the military. It still doesn't exist. And this would help us on veterans' preference, this would help us on recruiting the best people who understand the population they are going to serve, et cetera.

And last but not least, as we move forward into more enhancement of A–76, we would urge the VA as the leadership by example, the ones who should be practicing leadership by example, to forge a plan to get the dismal results in terms of contracting with service disabled veterans-owned businesses up to where it should be; and now it is nowhere near where it should be.

I thank you so much for your leadership in all these issues, Mr. Chair.

The CHAIRMAN. Thank you, Mr. Weidman; and thank you, all of you, for your testimony. I look forward to hearing from you again as we go forward. The hearing is adjourned.

[Whereupon, at 2:04 p.m., the committee was adjourned.]

APPENDIX

Opening Statement by Chairman Christopher H. Smith
February 11, 2003

Department of Veterans Affairs Budget for Fiscal Year 2004

Today, with our nation poised to engage in another war to secure the Blessings of freedom – freedoms won and protected for over 200 years by millions of soldiers, sailors, airmen and marines – we will examine the fiscal year 2004 budget for the Department of Veterans Affairs.

As the second largest agency in the federal government, VA employs over 220,000 people, most of them outside of Washington, DC, with an operating budget that will top $60 billion in FY 2004. VA programs touch millions of lives each year with benefits and services designed to rehabilitate those veterans injured from their service, and help all veterans transition into healthy and productive post-service careers.

This year, about 2.7 million veterans will receive disability compensation or pension payments from VA through the Veterans Benefits Administration this year. In addition, over 500,000 surviving spouses, children or parents of veterans will receive benefits. Today, more than 3 million GI Bill home loans are guaranteed by VA, and 250,000 more are added each year, helping to make homeownership more affordable for our former servicemembers and their families.

VA operates six life insurance programs, with more than 2.1 million policies, and administers the Servicemembers' Group Life Insurance and Veterans Group Life Insurance programs, which provide coverage to 3 million veterans, active duty military, reservists, Guardsmen, and their families.

Since 1944, the GI Bill college education program has provided assistance to almost 21 million veterans. With legislation in the 107th Congress substantially increasing the benefit level by 46%, VA has seen an increase in GI Bill utilization. More than 200,000 veterans will receive education and training under the GI Bill this year.

VA also contains the National Cemetery Administration, which operates 124 national cemeteries. About 100,000 veterans and family members are interred each year, and VA also provides headstones and markers for another 300,000 deceased veterans.

Under the auspices of the Veterans Health Administration, VA runs the largest integrated health care network in the world. This year, VHA will provide comprehensive medical services to more than 4.5 million veterans. VA health care is among the safest and most innovative in the world, having won numerous awards in recent years. At the same time, VA manages the largest medical education program in the country, and will train more than 80,000 health care professionals this year. In fact, more than half of all physicians practicing in the United States today received at least part of their medical training through VA.

Finally, VA's medical research programs are world class. Their cutting edge research in prosthetics, post-traumatic stress disorder, Hepatitis C, organ transplant and hundreds of other crucial areas have elevated the standard in medicine.

I say all of this because people in Washington are often in the habit of talking only about what is wrong, and rarely point out what is being done right. VA has much to be proud of, particularly under the leadership of Secretary Anthony Principi.

In fact, the highly respected weekly National Journal recently looked at the entire Bush Cabinet and gave all of them grades. Secretary Principi received an "A-minus." As far as I am concerned there is no minus to his service. A true veterans advocate, and a combat decorated veteran himself, Secretary Principi has been the most effective Secretary ever to run this department. President Bush made an inspired choice when he chose Secretary Principi, whose reputation for personal integrity, intellectual honesty, and professional persuasiveness are well earned. I am proud to have the honor of working with him on behalf of our nation's veterans.

Although there is much to be proud about, there are many challenges and much serious work that remain. The VA budget submitted for fiscal year 2004 begins another budget debate, in many ways similar to ones that have occurred for many years in Congress. For those of you new to the Committee, I'd like to put this budget in historical perspective. The Department of Veterans Affairs budget is primarily divided into two major components – the Veterans Health Administration and the Veterans Benefits Administration – and one smaller component – the National Cemetery Administration.

The Veterans Benefits Administration is expected to provide more than $33 billion in entitlement programs to more than 3 million veterans and spouses next year. Although the budget proposes almost no increase in administrative funding for VBA, it projects that the Secretary's ambitious performance objectives related to the quality and timeliness of benefit decisions will be met in most categories. If these projections hold up, the Secretary, Admiral Cooper and all those who have worked so hard to make it happen deserve a great deal of praise.

The budget proposed for the National Cemetery Administration looks less promising. The NCA operates 124 national cemeteries, only 61 of which are fully operational. NCA has opened eight new cemeteries in the last 15 years with five more expected to be opened in the next three years. The budget projects good progress on opening these five new cemeteries which Congress directed VA to open in the Millennium Act.

Unfortunately, the budget provides almost no additional funds to address the nearly $300 million maintenance backlog at VA's aging and closed cemeteries. Last year we reviewed a comprehensive and authoritative study of all of VA's national cemeteries and the results were disappointing. Capacity remains uneven across the country and many national cemeteries need significant repairs. VA can and must do better.

Finally, the budget for the Veterans Health Administration has been and remains the most vexing and contentious part of VA's budget -- year in and year out. Looking back over the last five fiscal years, only one Administration budget projected a match between health care funding and the expected need, and it turned out that funding for that year was short by at least half a billion dollars. For the twenty-three years I have been in Congress and a Member of this Committee, the Administrations' proposed budgets, Republican and Democrat alike, have all been starting points, not ending points, in determining funding to meet the health care needs of our nation's veterans. This year will be no exception.

While I commend the Secretary for taking an honest approach to matching a rapidly growing demand with severely constrained resources, I fear that unless we make significant changes to this budget, far too many veterans who need health care services may not be able to receive them next year. I also have serious reservations about several of the proposals contained in the budget.

Even if we were to accept all of the assumptions contained in the budget, such as the record $1.1 billion in "management efficiencies" and the $2.1 billion in anticipated collections, the funding would still not be enough to meet the legitimate demand. This statement is true, moreover, even if we were to accept all of the proposals in the budget, such as to increase fees, reduce nursing home services, and restrict the number of veterans who can get care.

A few of these proposals, however, simply won't fly. The FY 2004 budget proposes closing 5,000 VA nursing home beds, at a time when veterans' demand for nursing home care is skyrocketing. It also proposes that Congress enact legislation to more-than double the prescription copayment. As far as I am concerned, there is no need for this Committee to spend time analyzing these two proposals; we can end the debate right now.

The proposal to impose an enrollment fee on veterans also raises questions. While I am concerned about the effect this legislation will have on enrolled veterans, especially the near-poor with incomes just above specified low-income limits, I am willing to work with the Secretary, Mr. Evans and veterans organizations to see if we can arrive at a solution that is acceptable to all of us.

Furthermore, there are other steps that can and should be pursued to improve the fiscal solvency of the VA health care system. We could help to address VA's rising prescription drug costs through a provision in the Medicare prescription drug bill that I am hopeful Congress will enact this year. Mr. Bilirakis has pledged to join me in this effort, and initial discussions to provide a measure of funding equity for VA are now underway. I also believe that if a veteran has health insurance, whether it's through a private employer or the federal government, VA should have access to that information, and I support the Secretary's mandatory disclosure requirement. We also need more cooperation from the Defense Department when a fully-insured retiree comes to VA for care.

The bottom line is that without a complete overhaul of the funding system for VA health care, we can expect to have this same contentious debate for many years to come. The current system of delayed and uncertain funding from year to year is no way to honor veterans' service, and it's certainly detrimental to orderly planning for such a vital function. It's time to face the fact that the system of funding VA health care – not VA health care, but the funding system – is broken and it is up to us to fix it.

There can and should be debate about who should be funded and who should not be funded, but there has to be agreement that if 5 million veterans should get care, there will be sufficient funding for each and every one of those 5 million men and women. That is the direction this Congress must take, and I will do everything I can, working with everyone who is willing, to achieve such a solution.

I look forward to hearing from all of our witnesses today, Secretary Principi, the authors of the Independent Budget, and representatives from other veterans' organizations.

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Introduction of Panel 1

I would like to welcome our first witness today, our good friend, the Honorable Anthony J. Principi, Secretary of Veterans Affairs. I'm sure most people in this room know the Secretary's background. However, for those of you who don't, and especially for our new Members, here are some highlights of his career.

Prior to his nomination, Mr. Principi was president of QTC Medical Services, Inc., a group of professional service companies providing independent medical administrative services and examinations. Before this, he was senior vice president at Lockheed Martin, and a partner in the San Diego law firm of Luce, Forward, Hamilton & Scripps.

Mr. Principi has worked on national policy issues and has held several executive-level positions in federal government. He chaired the Federal Quality Institute in 1991 and was chairman of the Commission

on Servicemembers and Veterans Transition Assistance established by Congress in 1996. He also has no trouble getting around on Capitol Hill, having served as chief counsel and staff director of both the Senate Armed Services and Veterans' Affairs Committees.

A graduate of the U.S. Naval Academy in Annapolis and a combat-decorated Vietnam veteran, Mr. Principi first saw active duty aboard the destroyer USS Joseph P. Kennedy. He also commanded a River Patrol Unit in Vietnam's Mekong Delta.

Secretary Principi you have served our nation proudly and well, and we welcome you.

Introduction of Panel 2

We would like to welcome our next panel, the Independent Budget, which consists of four veterans service organizations: DAV, PVA, AMVETS and VFW.

Joseph A. Violante, a disabled Vietnam veteran, was appointed National Legislative Director of the million member Disabled American Veterans in July 1997. A New Jersey native, Mr. Violante joined the Marine Corps in 1969. He served with the 2nd Battalion, 4th Marines in Vietnam and was discharged in 1972 with the rank of Sergeant. He attended the University of New Mexico and received a bachelor's degree in history and political science and earned his law degree from the University of San Fernando Valley, College of Law, in California. Mr. Violante was a practicing attorney in Thousand Oaks, California, before moving to Washington, DC where he then worked as a Staff Attorney for the Department of Veterans Affairs' Board of Veterans Appeals in 1985.

Mr. Violante's involvement with veterans' issues reaches beyond the DAV. He chairs the Legislative Committee of the Federal Circuit Bar Association, and previously chaired the Veterans Appeals Committee of the Federal Circuit Bar Association from 1992 to 1996. He is also a member of the Veterans of Foreign Wars and 3rd Marine Division Association.

John Bollinger became deputy executive director for the Paralyzed Veterans of America (PVA) in January 1992. Previously he served as the organization's national advocacy director and was responsible for all civil rights disability issues affecting PVA members.

Prior to his employment at PVA, he worked for the VA from 1972 to 1987. While at VA, he held a number of positions in the Veterans Benefits department, including veterans' benefits counselor and management analyst.

Mr. Bollinger grew up in Pittsburgh, PA and is a veteran of the United States Navy. He was retired from the Navy in 1970 due to a service-connected disability.

Richard "Rick" Jones has been the National Legislative Director of AMVETS since January 2001. He is the primary individual responsible for promoting AMVETS legislative, national security, and foreign affairs goals before the Department of State, Defense and Veterans Affairs and the Congress.

Rick is an Army veteran who served as a medical specialist during the Vietnam War era. His assignments included duty at Brooke General Hospital in San Antonia, Texas, Fitzsimmons General Hospital in Denver, Colorado, and Moncrief Community Hospital in Columbia, South Carolina.

Rick completed undergraduate work at Brown University prior to his Army service and earned a Masters Degree in Public Administration

from East Carolina University in Greenville, North Carolina, following military service.

Dennis M. Cullinan is the Director, National Legislative Service, Veterans of Foreign Wars of the United States.

Prior to being honorably discharged from the U.S. Navy in 1970, Dennis served as an electronics technician aboard the USS Intrepid and completed three tours of duty in Vietnamese waters. After his discharge, Dennis studied abroad with two years at Catholic University in the Netherlands. He later completed his undergraduate education at State University of New York in Buffalo where he also received his M.A. degree in English.

After several years of teaching freshmen composition and creative writing, Dennis became a member of the VFW Washington Office staff in its National Veterans Service department. He later advanced to positions in the VFW's National Legislative Service department and became its Director in August 1997.

Introduction of Panel 3

I would like to ask our final panel be seated. Richard Weidman serves as Director of Government Relations on the National Staff of Vietnam Veterans of America. He served as a medic with Company C, 23rd Med, America Division, located in I ("EYE") Corps of Vietnam in 1969.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans, and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities on Disabled Veterans, and numerous other advocacy posts in veterans affairs.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970's, where he was also active in community and veterans affairs. He attended Colgate University and did graduate study at the University of Vermont.

Mr. Peter S. Gaytan is the Principal Deputy Director, Veterans Affairs and Rehabilitation Division, The American Legion.

Mr. Gaytan attended Wesley College in Dover, Delaware where he earned a B.A. in Political Science. He is also a graduate of the Defense Information School, Fort Meade, Maryland and earned an Associate of Science Degree in Public Affairs from the Community College of the Air Force.

In 1991, Mr. Gaytan entered the U.S. Air Force and after completing initial training, he served as Military Protocol Liaison with the 435th Airlift Wing at Dover AFB, Delaware. While serving there, he worked with military, diplomatic, and congressional leaders. He is current serving his sixth year with the 5412th Airlift Wing, U.S. Air Force Reserve as a Public Affairs Specialist.

Colonel Robert F. Norton, U.S. Army (Ret.) is MOAA's Deputy Director, Government Relations, responsible for its legislative goals for veterans' health care and benefits. Today, however, he is appearing as the Co-Chair, Veterans Committee, The Military Coalition.

After earning his undergraduate degree, he enlisted in the U.S. Army as a private and was commissioned a second lieutenant of infantry after completing officer candidate school. After a tour of Vietnam as a civil affairs platoon leader with the 196th Infantry Brigade in I ("EYE") Corps, he transferred to the Army Reserve and taught school at the secondary level. Colonel Norton served in various staff positions with the 356th Civil Affairs Brigade, US Army Reserve until he volunteered to return to active duty in 1978. He served two tours in the Office of the Secretary of Defense. He finished his career as special assistant to the Principal Deputy Assistant Secretary for Defense, Special Operations/Low Intensity Conflict, and retired in 1995.

Statement of the Honorable Steve Buyer
Full Committee Hearing
on the FY 2004 Budget of the
Department of Veterans Affairs
February 11, 2003

Thank you, Chairman Smith, for holding this important hearing to review the Department of Veterans Affairs budget request for fiscal year 2004.

With passage of H.R. 3118, the Veterans Health Care Eligibility Reform Act of 1996, Congress created a great problem for you - one that we never anticipated!

Mr. Secretary, last year you proposed a $1500.00 deductible for veterans with higher-incomes who were seeking health care treatment for non-service connected problems. It was a gutsy move on your part. It shows me you're willing to defend the core purpose of the VA.

I know that no one is more committed to ensuring that all our veterans receive their rightful benefits than you, Secretary Principi. It's easy to criticize and not so easy to find solutions. Congress has left you in a very untenable situation because as the top VA official you are expected to deliver more with less.

Let's take a look at the VA's budget. The President has requested $61.4 billion for the VA for fiscal year 2004, which includes a 7.4 percent increase in discretionary funding. Under the budget you present today, the VA health care system would receive $27.5 billion – which represents a $2.0 billion increase.

As I have already stated, you have sought to find solutions through innovative means. The problems you are being asked to address have, to some degree, been

caused by Congressional actions. That brings me to the issue of freezing enrollments for category 8s. I support you, because I believe one of the core missions of the VA is to provide health care to those veterans with service-connected conditions, lower income veterans, as well as those with special needs. Right now, we have 6.8 million veterans who are enrolled, and more than 200,000 must wait at least six months before getting their first doctor's appointment. That is just not right. In 2002, over half of the 830,000 veterans who enrolled were classified as Category 8. With the possibility of war and veterans returning home, some with the physical and psychological wounds of war, an already overstressed system may find itself unable to provide quality care for those who need it most.

Because I think it is our duty to ensure these returning men and women will have access to such care if needed, I want to go on record in support of your proposals to: assess an annual enrollment fee and increased co-payments for primary for non-service connected Priority 7 and all Priority 8 veterans.

We are all in this together. We have many options to improve efficiencies thereby freeing up funds that are desperately needed in VA health care.

As my colleagues who were here in previous Congresses will attest, I believe the VA must do a better job of capturing third party collections. Third party collections rose by 32 percent in fiscal

year 2002. But what does that mean in actual dollars?

Another area where I believe we can offer assistance, the Members of this Committee along with our VSOs, is to find ways to streamline and improve services. I contacted Veterans Service Organizations by letter on January 31, 2003, requesting their valuable input on how they believe we could accomplish our mutual goal of providing veterans and their families with the best care and timely delivery of their benefits in the most efficient and cost saving manner. I look forward to receiving their comments at the end of this month.

In addition, there are other cost saving avenues we need to continue pursuing such as VA-DOD sharing, the CARES initiative, and a VA+Choice Medicare plan

for veterans who would like to have such an option.

Mr. Secretary, in closing I want to again pledge my support for your proposal concerning participation in the VA health care system by Priority 7 and Priority 8 veterans. Again, thank you for your strong and bold leadership.

House Veterans Affairs Committee
Full Committee Hearing on the Department of Veterans' Affairs
10:00 am in Room 334 Cannon

OPENING STATEMENT OF HON. CIRO RODRIGUEZ
February 11, 2003

Thank you, Mr. Chairman. I am very disappointed that as our Nation once again prepares for war, the Administration's budget for the year 2004 does not provide the men and women who have served in uniform with an adequate budget for the benefits and services provided by Department of Veterans Affairs (VA).

I read in the Washington Post that the VA fared better than most agencies, being recommended for an 11% increase. I thought that would be great! Then, I read the fine print. As far as I can tell, the 11% is arrived at only by using "fuzzy math" or "Enron economics."

The alleged increase is based on an additional $3.2 billion in funds, most of which comes from the pockets of so called "high income veterans,"— those with income over $24,000 a year.

Mr. Chairman, the cost of living in San Antonio is a lot less than in Washington, D.C., but even in south Texas, we don't consider people with income of $24,000 a year to be "high income."

Essentially, this Administration has drafted a budget that can only be met by discouraging veterans from seeking VA health care. What tools have they chosen to discourage veterans from seeking health care? Try an enrollment fee of $250.00, plus dramatic increases in the cost of their prescription drugs and primary care. This is ridiculous.

While the Administration is requesting a 5% increase, the bulk of the "$2.5 billion increase" for VA health care is paid for by veterans classified as "high income" (both paying higher premium and excluding some all together) and unspecified "management efficiencies." When all the smoke clears, the net effect is a budget which does not even come close to covering the cost of medical inflation, much less dealing with the thousands of veterans awaiting care.

Last year this Congress passed additional money for VA health care in the supplemental appropriation for fiscal year 2002. The President apparently felt that $275 million of the money approved by Congress was inappropriately designated as emergency spending. Therefore, the money could not be spent. I can assure you that it was considered an emergency by the thousands of

veterans waiting on the doorsteps of VA medical centers for needed care.

I am also concerned with the budget's projected increase in the backlog of claims at the Board of Veterans Appeals and the impact on the Board's primary function of hearing and deciding appeals of veterans' claims. Even with a 25% productivity increase, the backlog at the Board is expected to grow to between 6,000 and 8,000 claims.

According to statistics for the first quarter of this fiscal year, the Board's remand rate has been decreased to 8%. While this would be commendable if real, the percentage of claims being developed at the Board has increased to 36%. Thus the real number of claims needing "remand-type actions" continues to be an unacceptable 44%.

With the Board now doing the job of regional offices, without additional resources or a return to the Board's primary mission, veterans will continue to wait for decisions. Some advocates have described the development of claims at the Board as a "black hole" into which many claims enter, but few emerge.

I believe that the budget should be increased to provide the Board with the resources needed to do the Board's job. Additional necessary resources should be provided to focus on the proper development of claims at the regional office level where Congress has placed such responsibility. If additional resources are needed to improve the development of claims at the National Personnel Records Center or the Center for Research of Unit Records, or the regional offices, the Administration should propose appropriate allocations and Congress should provide them.

I am also concerned about the attrition rate for new employees in the Veterans Benefits Administration (VBA) reported by the General Accounting Office. VBA makes a substantial investment in the hiring and training of new employees. GAO's testimony suggests that more human resource personnel may be needed in order to properly analyze and address factors involved in attrition of new employees, especially in large urban areas.

I believe that there is substantial work for this committee and the Congress to do in assuring that we provide a just budget for our veterans. Not a budget, which demands so-called "high income"

veterans to pay higher premiums for health care and even further, excludes others all together.

I thank the witnesses who are appearing before us and I look forward to your testimony.

Tuesday, February 11, 2003

House Veterans Affairs Committee
Full Committee Budget Hearing on the Department of Veterans Affairs (VA) Budget Request for Fiscal Year 2004

Opening Statement for Congressman Michaud

Thank you Mr. Chairman.

I consider it a privilege and an honor to be assigned to this Committee. I look forward to working with all Members of this Committee to assure that America's veterans receive: proper care – proper service – proper respect.

I especially look forward to working with you Mr. Evans and also with you Chairman Smith in this regard. Together, we can continue to do what's right for veterans.

I also would like to welcome Secretary Principi and the other distinguished guests on all of our panels for today's hearing on the FY 2004 budget for VA.

Like the others who have spoken before me here today, I too have concerns regarding the sufficiency of the VA budget proposal.

We constantly ask VA to do more with less.

Sometimes the gap between the "funds needed" and the "funds available" is filled with little more than catch-all phrases such as "management efficiencies." This year's budget promises over one billion dollars in management efficiencies. Will the savings that follow be real or illusory – will maintenance of veterans' services be real or definitional – will the management efficiencies be just a flash in the pan, or will they yield long-term benefit for our two stakeholders, taxpayers and veterans?

Yield back

STATEMENT OF BOB FILNER

HEARING ON FY 04 DEPARTMENT OF VETERANS AFFAIRS BUDGET
FEBRUARY 11, 2003

Thank you, Mr. Chairman. It is strange to begin talking about a budget for a future fiscal year when funding for the current fiscal year is still undecided. How much will be included in the final appropriation for fiscal year 2003—will we be on a continuing resolution for the rest of the year? Will it add $400 million? $900 million? or add the full $1.1 billion approved in both the House and Senate Appropriations Committees? It remains to be seen how VA will fare against the President's tax cuts and other priorities that are severely restricting the funds remaining for increases in domestic discretionary programs.

Mr. Secretary, I am pleased you are here today. You know that I believe you are a true veterans' advocate, but I believe we have a fundamentally different view of this budget.

As I understand it, VA has identified a need for an increase of almost $4 billion over the level of funding Congress is "expected" to pass for FY 03 just to maintain its current services. To achieve this funding increase, it has requested funds for about one-third of this amount ($1.2 billion over the FY 03 funding request). It resorts to belt-tightening for another third (about $1.2 billion). Finally, to make up the final third of the budget it's "Katie—bar the door!" A number of the legislative and policy proposals are crafted to limit the availability of services to veterans and increase their cost sharing. This is particularly ironic, since as recently as a couple of years ago VA was working hard to *recruit* new veterans—including those "rich" veterans whose means exceed about $25,000—into the system. I can certainly understand how confusing these shifting sands must be to our veterans.

These are the sorts of machinations that seem to accompany every budget request we have received in recent years—particularly since VA has experienced

large increases in demand for its services. Assuming you get the most optimistic increase in your budget—$1.1 billion for the remainder of fiscal year 2003—you are requesting a 5% increase over that in the funding level appropriated for VA medical care. Even with all the new restrictions on enrollment and services and the additional efficiencies that I believe will put the system under enormous pressure, this increase is barely enough for inflation.

There are additional priorities that are not funded in this budget. It is unclear how waiting times will be addressed. I still have tremendous concerns about the availability of mental health and substance programs, and I am not clear that the new funds to fully implement the Homeless Veterans Comprehensive Assistance Act of 2001 are included in the budget. I was pleased to see that funding to provide full compensation payments to New Philippine Scouts and DIC survivors of Filipino veterans living in the United States was

included in this budget request, but the $11.6 million required to treat Filipino veterans residing in the U.S. which you support was not included. I hope that Mr. Secretary, you will continue to work with me to ensure that these funds are found.

Finally, I would like to mention my concern about the lack of funding in this budget request for cemetery restoration and repairs. Ft. Rosecrans, in San Diego, is in dire need of repairs, and I have recently communicated with Under Secretary Benson about this issue. I know many other cemeteries are in the same situation.

Ladies and Gentlemen, the situation looks bleak, but, fortunately our veterans' service organizations have identified a solution. We can work together to win mandatory funding for veterans' health care. The bill the Chairman of this Committee, Christopher Smith, and Ranking Member Lane Evans introduced in the

last Congress, would allow VA to project new enrollees and health care inflation and adjust its funding accordingly. This would create a funding stream where demand would meet supply, and we would not have to resort to gimmicks to get a barebones budget passed. I will be continuing the work that we began in the last Congress to ensure that this bill for mandatory funding for VA health care is approved.

STATEMENT OF THE HONORABLE CLIFF STEARNS
COMMITTEE ON VETERANS AFFAIRS
HEARING ON ADMINISTRATION'S FISCAL YEAR 2004 BUDGET
February 11, 2003
558 Words

I am pleased to be here this morning. I would like to thank you, Chairman Smith, for holding this hearing today. I would also like to welcome Secretary Anthony Principi and the other VA officials, and distinguished representatives of the VSOs. I am sure I speak for everyone when I say that we look forward to hearing their insightful testimony. In some ways, we all feel encouraged by this record increase the Administration proposes. However, there is also concern about the fact that we are starting $1.9 billion in the red already.

While I applaud the fact, Mr. Secretary, that you have requested a total of $28 billion in funding for medical care, I am concerned as always about relying on collections from third-party payers, talking of raising copayments and deductibles, and cutting off enrollment to Priority 8's. I believe we need to find a way to increase medical care above the President's request for 2003. While we obviously face limited resources and a burgeoning demand for VA health care delivery, we must scrutinize our position seriously before we consider what would be denials of care for these veterans.

Fair and rapid implementation of VERA is again a paramount concern to me. One of the most pressing issues of concern is that the veterans population continues to increase in a number of states and many

of these same states have seasonal increases in the number of veterans seeking care. This causes long waiting periods and puts a strain on not only the facility but also the personnel in attendance. We must provide some type of relief for these overburdened facilities. Why should residents that live in these regions be subjected to such delays before receiving treatment?

In my home state of Florida, not a day goes by that I do not hear from a veteran constituent who tells me that he or she must wait for many months before getting an appointment at the VA. It is unconscionable that veterans must wait so long to be assigned to a primary care physician. This should be top priority for us all.

I also want to hear some discussion on where we are going with nursing home beds. As you know, long-term care for veterans was the centerpiece of the Millennium Health Care Act and I plan to work vigorously to make certain that it is fully implemented an fully funded.

Finally, I salute the President's commitment to maintaining the dignity and ceremony of our national veterans cemeteries. I hope that this sentiment might be broadened soon to take another look at cemetery expansion. Florida has our nation's 2nd largest veterans population, and the #1 oldest. I am pleased for my fellow Floridians in the Southern part of the State who are on their way to establishing a new cemetery, but I am concerned about the large veteran population in north central Florida as well. Nearly 325,000 veterans call home somewhere in the

Jacksonville vicinity as well as in nearby southern Georgia. Yet, the closest VA cemetery is at least a three-hour drive from Jacksonville. The next closest in proximity lies in Marietta, Georgia, just north of Atlanta. A new national VA cemetery in Jacksonville would answer this unmet need for north Floridians and southern Georgians.

In conclusion, thank you for being here today, and let's see what we have.

STATEMENT OF THE HONORABLE ANTHONY J. PRINCIPI

SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

February 11, 2003

Mr. Chairman and members of the Committee, good morning. I am pleased to be here today to present the President's 2004 budget proposal for the Department of Veterans Affairs (VA). The centerpiece of this budget is our strategy to bring balance back to our health care system priorities. I have by my decisions and by my actions focused VA health care on veterans in the highest statutory priority groups—the service-connected, the lower income, and those veterans who need our specialized services. This budget reflects those priorities.

The President's 2004 budget request totals $63.6 billion—$33.4 billion for entitlement programs and $30.2 billion for discretionary programs. This represents an increase of $3.2 billion, which includes a 7.4 percent rise in discretionary funding, over the expected level for 2003, and supports my three highest priorities:

- sharpen the focus of our health care system to achieve primary care access standards that complement our quality standards;
- meet the timeliness goal in claims processing;
- ensure the burial needs of veterans are met, and maintain national cemeteries as shrines.

Virtually all of the growth in discretionary resources will be devoted to VA's health care system. Including medical care collections, funding for medical programs rises by $2.0 billion. As a key component of our medical care budget, we are requesting $225 million to begin the restructuring of our infrastructure as part of the implementation of the Capital Asset Realignment for Enhanced Services (CARES) program.

We are presenting our 2004 request using a new budget account structure that more readily presents the funding for each of the benefits we provide veterans. This will allow the Department and our stakeholders to more effectively evaluate the program results we achieve with the total resources associated with each program.

Medical Care

The President's 2004 budget includes $27.5 billion for medical care, including $2.1 billion in collections, and represents a 7.7 percent increase over the expected level for 2003. These resources will ensure we can provide health care for over 4.8 million unique patients in 2004.

The primary reason VA exists is to care for service-connected disabled veterans. They have made enormous sacrifices to help preserve freedom, and many continue to live with physical and psychological scars directly resulting from their military service to this Nation. Every action we take must focus first and foremost on their needs. In addition, our primary constituency includes veterans with lower incomes and those who have special health care needs. By sharpening the focus of our health care system on these core groups, we will be positioned to achieve our primary care access standards.

The demand for VA health care has risen dramatically in recent years. From 1996 to 2002, the number of patients to whom we provided health care grew by 54 percent. Among veterans in Priority Groups 7 and 8 alone, the number treated in 2002 was about 11 times greater than it was in 1996. The combined

effect of several factors has resulted in this large increase in the demand for VA health care services.

First, the Veterans Health Care Eligibility Reform Act of 1996 and the Veterans Millennium Health Care Act of 1999 opened the door to comprehensive health care services to all veterans. Second, the national reputation and public perception of VA as a leader in the delivery of quality health care services has steadily risen, due in part to widespread acknowledgement of our major advances in quality and patient safety. Third, access to health care has greatly improved with the opening of hundreds of community-based outpatient clinics. Fourth, our patient population is growing older and this has led to an increase in veterans' need for health care services. Fifth, VA has favorable pharmacy benefits compared to other health care providers, especially Medicare, and this has attracted many veterans to our system. And finally, some feel that public disenchantment with Health Maintenance Organizations, along with their economic failure, may have caused many patients to seek out established and traditional sources of health care such as VA. All of these factors have put a severe strain on our ability to continue to provide timely, high-quality health care, especially for those veterans who are our core mission.

Through a combination of proposed regulatory and legislative changes, as well as a request for additional resources, our 2004 budget will help restore balance to our health care system priorities and ensure we continue to provide the best care possible to our highest priority veterans. The most significant changes presented in this budget are to:

- assess an annual enrollment fee of $250 for nonservice-connected Priority 7 veterans and all Priority 8 veterans;
- increase co-payments for Priority 7 and 8 veterans—for outpatient primary care from $15 to $20 and for pharmacy benefits from $7 to $15;
- eliminate the pharmacy co-payment for Priority 2-5 veterans whose income is below the pension aid and attendance level of $16,169;
- expand non-institutional long-term care with reductions in institutional care in recognition of patient preferences and the improved quality of life possible in non-institutional settings.

Revolutionary advances in medicine moved acute medical care out of institutional beds and rendered obsolete "bed count" as a measure of health care capacity. The same process is underway in long-term care and this budget proposes to focus VA's long-term care efforts on increased access to long-term care for veterans, rather than counting institutional beds. This budget focuses long-term care on the patient and his or her needs. Our policies expand access to non-institutional care programs that will allow veterans to live and be cared for in the comfort and familiar setting of their home surrounded by their family.

While we will shift our emphasis to non-institutional forms of long-term care, we will continue to provide institutional long-term care to veterans who need it the most—veterans with service-connected disabilities rated 70 percent or greater and those who require transitional, post-acute care. Coupled with this, our budget includes an increase of 15 percent in grants for state nursing homes.

In addition, we are working with the Department of Health and Human Services to implement the plan by which Priority 8 veterans aged 65 and older, who cannot enroll in VA's health care system, can gain access to a new "VA+Choice Medicare" plan. This would allow for these veterans to be able to use their Medicare benefits to obtain care from VA. In return, we would receive payments from a private health plan contracting with Medicare to cover the cost of the health care we provide. The "VA+Choice Medicare" plan will become effective later this year as the two Departments finalize the details of the plan.

Coupled with my recent decision on enrollment, these proposed regulatory and legislative changes would help ensure that sufficient resources will be available to provide timely, high-quality health care services to our highest priority

veterans. If these new initiatives are implemented, veterans comprising our core mission population will account for 75 percent of all unique patients in 2004, a share noticeably higher than the 67 percent they held in 2002. During 2004, we will treat 167,000 more veterans in Priority Groups 1-6 (those with service-connected disabilities, lower-income veterans, and those needing specialized care).

In return for the resources we are requesting for the medical care program, we will be able to build upon our noteworthy performance achievements during the past 2 years. During 2002, VA received national recognition for its delivery of high-quality health care from the Institute of Medicine in the report titled "Leadership by Example." In addition, the Department received the Pinnacle Award from the American Pharmaceutical Association Foundation in June 2002 for its creation of a bar code medication administration system. This important patient safety initiative ensures that the correct medication is administered to the correct patient at the proper time. Patient satisfaction rose significantly last year, as 7 of every 10 inpatients and outpatients rated VA health care service as very good or excellent.

We will continue to use clinical practice guidelines to help ensure high-quality health care, as they are directly linked with improved health outcomes. We will employ this approach most extensively in the management of chronic disease and in disease prevention. For 16 of the 18 quality of care indicators for which comparable data from managed care organizations are available, VA is the benchmark exceeding the best competitor's performance.

Mr. Chairman, one of our most important focus areas in our 2004 budget is to significantly reduce waiting times, particularly for patients who are using our health care system for the first time. As we begin to rebalance our health care system with a heightened emphasis on our core service population, we will drive down waiting times. By 2004, VA will achieve our objective of 30 days for the average waiting time for new patients seeking an appointment at a primary care clinic. In addition, we have set a performance goal of 30 days for the average waiting time for an appointment in a specialty clinic. With this budget and the expected funding level for 2003, we will eliminate the waiting list by the end of 2003.

We remain firmly committed to managing our medical care resources with increasing efficiency each year. The 2004 budget includes management savings of $950 million. These savings will partially offset the need for additional funds to care for an aging patient population that will require an ever-increasing degree of health care service, and rising costs associated with a sharply growing reliance on pharmaceuticals necessary to treat patients with complex, chronic conditions. We will achieve these management savings by implementing a rigorous competitive sourcing plan, reforming the health care procurement process, increasing employee productivity, increasing VA/DoD sharing, continuing to shift from inpatient care to outpatient care, and reducing requirements for supplies and employee travel.

Our projection of medical care collections for 2004 is $2.1 billion. This total is 32 percent above our estimated collections for 2003 and will nearly triple our 2001 collections. By implementing a series of aggressive steps identified in our revenue cycle improvement plan, we are already making great strides towards maximizing the availability of health care resources. For example, we have mandated that all medical facilities establish patient pre-registration to include the use of software that assists in gathering and updating information on patient insurance. We are in the midst of a series of pilot projects at four Veterans Integrated Service Networks to test the implementation of a new business plan that calls for reconfiguration of the revenue collection program by using both in-house and contract models. In addition, the Department will award the Patient Financial Services System this spring to Network 10 (Ohio) which will acquire and deploy a commercial system of this type. This project involves

comprehensive implementation of standard business practices and information technology improvements.

As you know Mr. Chairman, one of the President's management initiatives calls for VA and the Department of Defense (DoD) to enhance the coordination of the delivery of benefits and service to veterans. Over the past year, our two Departments have undertaken unprecedented efforts to improve cooperation and sharing in a variety of areas through a Joint Executive Council (JEC). To expand the scope of interdepartmental cooperation, a benefits committee has been added to complement the longstanding Health Executive Council. The VA and DoD Benefits Executive Council is exploring improved transfer and access to military personnel records and a pilot project for a joint physical examination to improve the claims process for military personnel. The JEC provides overarching policy direction, sets strategic vision and priorities for the health and benefits committees, and serves as a forum for senior leaders to oversee coordination of initiatives. To address some of the remaining challenges, the Departments have identified numerous high-priority items for improved coordination such as the joint strategic mission and planning process, computerized patient medical records, eligibility and enrollment systems, joint separation physicals and compensation and pension examinations, and a joint consolidated mail-out pharmacy pilot.

Capital Asset Realignment for Enhanced Services (CARES)

The 2004 budget includes $225 million of capital funding to move forward with the Capital Asset Realignment for Enhanced Services (CARES) initiative. This program addresses the needed infrastructure realignment for the health care delivery system and will allow the Department to provide veterans with the right care, at the right place, and at the right time. CARES will assess veterans' health care needs across the country, identify delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets so that we can optimize health care delivery in terms of both quality and access.

As demonstrated in Veterans Integrated Service Network 12, restructuring will require significant investment to achieve a system that is appropriately sized for our future. Our preliminary estimate for resources that can be redirected to medical care between now and 2010 as a result of the appropriate alignment of assets and health care services, and the sale or enhanced-use leasing of underutilized or non-performing assets, is $6.8 billion. It is extremely important to have funding in 2004 to begin the multiyear effort to restructure. Given the timing associated with identifying CARES projects, we will be working with your committee on the authorization process in order not to delay the start of these projects.

Medical and Prosthetic Research

Mr. Chairman, we are requesting $822 million in funding for VA's clinical research program, an increase of 3.5 percent from the 2003 level. For the first time, our request includes funds in the form of salary support for clinical researchers, resources that previously were a component of the Medical Care request. This approach provides a more complete picture of VA's resources devoted to this program. In addition to the Department's funding request, nearly $700 million in funding support comes from other federal agencies such as DoD and the National Institutes of Health, as well as universities and other private institutions.

This $1.5 billion will support more than 2,700 high-priority research projects to expand knowledge in areas critical to veterans' health care needs—Gulf War illnesses, diabetes, heart disease, chronic viral diseases, Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, women's health care concerns, and rehabilitation programs.

Veterans' Benefits

The Department's 2004 budget request includes $33.7 billion for the entitlement and discretionary costs supporting the six business lines administered by the Veterans Benefits Administration (VBA). Within this total, $1.17 billion is included for the management of these programs—compensation; pension; education; vocational rehabilitation and employment; housing; and insurance.

Improving the timeliness and accuracy of claims processing is a Presidential priority, and during the last year we have made excellent progress toward achieving this goal. A year ago, I testified that I had set a performance goal of processing compensation and pension claims in an average of 100 days by the summer of 2003. I am pleased to report that we are on target to meet that goal and we will maintain that improved timeliness standard for 2004. When we reach this goal, we will have reduced the time it takes to process claims by more than 50 percent from the 2002 level.

At the same time that we are improving timeliness, we will be increasing the accuracy of our claims processing. The 2004 performance goal for the national accuracy rate is 90 percent, a figure 10 percentage points higher than last year's level of performance, and markedly above the accuracy rate of 59 percent in 2000.

The driving force that will allow us to make this kind of progress with only a slight budget increase continues to be the initiatives we are implementing from the Claims Processing Task Force I established in 2001. Located at the Cleveland Regional Office, our Tiger Team has been working over the last year to eliminate the backlog of claims pending over 1 year, especially for veterans 70 years of age or older. This aggressive effort of reducing the backlog and improving timeliness is underway at all of our regional offices. VBA has established specialized processing teams, such as triage, pre-determination, rating, post-determination, appeals, and public contact. Other Task Force initiatives, such as changing the procedure for remands, revising the time requirements for gathering evidence, and consolidating the maintenance of pension processing at three sites, have allowed us to free up resources to work on direct processing at the regional offices.

This budget includes additional staff and resources for new and ongoing information technology projects to support improved claims processing. We are requesting $6.7 million for the Virtual VA project that will replace the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a web-based solution. We are seeking $3.8 million for the Compensation and Pension Evaluation Redesign, a project that will result in a more consistent claims examination process. In addition, we are requesting $2.6 million in 2004 for the Training and Performance Support Systems, a multi-year initiative to implement five comprehensive training and performance support systems for positions critical to the processing of claims.

In support of the education program, the budget proposes $7.4 million for continuing the development of the Education Expert System. These resources will be used to expand upon an existing prototype expert system and will enable us to automate a greater portion of the education claims process and expand enrollment certification. This initiative will contribute toward achievement of our 2004 performance goal of reducing the average time it takes to process claims for original and supplemental education benefits to 27 days and 12 days, respectively.

VA is requesting $13.2 million for the One-VA Telephone Access project, an initiative that will support all of VBA's benefits programs. This initiative will result in the development of a Virtual Information Center that forms a single telecommunications network among several regional offices. This technology will

allow us to answer calls at any place and at any time without complex call routing devices.

All of these information technology projects are consistent with the Department's Enterprise Architecture and will be supported by improved project administration from our Chief Information Officer.

Burial

The President's 2004 budget includes $428 million for VA's burial program, which includes operating and capital funding for the National Cemetery Administration (NCA), the burial benefits program administered by VBA, and the State Cemetery Grant program. This total is $18 million, or 4.3 percent, over the 2003 level.

This budget request includes $4.3 million for the activation and operation of five new national cemeteries in 2004. NCA plans to open fast-track sections for interments at four new national cemeteries planned for Atlanta, South Florida, Pittsburgh, and Detroit. Fort Sill National Cemetery opened a small, fast-track section for interments in November 2001, and Phase 1 construction of this cemetery should be complete by June 2003. In addition to resources for these five new cemeteries, this budget request also includes resources to prepare for the future opening of a fast-track section of an additional national cemetery near Sacramento. The locations of these national cemeteries were identified in a May 2000 report to Congress as the six areas most in need of a new national cemetery.

With the opening of these new cemeteries, VA will increase the proportion of veterans served by a burial option within 75 miles of their residence to nearly 82 percent.

The $108.9 million in construction funding for the burial program in 2004 includes resources for Phase 1 development of the Detroit cemetery, expansion and improvements at cemeteries in Fort Snelling, Minnesota and Barrancas, Florida, as well as $32 million for the State Cemetery Grant program.

The budget request includes $10 million to support the Department's commitment to ensuring that the appearance of national cemeteries is maintained in a manner befitting a national shrine. One of the key performance goals for the burial program is that 98 percent of survey respondents rate the appearance of national cemeteries as excellent.

A new performance measure established for NCA is marking graves in a timely manner after interment. We have established a 2004 performance goal of marking 75 percent of graves in national cemeteries within 60 days of interment. When we achieve this goal, it will represent a dramatic improvement over the 2002 level of 49 percent.

Management Improvements

Mr. Chairman, we have made excellent progress during the last year in implementing, or developing, several management initiatives that address our goal of applying sound business principles to all of the Department's operations. We are particularly pleased with our accomplishments in addressing the President's Management Agenda that focuses on strategies to improve the management of the Federal government in five areas—human capital; competitive sourcing; financial performance; electronic government; and budget and performance integration.

We have developed a sound workforce and succession plan that includes strategies VA will pursue to implement a more corporate approach to human capital management, and a workforce analysis of several of the Department's critical positions—physicians, nurses, and compensation and pension veterans

service representatives. We are moving forward with a competitive sourcing study of our laundry service, and other studies will be conducted of our pathology and laboratory services, and facilities management and operations. With regard to financial performance, we achieved an unqualified audit opinion for the fourth consecutive year. During 2003 and 2004, we will be involved in 10 electronic government studies. And finally, we continue to progress in our efforts to better integrate resources with results. One major accomplishment in this area is the restructuring of our budget accounts. This new account structure is presented in our 2004 budget and will lead to a more complete understanding of the full cost of each of our programs.

VA has a variety of other management improvement efforts underway that will lead to greater efficiency and will be accomplished largely through centralization of several of our major business processes. I am committed to reforming the way we conduct our information technology (IT) business, and to help the Department meet this objective, we have aggressively pursued new approaches to accomplishing our IT goals. We have developed a One-VA enterprise strategy, embarked on a nationwide telecommunications modernization program, and laid a solid foundation for a Departmental cyber security program. In order to facilitate and enhance these efforts, I recently centralized the IT program, including authority, personnel, and funding, in the office of the Chief Information Officer. This realignment will serve to strengthen the IT program overall and ensure that our efforts remain focused on building the infrastructure needed to better serve our Nation's veterans.

This budget includes $10.1 million to continue the development of the One VA Enterprise Architecture and to integrate this effort into key Departmental processes such as capital planning, budgeting, and project management oversight. Our request also includes $26.5 million for cyber security initiatives to protect our IT assets nationwide. These initiatives aim to establish and maintain a secure Department-wide IT framework upon which VA business processes can reliably deliver high-quality services to veterans.

The 2004 budget includes funds to continue the CoreFLS project to replace VA's existing core financial management and logistics systems—and many of the legacy systems interfacing with them—with an integrated, commercial off-the-shelf package. CoreFLS will help VA address and correct management and financial weaknesses in the areas of effective integration of financial transactions from VA systems, necessary financial support for credit reform initiatives, and improved automated analytical and reconciliation tools. Testing of CoreFLS is underway, with full implementation scheduled for 2006.

We are developing a realignment proposal for finance, acquisition, and capital asset functions in the Department. A major aspect of this effort centers on instituting much clearer delegations of authority and improved lines of accountability. This plan would establish a business office concept across the Department and would enhance corporate discipline that will lead to uniformity in operations and greater accountability, and will make the transition to the new financial and logistics system much easier to implement. A component of the plan under review and consideration will result in a consolidated business approach for all finance, acquisition, and capital asset management activities.

Closing

Mr. Chairman, I am proud of our achievements during the last year. However, we still have a great deal of work to do in order to accomplish the goals I established nearly 2 years ago. I feel very confident that the President's 2004 budget request for VA will position us to reach our goals and to continue to provide timely, high-quality benefits and services to those who have served this Nation with honor.

That concludes my formal remarks. My staff and I would be pleased to answer any questions.

STATEMENT OF
JOSEPH A. VIOLANTE
NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 11, 2003

Mr. Chairman and Members of the Committee:

I am pleased to appear before you on behalf of the Disabled American Veterans (DAV), one of the organizations presenting *The Independent Budget* (IB), to discuss the President's fiscal year (FY) 2004 budget proposal for the Department of Veterans Affairs (VA). This is naturally one of the most important hearings of the year for your constituents and our members because the viability of all veterans' programs depends on funding sufficient to support timely and effective delivery of benefits and because government performance and public policy considerations are inextricably linked to the budget.

As usual, we have compelling issues and important challenges to address together. As usual, the President's budget symbolically provides a platform for beginning deliberations, but does not necessarily always provide accurate groundwork on which to base your choices on funding levels or policy matters. As what we believe to be a more realistic assessment of VA's funding requirements and appropriate program improvements, the DAV presents the IB in collaboration with AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW).

Each of the four coauthors takes primary responsibility for selected parts of the IB. In the interest of time and avoidance of duplication, the four organizations primarily focus their testimony here on their area of responsibility in the IB. Therefore, my testimony will predominantly concern the Benefits Programs, administrative expenses, and Judicial Review in Veterans' Benefits. However, before I address those issues, I do want to briefly discuss an issue of major concern to all the IB coauthors, and, indeed, a major concern for thousands of veterans who reside in your districts and all across this Nation.

Medical care for veterans is one of the most important, if not the most important, obligations of our Government. VA's health care system is undeniably one of the world's largest health care systems, which was created and designed for, and dedicated solely to, the care of those who have earned it by sacrifices and blood. More than half of the Nation's practicing physicians received medical training in VA, and VA employs a substantial number of all the Nation's physicians. VA is the Nation's largest employer of nurses and psychologists, for example, and employs large numbers of other health care professionals, such as pharmacists, social workers, dieticians, and physical therapists to name just a few. VA is the one national institution that we most associate with services to veterans.

Like the changing world in general, the VA health care system has changed. These changes involve profound improvements in methods and means for delivering health care. They involve expansion to meet growing demand and to increase efficiency by obtaining economies of scale. The VA health care system has been, and is even more so today, a world leader in research, innovations, and the capacity to deliver quality health care to a large patient population despite the fact that, on the whole, VA's patients are older, more disabled, and have a greater need for medical care that places a heavier strain on finite resources. The VA health care system is undeniably a phenomenal success. The total dimensions of the value and importance of this national asset cannot be overstated. Its importance is not only to veterans, but also to the national economy and to the advancement of medical science generally. The incidental benefits and positive impact of this unique national health care system are immeasurable. This is a resource that we simply cannot afford to neglect and thereby allow its deterioration.

No such world-class organization can be built and maintained without a genuine national commitment and an investment comparable to the magnitude of this system's worth. Yet, we see the viability of this invaluable asset imperiled year after year by inadequate funding from our

Government. We see VA's best efforts to improve services, to plan strategically, and to find long-term savings and efficiencies frustrated and offset by the uncertainties of the politics of the annual appropriations process. Consequently, and worst of all, we see the benefits of good medicine being diminished by delayed care, and we see sick and disabled veterans being denied desperately needed care altogether. It all seems so shortsighted, so contrary to the noble mission of the VA health care system, and so at odds with the moral obligation we have to ensure veterans' care remains a top national priority. Like the funding necessary to meet the obligations of the mandatory programs, the funding necessary to sustain medical care services for veterans can be projected and should be guaranteed in authorizing legislation. As we expect, our servicemembers make whatever extraordinary sacrifices are necessary to maintain our national defense. As we expect, VA's medical care system meets extraordinary demands to care for those servicemembers when they become veterans. We have a right to expect our Government to provide VA the resources it must have to meet those extraordinary demands and fully honor our obligation to care for veterans in their time of need. Unlike many complex problems that confront us, the solution here is not elusive technically. The solution is funding through a permanent authorization under a formula that ensures resources correspond to demand. While such legislation does not present any exceptional technical challenge, it does require a genuine commitment by legislators to maintain our veterans' health care system. We hope to see a genuine commitment to disabled veterans in the form of legislation to guarantee funding for VA's premiere health care system. Incidentally, we note that the President's budget recommends mandatory health care funding for non-Medicare-eligible military retirees similar to mandatory funding already authorized by Public Law 106-398 for Medicare-eligible retirees.

Let me also add here, that the DAV is troubled by the Administration's trend toward reducing the Government's obligation to fund veterans' programs by shifting more and more costs directly to veterans themselves. The President's budget would rely on a projected $2.1 billion in collections to operate VA's medical care program for veterans. The IB opposes the imposition of copayments or user fees of any kind upon veterans. We believe requiring veterans to pay for the benefits a grateful nation provides them is fundamentally at odds with the purposes of veterans' benefits.

The President's total budget request of $63.6 billion includes appropriations and collections. The President's budget for the Veterans Benefits Administration (VBA) includes $33.695 billion in mandatory spending and $1.218 billion in discretionary spending. The budget for mandatory spending includes the costs of proposed new legislation, principally $355.2 million to cover a proposed cost-of-living adjustment (COLA) for compensation, which would be based on the increase in the cost of living as measured under the Consumer Price Index (CPI), projected to be 2.0 percent. The compensation COLA applies to disability compensation, dependency and indemnity compensation (DIC), and the clothing allowance.

In addition to the compensation COLA, the President's budget proposes several other legislative changes in the benefit programs, the total cost of which, including the COLA, would be $412.728 million. However, based on projected savings of $127.007 million from a legislative proposal to eliminate compensation for certain service-connected disabilities, the net cost of these changes would be $285.721 million for FY 2004. While we support the compensation COLA and other beneficial legislative proposals, we strongly object to eliminating compensation for certain service-connected disabilities to offset part of the costs of the changes.

As does the President's budget, the IB recommends a compensation COLA to maintain the value of compensation in relation to the cost of living. Let me add here, however, that the DAV believes the COLA for disability compensation should be based on the Labor Department's Employment Cost Index (ECI) for private sector wages and salaries. Disability compensation is intended primarily to make up for average impairments in earning capacity in civil occupations, and the ECI would appear to be a more appropriate index for this purpose.

For the compensation program, the Administration proposes legislation to authorize full compensation benefits to New Philippine Scouts and full DIC for eligible survivors of Filipino veterans. This proposal has an equitable purpose, and we do not oppose it.

For the pension program, the President's budget proposes restoration of provisions that would make awards of death pension effective the first day of the month in which death occurred if the claim is filed within 1 year of the date of death. Prior amendments reduced this period

from 1 year to 45 days. The IB has no recommendation on this issue, but it would liberalize the program for needy widows of wartime veterans, and in the process, restore uniformity to effective date provisions and thus restore uniformity to the administration of the compensation and pension programs.

The President's budget recommends two legislative changes for education benefits: (1) extension of time for use of education benefits by members of the National Guard, and (2) authorization for on-the-job training in self-employment under the Montgomery GI Bill. We have no objections to these changes. The Administration also recommends elimination of the Education Loan Program because more than 10 years have passed since the last loan was made under the program. We have no position on this recommendation.

For the VA housing program, the budget recommends legislation to convert the direct loan program for Guaranteed Transitional Housing for Homeless Veterans from a mandatory program to a discretionary grant program. The IB has no position on this issue, but we question how the program would be more effective with this change.

As noted, the President's budget proposes to achieve savings by legislation that would eliminate compensation for certain service-connected disabilities. Specifically, the proposal would eliminate compensation for that part of the impairment from a service-connected disability attributable to alcohol or drug abuse. Except where secondary to another service-connected disability, the law already prohibits compensation for disability from alcohol or drug abuse. For several years, through an erroneous interpretation of law and one that was inconsistent with another interpretation within VA itself, VA denied compensation for disability from alcohol or drug abuse although the abuse was caused by the effects of another service-connected mental or physical disability. Congress intended to prohibit compensation for alcohol and drug abuse as primary conditions, but did not intend to deny compensation when a veteran's service-connected mental or physical disability induced use of alcohol or drugs to escape mental or physical pain. Alcohol use, particularly, is more prevalent among veterans who suffer from the disordered thinking of serious mental conditions or who suffer from the disturbing symptoms of posttraumatic stress disorder caused by severe psychological trauma such as the death and destruction of combat. Having misinterpreted the law against veterans and having that misinterpretation set aside by the United States Court of Appeals for the Federal Circuit, the VA now wants Congress to change the law to conform to VA's improper view of what the law should be. Regrettably, this recommendation reflects very negatively upon the agency that is charged with understanding and having insight into the effects of trauma and severe disabilities upon veterans. It evidences a narrow-minded insensitivity to the real nature of the effects of severe trauma and severe disability upon young men and women who bear these extraordinary burdens and suffer these extremely traumatic experiences. We oppose such an unwarranted, inequitable change in the strongest possible terms, and we urge this Committee to appropriately dismiss this recommendation with no consideration whatsoever.

We are similarly disappointed that the President's budget continues to make so few recommendations to improve veterans' benefits when so many improvements are needed. For the Benefits Programs, the IB makes the following legislative recommendations in addition to its recommendation for a compensation COLA:

- to exclude compensation as countable income for Federal programs
- to repeal the prohibition of service connection for disabilities related to tobacco use
- to repeal delayed effective dates for payment of increased compensation based on temporary total disability
- to expand Montgomery GI Bill eligibility to persons who, but for service on or before June 30, 1985, would be eligible for education benefits under this program
- to authorize refund of contributions to veterans who become ineligible for the Montgomery GI Bill by reason of discharges characterized as "general" or "under honorable conditions"

- to increase the amount of the grants for specially adapted housing and to provide for automatic annual adjustments for increased costs
- to provide a grant for adaptations to a home that replaces the first specially adapted home
- to authorize specially adapted housing grants to servicemembers with qualifying service-connected disabilities who are awaiting discharge
- to authorize payment of reasonable fees for compliance inspections on housing being constructed or adapted under the specially adapted housing program
- to increase the amount of the automobile grant and to provide for automatic annual adjustments for increased costs
- to increase the maximum VA home loan guaranty and provide for automatic annual indexing to 90% of the Federal Housing Administration-Federal Home Loan Mortgage Corporation loan ceiling
- to exempt the dividends and proceeds from and cash value of VA life insurance policies from consideration in determining entitlement under other Federal programs
- to authorize VA to use modern mortality tables instead of 1941 mortality tables to determine life expectancy for purposes of computing premiums for Service-Disabled Veterans' Insurance
- to increase the maximum protection available under the base policy of Service-Disabled Veterans' Insurance from $10,000 to $50,000
- to increase the maximum coverage under Veterans' Mortgage Life Insurance from $90,000 to $150,000
- to repeal the 2-year limitation on payment of accrued benefits
- to protect veterans' benefits from unwarranted court-ordered awards to third parties in divorce actions

The IB also recommends legislation to remove the offset between military retired pay and disability compensation and legislation to extend the 3-year limitation on recovery of taxes withheld from disability severance pay and military retired pay later determined exempt from taxable income.

Where in the past, the President's budget has separated requests for mandatory funding for the benefit programs from requests for discretionary funding for VBA's General Operating Expenses, the President's budget this year eliminates that traditional bifurcation, and, in addition, includes in the discretionary funding appropriations for construction. The new format merges the requests for both mandatory and discretionary funding associated with each business line of VBA. The President's request for discretionary funding for all VBA business lines, minus funding for construction, is essentially at the same level as the budget request for FY 2003.

In the business lines under VBA, VA is continuing its several ongoing initiatives to improve the administration of the benefit programs. The most formidable and longest running challenge is the compensation and pension claims backlog. VBA continues to address this problem through a combination of measures, including process changes, improved skills through better training, new technology, and accountability. So many initiatives affecting so many aspects of compensation and pension claims processing are in play simultaneously that the net effect is difficult to appreciate at this time, although we are continually monitoring VA's reported processing times and accuracy rates. New technology plays a major role in the efforts to improve program administration and benefits delivery in the other VBA business lines as well.

This year's budget request would authorize 12,720 total full-time employees (FTE) for VBA, a net reduction of 61 FTE from FY 2003 levels. Compensation and Pension (C&P) Service would maintain FY 2003 levels, which was down 190 FTE from FY 2002. Education Service would gain 17 FTE, while Loan Guaranty Service would lose 73 FTE, Insurance Service would lose 4 FTE, and Vocational Rehabilitation and Employment Service would lose 1 FTE. In this period of change for VBA, the IB has not included recommendations for increased staffing, but we watch with guarded concern for the time being.

In the IB, we have recommended that VBA's program directors be given line authority over their field employees who process and decide benefit claims. Under VBA's current management structure, the C&P Director, for example has no authority to enforce quality standards and VA policy. This presents an obstacle to enforcement of accountability, which is essential to VA's success in overcoming its quality problems.

We have recommended that the Secretary of Veterans Affairs take the steps necessary to improve VA's rulemaking. From our experience over the last several years, we have seen VA's regulations become more self-serving and arbitrary. Veterans' organizations are challenging new VA regulations in court with regularity. Currently, several veterans' organizations have before the United States Court of Appeals for the Federal Circuit a challenge to VA's regulations to implement the legislation that restored VA's duty to assist veterans. If these regulations are invalidated by the court, VA may have to rework a large number of the claims that were developed and decided under the invalidated rules. Additionally, veterans' organizations have before the Federal Circuit a challenge to VA regulations that authorize the Board of Veterans' Appeals (BVA) to obtain new evidence and make initial decisions on issues in claims. This procedure deprives veterans of the statutory right to an initial decision and one review on appeal when they believe the initial decision to be wrong. It creates conditions for increased inefficiency because field office adjudicators can avoid fully developing claims as required by law with the knowledge that BVA will correct record deficiencies on appeal. This shifts the work that should be done in regional offices to VA's appellate board, which was created to "review" field office actions in record development and field office decisions, not develop the record itself and "make" initial decisions on new evidence. Because BVA is now conducting its own record development to correct the deficiencies it identifies in field office development, we are seeing a growing claims backlog at BVA. If the court agrees with our view that VA's regulations authorizing this practice are contrary to law, BVA may well be required to vacate many of its decisions and send the cases back to regional offices to correct record deficiencies and afford veterans the due process required by law. Just last year this Committee reported legislation that was later enacted to override an arbitrary VA regulation on anatomical loss of a breast for compensation purposes. In the IB, we have recommended that Congress scrutinize VA's rulemaking more closely as a part of its oversight role.

Although VBA's C&P Service has many reforms underway to improve compensation and pension claims processing, the IB recommends that the primary focus should be more on correcting the root causes of the claims backlog. Those who have witnessed C&P's repeated failures to overcome its claims processing deficiencies know that those failures involve repetitive patterns in which VA develops plans but fails to follow through with decisive steps to solve the difficult problems. VA attempts to overcome its serious deficiencies by fine-tuning its procedures and employing new technology. While those efforts may aid in improving claims processing, alone or in combination they are not enough to enable VA to overcome its longstanding problem. The coauthors of the IB believe that it is obvious VA must resolve to focus primarily on eliminating the root causes of its claims backlog if it is to ever succeed in restoring the system to acceptable levels of performance and service. VA's adjudicators make erroneous decisions because they have not been properly trained in the law, they have operated in a culture that tolerated indifference to the law, and they have not been held accountable for poor performance and proficiency. Accordingly, in conjunction with the deployment of better training, VA must take bold steps to change its institutional culture, and it must make its decisionmakers and managers truly accountable.

If VA's ambitious goal of improving timeliness takes precedence over its goal of improving quality, VA will merely repeat the failures of the past. Speeding up the process with the single goal of reducing claims processing times and claims backlogs is self-defeating if, because quality is compromised, a substantial portion of the cases must be reworked. In this respect, VA has shown some inability to learn from its past mistakes.

To meet its workload demands, VA must take full advantage of automated information systems. These systems can facilitate case management, claims processing, and decisionmaking in ways that improve accuracy and efficiency. To determine and implement its optimum performance in record development, disability examinations, and claims disposition, VA is undertaking a review of its claims process with the goal of developing an integrated electronic format to aid in uniform and correct application procedures and substantive rules and to allow for the electronic transmission of data from its source into the claims database. Known as the C&P Evaluation Redesign (CAPER) initiative, this project is being undertaken by a CAPER team, working with outside experts. VA began work on this initiative in 2001 with a goal of nationwide deployment by April 2005. VA now hopes to have this system fully in place by September 2005. To achieve that goal, VA needs approximately $7 million in FY 2004 for business consultants, software/systems integration, independent validation and verification, equipment and software, and employee travel and training. VA needs this funding to stay on its schedule to complete testing of the prototype system it is developing in FY 2003 and have the system fully deployed by September 2005. The IB therefore recommends that Congress provide $7 million for CAPER in the FY 2004 budget. The President's budget requests only $3.8 million. We understand that the President's budget would spend less than our recommendation by completing less of the development in FY 2004.

Inadequate disability examinations have been a major factor in VA's claims processing problems. Experience gained from a pilot project and a contract authorized by Public Law 104-275 demonstrates that a private contractor can economically provide adequate and timely disability examinations to veterans at locations near their homes with a high level of veteran satisfaction. Authority for contract examinations at all VA regional offices would allow VA to improve claims processing nationwide. VA projects that it will request approximately 500,000 disability examinations in FY 2004. To obtain these examinations under contract would require an appropriation of approximately $250 million. The IB recommends that Congress authorize VA to use contractors for disability examinations at all VA regional offices and include $250 million in the budget for contract examinations. The President's budget requests only $50.4 million to continue the current limited use of contractors.

The President's budget request for BVA would essentially maintain the status quo. It requests 448 FTE and $50.443 million in budget authority, a reduction of 3 FTE and an increase of $1.692 million in appropriations. With these resources BVA expects to reduce appeals resolution time (the time from initiation of an appeal to final resolution) from 731 days in FY 2002 and a projected average 590 days in FY 2003 to 520 days in FY 2004. At the same time, BVA projects an increase in BVA cycle time (the time the case is physically at the BVA), from 86 days in FY 2002 and 250 days projected in FY 2003 to 300 days in FY 2004. This increase in the time it takes BVA to resolve its work on the appeal is attributed to BVA's new responsibility to develop evidence in cases where the regional office failed to properly develop the record.

The IB makes only one recommendation for BVA this year. We again recommend that VA amend its regulation that purports to exempt BVA from substantive rules on benefit entitlement that are binding on VA field adjudicators, just as if they were law. It makes no sense to allow BVA to ignore substantive rules in its decisions that field adjudicators are bound to apply in making claims decisions.

Although not a part of the budget, the DAV objects to new regulations that are apparently nearing publication in final form to authorize BVA members to call themselves "Veterans Law Judges." We raise this objection here because allowing Board members to proclaim themselves to be judges will do nothing to benefit decisionmaking for veterans. While the costs of changing titles in form letters and other materials may not be substantial, there will no doubt be some cost to the taxpayer. That added cost will have no benefit to taxpayers or veterans in return. In addition to the fact that BVA's members are not really judges, we object because this will unavoidably add unnecessary formality to proceedings Congress intended to remain informal. If Board members desire to have titles that include the word "judge," they will no doubt expect to have the formal demeanor of judges and will expect others to address them and treat them as judges. Congress previously rejected VA efforts to obtain legislation to authorize this change in the title of Board members. Now, VA will promulgate a rule to authorize Board members to call themselves, and expect others to call them, judges although all pertinent statutes refer to them as

"members." The DAV recommends legislation to prohibit VA from assigning Board members any title or status other than what is provided in statute.

The IB also includes recommendations for improving judicial review in veterans' benefits. In enacting legislation in 1988 to authorize veterans to challenge VA decisions in court, Congress recognized the importance of the right to have VA's decisions reviewed by an independent body. Judicial review has had the beneficial effect of exposing administrative departure from the law and forcing reforms within VA. For the most part, judicial review of the claims decisions of VA has lived up to the positive expectations of its proponents. To some extent, it has also brought about some of the adverse consequences seen by its opponents. Based on recommendations in last year's IB, Congress made some important adjustments to correct some of the unintended effects of the judicial review process. We hope to see these changes applied in a manner that will fulfill congressional intent to ensure that veterans have meaningful judicial review in all aspects of their appeals. Other adjustments are still needed, however.

Last year, the IB recommended legislation to change the standard under which the Court of Appeals for Veterans Claims (CAVC or "the Court") reviews VA's findings of fact in claims decisions. The Court's application of the "clearly erroneous" standard has conflicted with and undermined the benefit-of-the-doubt rule. Under the statutory benefit-of-the-doubt rule, VA is mandated to resolve factual questions in the veteran's favor unless the evidence against the veteran is stronger than the evidence for him or her. However, CAVC had been upholding a VA decision when there was any evidence to support it, and this rendered the benefit-of-the-doubt rule unenforceable. Although the legislation eventually enacted did not make the changes recommended by the IB, Congress did amend the law to expressly require CAVC to consider, in its clearly erroneous analysis, whether a finding of fact is consistent with the benefit-of-the-doubt rule. The IB now recommends that the Veterans' Affairs Committees conduct oversight hearings to evaluate whether CAVC is fully carrying out the congressional intent of last year's amendments.

When Congress authorized judicial review of veterans' claims, one of its foremost concerns and intents was preservation of the informality of VA's administrative claims process under conditions in which BVA's decisions would be subject to review by a court. Congress was very much aware of the dangers that the courts might attempt to impose their own formal rules of adversarial proceedings upon VA's informal claims process and therefore sought to prevent this adverse consequence. In imposing its own requirement upon veterans that they must have expressly argued a technical or legal point before BVA to have the point considered by the Court, CAVC has, for its own expedience, largely ignored congressional intent, the law, and the unique nature and purposes of veterans' programs. The Court has done the very thing Congress so carefully and clearly acted to forestall.

Unlike judicial or more formal administrative proceedings where it is the responsibility of the parties to raise and plead all legal arguments and discover and present all material evidence, veterans are not expected to know and plead the legal technicalities of veterans' benefits. Veterans file simple claims forms with basic information, not detailed legal pleadings. Congress repeatedly stated its intent to preserve and maintain this informal process throughout the legislative history of its law to authorize judicial review. It is VA's legal obligation to assist the veteran in filing the claim and developing the evidence, and it is VA's obligation under the law to consider all relevant legal authorities and potential bases of entitlement regardless of whether they are expressly raised by the veteran. When a veteran appeals to BVA and receives an unfavorable decision, the veteran has exhausted his or her administrative remedies. Any failure to fully develop the record, to fully explore all avenues of entitlement, or to apply all pertinent law is an error of omission by BVA which CAVC should address in its appellate review irrespective of whether the veteran knew of or raised the specific point before BVA. Yet, for its own purposes, CAVC refuses to consider points of argument that were not specifically raised before BVA. By requiring veterans to know and expressly raise and argue all the complex legal points relevant to a claim, CAVC shifts the government's obligations to veterans, imposes unnecessary formalities upon VA's administrative claims process, and fundamentally alters the non-adversarial, pro-veteran nature of VA proceedings. The Court seems unable or unwilling to grasp the simple fact that, in considering veterans' appeals, it reviews a claims record, not a litigation record. The IB therefore recommends legislation to prohibit judicial imposition of formal pleading or so-called "exhaustion" requirements upon the VA claims process.

Currently, VA regulations, with the exception of provisions in the *Schedule for Rating Disabilities*, are subject to challenge in the Court of Appeals for the Federal Circuit (CAFC). The IB recommends expanding CAFC jurisdiction to permit it to review challenges to the validity of the rating schedule on the narrow basis of whether the rating is contrary to law or is arbitrary and capricious. The coauthors of the IB believe that no unlawful or arbitrary and capricious rating schedule provision should be immune to review and correction.

Obviously, much of what this Committee will seek to accomplish on behalf of veterans this year will be subject to what Congress appropriates for veterans' programs. We urge the Committee to press for a budget that is adequate for existing programs and allows for some improvement in benefits and services for veterans. We hope our independent analysis of the resources necessary for veterans' programs and our legislative and policy recommendations are helpful to you, and we sincerely appreciate the opportunity to present our views and recommendations to the Committee.

STATEMENT OF

JOHN C. BOLLINGER

DEPUTY EXECUTIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE INDEPENDENT BUDGET

AND THE DEPARTMENT OF VETERANS' AFFAIRS BUDGET

FOR FISCAL YEAR 2004

FEBRUARY 11, 2003

Mr. Chairman and members of the Committee, as one of the four veterans services organizations publishing *The Independent Budget*, Paralyzed Veterans of America (PVA) is pleased to present our views on the state of funding for the Department of Veterans Affairs (VA) health care system and the Administration's FY 2004 budget request.

I am John Bollinger, PVA Deputy Executive Director. PVA is the only national veterans' service organization chartered by Congress to represent and advocate on behalf of our members and all Americans with spinal cord injury or disease. All of PVA's members, in each of the fifty states and Puerto Rico, are veterans with spinal cord injury or dysfunction.

This is the seventeenth year, PVA, along with AMVETS, Disabled American Veterans and Veterans of Foreign Wars have presented *The Independent Budget*, a policy and budget document that represents the true funding needs of the Department of Veterans Affairs. *The Independent Budget* uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year the document is endorsed by 45 veterans service organizations, and medical and health care advocacy groups.

Mr. Chairman, we are deeply troubled by the Administration's budget request for VA health care programs. Analysis of these budget numbers and their impact on health care next year is extremely problematic due to the lack of an enacted appropriation for FY 2003. However, under any scenario, depending how the Congress resolves this year's funding levels, the Administration's request is woefully inadequate. It will not come close to meeting the projected needs of the veterans seeking VA health care next year.

The VA health care system is already strapped due to the failure of the Congress and the Administration to agree on FY 2003 funding levels. Already five months into the fiscal year VA health care is running on seriously inadequate FY 2002 funding levels. Health care demand is rising; the cost of that care is soaring as well. In reaction, the Secretary of Veterans Affairs has taken the unprecedented step of stopping enrollment of Category 8 veterans. Despite touted increases in the FY 2004 request, the Administration proposes even more draconian steps to curtail access. The budget's proposed increases rely too heavily on increased collections from new copayments for services and prescription drugs and a new proposed enrollment fee imposed on Category 7 and 8 veterans. Any proposed additional increase derived by unspecified "management efficiencies" disappears completely with VA admitting just recently that it is currently running at a $1.9 billion deficit this year.

We have reworked the Administration's numbers from their unusual presentation this year to be able to make appropriate comparison with *The Independent Budget* recommendation in the customary way the budget and appropriations bills are usually presented. We have included with this testimony two charts that we have prepared that delineate these accounts and compare *The Independent Budget's* figures with those of the Administration. We have also included a chart prepared by the VA that displays its FY 2004 request in the traditional manner. As is the custom with *Independent Budget* recommendations, we have also removed the collections from the Medical Care line to indicate the true amount of federal appropriations needed to fund medical care next year. *The Independent Budget* Veterans Service Organizations (IBVSOs) strongly believe that

veterans' health care is a federal obligation. Increasing collections from veterans or their health care insurers only allows budgeteers to offset federal dollars that are needed. Once these recalculations have been done, the Administration is requesting $25.2 billion for VA health care. *The Independent Budget* is recommending $27.2, or two billion more than the Administration would allow. If the Congress approves appropriations contained in the on-going conference on H.J. Res. 2 of $23.9 billion for FY 2002, the budget request would only provide $1.3 billion this year over that level.

The Administration is proposing implementing an annual enrollment fee of $250 for all currently enrolled Category 7 and 8 veterans. It is also proposing more than doubling the prescription fee to $15 and raising the cost of each outpatient visit to $20. These punitive copayments are designed as much to swell the projected budget increase as they are, the VA admits, to deter veterans from seeking their care at VA medical facilities. The cost of these copayments is designed to have that effect of people who might want to seek care at VA. Imagine the effect of these additional costs on those who have no other choice but to get care at VA.

Mr. Chairman, *The Independent Budget* makes a strong statement in opposition to copayments. From PVA's standpoint, we can make an additional case in further opposition. The Congress gave the Secretary of Veterans Affairs the authority to set and raise fees. What was once thought of as only an administrative function has now become, in times of tight budgets, an easy way to try and find the dollars to fund health care for veterans. When appropriations are in short supply and demand for health care is high, copayments have become the new way to fund the VA out of the pockets of the veteran patient. The VA has stated that their objective in curtailing access to the so-called "higher income" veterans in Categories 7 and 8 is to focus their resources on the core mission of the VA, the service-connected, the poor and those in need of specialized services. Certainly PVA can appreciate that goal as our members, veterans with spinal cord injury and dysfunction, fall within those categories of veterans with special needs seeking care at VA spinal cord injury centers – but at what cost?

Our first concern rests on the fact that those increased copayments collected from Category 7 and 8 veterans are being used to pay for the treatment of Category 1 through Category 6 veterans. It is completely antithetical to PVA's view, for instance, to have one veteran in Category 8 paying for the care of a 100 percent service-connected disabled veteran in Category 1. The cost of that care is a federal duty and a federal responsibility.

Second, Committee members should not embrace the generalization that just because Category 8 veterans are considered "higher income" these copayments do not impose an undue burden on their ability to pay. There are few, if any, millionaires seeking VA health care in this category. For Category 7s, starting at income levels of $24,000, even with the geographic cost-of-living in the HUD index, these veterans, for the most part, are hardly wealthy. For many of them, particularly those who are older, retired, and on fixed incomes, these copayment increases could be devastating. Many of these veterans have sought VA health care because of the rising costs of other public and private health care plans and insurance. The VA has become their safety net. Sadly VA is following the private sector's lead and pricing itself out of their reach.

Because of their designation as "catastrophically disabled" nearly all PVA members can enroll in the system in Category 4. This, however, does not exempt all of them from the burden these copayment increases would impose. Those PVA members with non service-connected disabilities who, because of their incomes could be classified as Category 7 or 8, can be enrolled in Category 4 but are still subject to Category 7 or 8 copayments. PVA members go to the VA because there is no other system in the country that provides the level and quality of spinal cord injury care. Over 80 percent of our members use the VA for all or part of their care. Because of the nature of their disabilities they require a host of pharmaceuticals, equipment, devices and supplies to function on a daily basis. On average, the imposition of these punitive copayment increases would bring their total out-of-pocket cost to hundreds of dollars each month. An alternative for many would be to forego outpatient visits or re-filling prescriptions and risk endangering their health and enduring expensive inpatient care.

In other areas of health care, the *Independent Budget* groups are pleased that the Administration requested an increase in medical and prosthetic research. Still, its request at $408 million is $52 million below *The Independent Budget* recommendation of $460 million needed to fund this important research program.

In closing, the VA health care system faces two chronic problems. The first is underfunding which I have already outlined. The second is a lack of consistent funding. The budget and appropriations process this year is a text book example of how the VA labors under the uncertainty of not only how much money it is going to get, but, equally important, when it is going to get it. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they needs them.

Last years funding was insufficient. The Secretary said early in the year that he required a supplemental of $400 million to meet anticipated demand. The supplemental bill wasn't address until nearly the end of the fiscal year. But the White House only obligated $142 million of that amount. Congress tried to pass the FY 2003 appropriations bill before adjourning and failed. The lame duck session failed to address the appropriation. The VA is still on a continuing resolution at wholly inadequate FY 2002 funding levels. There is now talk of funding the government and the VA at those levels until the end of the year. This breakdown in the funding process has real and immediate impact on the lives of veterans. 230,000 are waiting six months or longer for doctors appointments. Health care delayed is health care denied. If the health care system cannot get the funds it needs when it needs those funds the resulting situation only fuels efforts to deny more veterans health care and charge veterans even more for the health care they receive.

The only solution we can see is for this Committee and the Congress as a whole to approve legislation removing VA health care from the discretionary side of the budget

process and making annual VA budgets mandatory. The health care system can only operate properly when it knows how much it is going to get and when it is going to get it. We greatly appreciate Chairman Smith and Ranking Democrat Evans introducing this legislation in the last Congress. We look forward to working with them and giving them every support in moving a bill through the House and Senate as soon as possible.

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

VA ACCOUNTS –February 5, 2003
(In Thousands)

	FY 2003	FY 2004 Request	FY 2004 IB	Difference 2004 & 2003	Difference IB & 2003	Difference IB & 2004
Medical Care	TBD	25,218,080	27,201,408			+1,993,328
Medical Research	TBD	408,000	460,000			+52,000
MAMOE	TBD	79,146	84,000			+4,854
GOE	TBD	1,283,272	1,545,000			+261,728
Inspector General	TBD	61,750	61,000			-750
National Cemetery	TBD	144,203	162,000			+17,797
Construction, Major	TBD	272,690	436,000			+163,310
Construction, Minor	TBD	252,144	440,000			+187,856
Grants, State Homes	TBD	102,100	150,000			+47,900
Grants, State Cemeteries	TBD	32,000	37,000			+5,000

N.B. Amounts for the Administration's request are displayed in accordance with the traditional account structure.
MAMOE – Medical Administration and Miscellaneous Operating Expenses
GOE – General operating Expenses (Veterans Benefits Administration and General Administration)

VA ACCOUNTS –February 5, 2003
(In Thousands)

	FY 2003* H.J. Res. 2	FY 2004 Request	FY 2004 IB	Difference 2004 & 2003	Difference IB & 2003	Difference IB & 2004
Medical Care	23,889,304	25,218,080	27,201,408	+1,328,776	+3,312,104	+1,983,328
Medical Research	400,000	408,000	460,000	+8,000	+60,000	+52,000
MAMOE	69,716	79,146	84,000	+9,430	+14,284	+4,854
GOE	1,256,418	1,283,272	1,545,000	+26,854	+288,582	+261,728
Inspector General	55,000	61,750	61,000	+6,750	+6,000	-750
National Cemetery	133,149	144,203	162,000	+11,054	+28,851	+17,797
Construction, Major	144,790	272,690	436,000	+127,900	+291,210	+163,310
Construction, Minor	210,700	252,144	440,000	+41,444	+229,300	+187,856
Grants, State Homes	100,000	102,100	150,000	+2,100	+50,000	+47,900
Grants, State Cemeteries	32,000	32,000	37,000	0	+5,000	+5,000

N.B. Amounts for the Administration's request are displayed in accordance with the traditional account structure.
MAMOE – Medical Administration and Miscellaneous Operating Expenses
GOE – General operating Expenses (Veterans Benefits Administration and General Administration)
*FY2003 figures from H.J.Res. 2 which is still in conference as of February 5, 2003.

FY 2004 Request Prior Structure Compared to FY 2003 Appropriations

Prepared by Office of Budget (041C/D)		FY 2002 Enacted 1/ Level Amount	President's 2003 Budget Request 2/ Amount	House Level 1/8/2003 3/ Amount	Senate (Excludes 2.9% Rescission) 1/23/2003 3/ Amount	President's 2004 Budget Request Prior Structure Amount	FY 2004 Compared to President's 2003 Request Amount	FY 2004 Compared to House Level Amount	FY 2004 Compared to Senate Level Amount
Benefit Programs									
Compensation & Pensions	M	$26,044,288	$28,949,000	$28,949,000	$28,949,000	$29,845,127	$896,127	$896,127	$896,127
Readjustment Benefits	M	2,135,000	2,264,808	2,264,808	2,264,808	2,529,734	264,926	264,926	264,926
Veterans Insurance & Indemnities	M	26,200	27,530	27,530	27,530	29,017	1,487	1,487	1,487
Veterans Housing Benefit Program Fund									
Program	M	203,278	437,522	437,522	437,522	305,834	-131,688	-131,688	-131,688
Administrative	D	164,497	168,207	168,207	168,207	154,850	-13,357	-13,357	-13,357
Native American Veterans Housing Program	D	544	558	558	558	571	13	13	13
Education Loan Program									
Program	D	1	1	1	1	0	-1	-1	-1
Administrative	D	64	70	70	70	0	-70	-70	-70
Vocational Rehabilitation Loan Program									
Program	D	72	55	55	55	52	-3	-3	-3
Administrative	D	274	289	289	289	300	11	11	11
Total Benefit Programs		28,574,218	31,848,040	31,848,040	31,848,040	32,865,485	1,017,445	1,017,445	1,017,445
Medical Programs									
Medical Care	D	21,473,164	22,743,761	23,889,304	23,889,304	25,218,080	2,474,319	1,328,776	1,328,776
MCCF	D	1,133,214	1,448,874	1,576,061 4/	1,576,061	2,100,000	651,126	523,939	523,939
Total Medical Care	D	22,606,378	24,192,635	25,465,365	25,465,365	27,318,080	3,125,445	1,852,715	1,852,715
Medical & Prosthetic Research	D	371,000	394,373	405,000	400,000	408,000	13,627	3,000	8,000
MAMOE	D	66,731	69,716	74,716	69,716	79,146	9,430	4,430	9,430
Total Medical Programs		23,044,109	24,656,724	25,945,081	25,935,081	27,805,226	3,148,502	1,860,145	1,870,145
Construction Programs:									
Construction, Major	D	183,180	193,740	193,740 5/	144,790	272,690	78,950	78,950	127,900
Construction, Minor	D	210,900	210,700	240,700	210,700	252,144	41,444	11,444	41,444
Parking Revolving Fund	D	4,000	0	0	0	0	0	0	0
Grants State Extended Care Facilities	D	100,000	100,000	100,000	100,000	102,100	2,100	2,100	2,100
Grants State Veterans Cemeteries	D	25,000	32,000	32,000	32,000	0	0	0	0
Total Construction Programs		523,080	536,440	566,440	487,490	658,934	122,494	92,494	171,444
General Operating Expenses & Misc:									
GOE - VBA	D	955,352	992,000	992,100	992,000	1,004,704	12,704	12,604	12,704
Credit Reform Administrative (non-add)		*160,648*	*164,513*	*164,513*	*164,513*	*150,975*	*-13,538*	*-13,538*	*-13,538*
Total GOE-VBA (non-add)		*1,116,000*	*1,156,513*	*1,156,613*	*1,156,513*	*1,155,679*	*-834*	*-934*	*-834*
GOE - General Administration	D	240,376	264,418	259,318	264,418	278,568	14,150	19,250	14,150
Credit Reform Administrative (non-add)		*4,731*	*4,611*	*4,611*	*4,611*	*4,746*	*135*	*135*	*135*
Total GOE- General Administration(non-add)		*245,107*	*269,029*	*263,929*	*269,029*	*283,314*	*14,285*	*19,385*	*14,285*
General Operating Expenses		1,195,728	1,256,418	1,251,418	1,256,418	1,283,272	26,854	31,854	26,854
National Cemetery Administration	D	121,169	133,149	133,149	133,149	144,203	11,054	11,054	11,054
Inspector General	D	52,308	55,000	61,000	55,000	61,750	6,750	750	6,750
Total GOE & Misc.		1,369,205	1,444,567	1,445,567	1,444,567	1,489,225	44,658	43,658	44,658
Total Appropriation		$53,510,612	$58,485,771	$59,805,128	$59,715,178	$62,818,870	$4,333,099	$3,013,742	$3,103,692
Total Discretionary (D)		**$25,101,846**	**$26,806,911**	**$28,126,268**	**$28,036,318**	**$30,109,158**	**$3,302,247**	**$1,982,890**	**$2,072,840**
Total Mandatory (M)		**$28,408,766**	**$31,678,860**	**$31,678,860**	**$31,678,860**	**$32,709,712**	**$1,030,852**	**$1,030,852**	**$1,030,852**

1/ FY 2002 Enacted level as shown in President's Budget without reflecting transfers; includes supplemental funding under P.L. 107-206 for Medical Care and Compensation and Pensions; excludes ad

2/ FY 2003 President's Budget as requested excluding CSRS & FEHB legislation.

3/ Senate and House action on FY 2003 excludes CSRS & FEHB legislation; denies the $1,500 deductible for Medical Care; and includes Mid-Session reestimates for Compensation and Pensions.

4/ The MCCF collections for House and Senate reflects VA's latest estimates. 4/ For Major Projects, the Senate provides funding for only 2 proposed seismic projects: Palo Alto #2 and San Francisco.

Testimony of Richard Jones, AMVETS National Legislation Director

Mr. Chairman, Ranking Member Evans, and members of the Committee:

AMVETS is honored to join fellow veterans service organizations at this hearing on the VA's budget request for fiscal year 2004. We are pleased to provide you our best estimates on the resources necessary to carry out a responsible budget for the fiscal year 2004 programs of the Department of Veterans Affairs. AMVETS testifies before you today as a co-author of *The Independent Budget.*

For over 17 years AMVETS has worked with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce a working document that sets out our spending recommendations on veterans' programs for the new fiscal year. Indeed, we are proud that over 45 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans must not be forced to wait for the benefits promised them. Veterans must be assured of access to high quality health care. Veterans must be guaranteed access to a full continuum of healthcare services, including long-term care. And, veterans must be assured burial in a state or national cemetery in every state.

It is our firm belief that the mission of the VA must continue to include support of our military in times of emergency and war. Just as this support of our military is essential to national security, the focus of the VA medical system must remain centered on specialized care. VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans healthcare system and to the advancement of American medicine.

In addition, the budget must be recognized that VA trains most of the nation's healthcare workforce. The VA healthcare system is responsible for great advances in medical science, and these advanced benefits all Americans. The VHA is the most cost effective application of federal healthcare dollars, providing benefits at 25 percent lower cost than other comparable medical services. In times of national emergency, VA medical services can function as an effective backup to the DoD and FEMA.

Noting the mission of the VA, it is important to understand the areas where VA funding must be increased. The VA budget must address the pending wage increases for VA employees. It must

address the enormous backlog in veterans waiting for health care and it must address, as well, VA's large benefits casework backlog. There are severely disabled veterans and those needing home-based healthcare in those backlogs, and I think we can all agree that this situation should be addressed and corrected.

As we look to fiscal year 2004, it is amazing that nearly halfway through the current fiscal year, VA's funding remains uncertain for the remainder of FY '03. We watch a live lesson about the challenges inherent to inadequate funding. Due to a lack of resources, VA took action on January 17 to ban healthcare access to 164,000 veterans who could have enrolled this year. The resource situation reaches the absurd when, after blocking entry to these so-called "high income" veterans, VA issued a healthcare directive (VHA Directive 2003-003, January 17, 2003) to its workers directing them to send banned veterans to Community Social Work for assistance.

Looking at the 2004 budget, released last week, AMVETS notes that the Administration is proposing a $1.3 billion increase in VA health care. It is interesting to note that about 40 percent of the administration's proposed increase, $525 million, comes directly from new premiums and co-payment increases for about 2 million veterans. The result of these proposals, according to VA, is to cause nearly 1.7 million currently enrolled veterans to leave the system, unwilling or unable to afford VA care.

To avoid implementation of the proposed exclusion of these veterans, *The Independent Budget* recommends Congress provide $27.2 billion to fund VA medical care for fiscal year 2004, an increase of $1.9 over the Administration's request. We ask Congress to recognize that the VA healthcare system is an excellent investment for America. However, it can only bring quality health care if it receives adequate funding.

We also ask Congress to understand that there are other potential challenges regarding veterans health care in the potential for war with Iraq. By last year's count, about 15,000 VA employees are reservists subject to activation and 13,000 work in the healthcare system. In the event of war, it is likely that many more than the current number of approximately 400 VA employees will receive the call for active duty.

It is also important to clearly state that AMVETS along with its IB partners strongly supports shifting VA healthcare funding from discretionary funding to mandatory. Mandatory funding would give some certainty to healthcare services. VA facilities would not have to deal with the whimsy of discretionary funding, which has proven inconsistent and inadequate. We believe that

mandatory funding would provide a comprehensive solution to the current funding problem. Once healthcare funding matches the actual average cost of care for veterans enrolled in the system, with annual indexing for inflation, the VA can fulfill its mission.

The National Cemetery Administration

Before I address budget recommendations for the National Cemetery Administration, which is AMVETS's primary responsibility in the development of *The Independent Budget*, I would like members of the Committee to know that AMVETS fully appreciates the strong leadership and continuing support demonstrated by the House Veterans' Affairs Committee. AMVETS is truly grateful to those who serve on this important committee. Through your work, you represent the veteran's voice and you have distinguished yourselves as willing to lead the country in addressing issues important to veterans and their families.

Since its establishment, the National Cemetery Administration (NCA) has provided the highest standards of service to veterans and eligible family members in the system's 120 national cemeteries.

Currently, the National Cemetery Administration maintains more than 2.5 million gravesites on 13,850 acres of cemetery land. Progress is underway at several sites around the country, including Atlanta, GA; Detroit, MI; Miami, FL; Oklahoma City, OK; Pittsburgh, PA; and Sacramento, CA, to complete construction of new national cemeteries. Clearly, without the strong commitment of Congress and its authorizing and appropriations committees, VA would likely fall short of burial space for millions of veterans and their eligible dependents.

The members of *The Independent Budget* are encouraged by the Administration's recommended increase in NCA resources for Fiscal Year 2004. However, it should be recognized that while the proposal addresses employment increases and equipment needs, it does not serve to address problems and deficiencies identified in the *Study on Improvements to Veterans Cemeteries*, a comprehensive report submitted in 2002 by VA to Congress on conditions at each cemetery.

Volume 2 of the *Study* identifies over 900 projects for gravesite renovation, repair, upgrade, and maintenance. According to the *Study*, these project recommendations were made on the basis of the existing condition of each cemetery, after taking into account the cemetery's age, its burial activity, burial options and maintenance programs. The total estimated cost of completing these projects is nearly $280 million, according to the *Study*.

Clearly, as any public facilities manager knows, failure to correct identified deficiencies in a timely fashion will surely result in continued deterioration of facilities and increasing costs related to necessary repair. The *IBVSOs* agree with this assessment and believe that Congress needs to carefully consider this report to address the condition of NCA cemeteries and ensure they remain respectful settings for deceased veterans and visitors. We recommend that Congress and VA work together to establish a timeline for funding these projects based on the severity of the problems.

Volume 3 of the *Study* describes veterans cemeteries as national shrines saying that one of the most important elements of veterans cemeteries is honoring the memory of America's brave men and women who served in the Armed Forces. "The commitment of the nation," the report says, "as expressed by law, is to create and maintain national shrines, transcending the provisions of benefits to the individual...even long after the visits of families and loved ones."

Indeed, Congress formally recognized veterans cemeteries as national shrines in 1973 stating, "All national and other veterans cemeteries...shall be considered national shrines as a tribute to our gallant dead." (P.L. 93-43:24 1003(c)) Moreover, many of the individual cemeteries within the system are steeped in history and the monuments, markers, grounds and related memorial tributes represent the very foundation of these United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Unfortunately, despite NCA continued high standards of service and despite a true need to protect and nurture this national treasure, the system has and continues to be seriously challenged. The current and future needs of NCA require continued adequate funding to ensure that NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the Nation.

The members of *The Independent Budget* recommend that Congress provide $162 million in fiscal year 2004 for the operational requirements of NCA, the national Shrine initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed Forces. This is an increase of $17.8 million over the Administration's request for next year.

Clearly, the aging veteran population has created great demands on NCA operations. Primarily because of the mortality rate of World War II and Korean War veterans is increasing, as is the

usage of burial services by Vietnam War Veterans, actuarial projections do not suggest a decline in these demands for many years. From current interment levels of 85,000 per year, the VA interment rate is projected to increase successively over the next several years peaking at 107,000 in the year 2008.

The State Cemetery Grants Program:

For funding the State Cemetery Grants Program, the members of *The Independent Budget* recommend $37 million for the new fiscal year, an increase of $5 million over the Administration proposal. The State Cemetery Grants Program is an important complement to the NCA. It helps States establish gravesites for veterans in those areas where NCA cannot fully respond to the burial needs of veterans. The enactment of the Veterans Programs Enhancement Act of 1998 has made this program very active and attractive to the states.

Clearly, the enactment of the Veterans Benefits Improvements Act of 1998 has heightened the interest in the state cemetery grants program and increased participation of states in establishing fully equipped cemeteries for veterans. At the start of fiscal year 2003, the state cemetery grant program had eleven new cemeteries under design and thirteen new cemeteries in planning. In addition, the program had on hand 37 pre-applications for a total of $165 million. As before the 1998 legislative change, States remain totally responsible for operations and maintenance expenses to ensure conditions remain in a manner appropriate to honor the memory of veterans.

To augment support for veterans who desire burial in state facilities, members of *The Independent Budget* support increasing the plot allowance to $670 from the current level of $300. The plot allowance now covers less than 6 percent of funeral costs. Increasing the burial benefit to $670 would make the amount nearly proportional to the benefit paid in 1973. In addition, we firmly believe the plot allowance should be extended to all veterans who are eligible for burial in a national cemetery not solely those who served in wartime.

The Independent Budget veterans service organizations (IBVSOs) also request Congress review a series of burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973, when they were initiated.

The IBVSOs recommend an increase in the service-connected benefits from $2,000 to $3,700. Prior to action in the last Congress, increasing the amount $500, the benefit had been untouched since 1988. The request would restore the allowance to its original proportion of burial expense.

The IBVSOs recommend increasing the nonservice-connected benefit from $300 to $1,135, bringing it back up to its original 22 percent coverage of funeral costs. This benefit was last adjusted in 1978, and today covers just 6 percent of burial expenses.

The IBVSOs also recommend that Congress enact legislation to index these burial benefits for inflation to avoid their future erosion.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

STATEMENT OF

DENNIS CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS CONSTUCTION BUDGET REQUEST FOR FISCAL YEAR 2004

WASHINGTON, DC FEBRUARY 11, 2003

DEAR MR. CHAIRMAN AND MEMBERS OF THIS COMMITTEE:

On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I wish to convey our appreciation for inclusion in today's important hearing.

As an organization, and as a proud coauthor of the Independent Budget (IB), we are strong advocates for an adequate budget for the Department of Veterans Affairs (VA). While the primary focus of that attention is on the actual delivery of health care and benefits for our nation's veterans, we cannot afford to forget the importance that construction and maintenance play in the process. If VA does not invest proper amounts of money in its infrastructure, it will have immense repercussions in the coming years when patient comfort, safety and VA's ability to modernize equipment and facilities are compromised. Supporting additional funding now will lessen future burdens on patients and staffs, improve patient and worker safety, make health care delivery simpler, and even reduce costs in the end.

Despite the importance of those factors, we are once again left with a budget that falls short of these important goals. Using the old budgetary methodology, the request calls for $272.7 million and $252.1 million for major and minor construction projects respectively. This is far short of the $436 million and $425 million the IB recommends for those same major and minor construction projects. Further, VA's request for major and minor construction includes funding for the Capital Assets Realignment for Enhanced Services (CARES) process, something we believe should be kept separate. Besides the $183 million earmarked for the CARES, VA requested a paltry $89.3 million for major construction projects. Our request of $436 million does not include these CARES projects. When we consider the CARES numbers separately, the construction accounts are even more strikingly deficient.

The Veterans Health Administration (VHA) is charged with maintaining over 2,026 buildings, which includes 162 hospitals, 675 outpatient clinics and 137 Nursing Homes, with almost half of them over fifty years old. It is essential that VA repair and enhance this vital, but aging, infrastructure to delay the erosion of the initial capital investment. As in past years, we cite an independent study of VA's facilities conducted by Price Waterhouse. Their study indicated that VA should allocate between two and four percent of their asset value into maintenance and an additional two to four percent for improvements. Again, the budget is not sufficient to meet these needs. VA should spend over $700 million annually on upkeep alone.

This insufficient request when combined with years of under funding will create an even lengthier backlog of nonrecurring maintenance issues that must be addressed before VA's aged properties deteriorate further. This backlog includes the 890 buildings deemed at "significant risk" and the 73 buildings considered an "exceptionally high risk" of catastrophic collapse or major damage because of seismic deficiencies. The IB believes that VA needs $285 million to begin the correction of these seismic deficiencies while the FY '04 budget provides less then 10% of that amount, $20 million. We also believe that VA should have an additional $400 million for the reduction in backlog of nonrecurring maintenance issues. VA must focus on these problems before patient safety and access become a larger crisis.

We recognize the difficulty of VA's position with regard to the construction budget. VA must often carry out these backlogged maintenances and improvements within the context of the larger CARES process. Despite this, just as we strongly urge VA not to divest itself of properties until the process is complete, we also point out that it is essential that construction and repair continue on existing facilities. The pending status of CARES has led to the deferral of many basic projects vital to the sustenance of VA's physical plant. VA has identified a number of high risk buildings in desperate need of repair, and the CARES process should not distract VA's obligation to protect its assets, whether they are to be used for current capacity or to be realigned.

With respect to the CARES process, as a whole, we generally remain supportive. We acknowledge that there are some VA facilities that are unusable or unnecessary due to the aging infrastructure as well as the transformation of VA health care into a more outpatient-focused system. If the process truly does enhance services, then we are fully behind it. Unfortunately, the results from Phase I, the pilot project in Veterans Integrated Service Network (VISN) 12, are so far inconclusive.

We remain concerned that the actuarial service VA used for projections during planning may not have the proper data. VA has many specialized programs for illnesses and diseases unique or particularly problematic for an aging veterans' population. The specialized care provided for chronic mental illness, spinal cord injuries, post-traumatic stress disorder, and other similar illnesses would not be accurately reflected in statistical data based on outside medial facilities. VA must ensure that the statistical model used reflects the particulars of VA's many specialized treatments to ensure that CARES really does serve the veterans population both now and in the future.

Another concern, that was particularly problematic in Phase I, is the lack of clear communication. As Phase II begins, and rapidly expands the process throughout the country, we must ensure that veterans—VA's patients and customers—have a voice in the process. We simply must know what is going on, and what the planning process is so we can make informed decisions and suggestions.

Perhaps our greatest misgiving is with the way that VA has delayed major construction projects because of the CARES process. As expressed previously, VA absolutely must continue maintenance and upgrades to existing facilities for the health of the infrastructure. If it is clear that CARES will not affect a particular hospital or facility, it is essential that VA begins, and Congress appropriates the money for, the major construction projects many of these facilities desperately need. We are optimistic that the $225 million contained in the request for CARES is a sign that VA recognizes the complications that delaying important construction would create. However, the IB has recommended $1 billion as a down payment toward immediate construction needs under the CARES process. Further, we urge VA and Congress to work together in future years to ensure a proper and steady stream of funding to begin construction on projects as they are identified by the CARES process to avoid losing as much time as possible.

On a final note, we would also request a fundamental change to the way major and minor construction projects are designated, which would greatly enhance VA's ability to solve problems and deficiencies. We urge the Congress to enact legislation that would raise the limit on minor construction projects from $4 million to $10 million. This cap inhibits many VA facilities from properly carrying out construction projects by forcing them to reduce the scope of the project or to group several small projects in an uneconomical, piecemeal approach. Raising this cap would allow VA to conduct more essential projects in an efficient and safe manner that would greatly lessen the burden and inconvenience on patients and staff. We thank this Committee and the House of Representatives for your efforts to approve H.R. 4514, legislation that would have increased this threshold to $6 million, during the 107th Congress, and we urge the reintroduction of similar legislation this session. It indicates to us, that you recognize the many problems and inefficiencies this low threshold creates.

VA simply must do a better job protecting and investing in its capital infrastructure. If basic care is not provided, the physical health of the system will continue to deteriorate. Addressing these issues in a timely manner and with proper planning will be of great benefit. If these issues are not addressed, it will only serve to increase the burden on patients and staff and be a detriment to patient safety and VA's ability to deliver health care long into the future. We strongly urge that Congress take steps to correct this inadequate construction request and to support the funding levels and suggestions we have brought before you today.

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

STATEMENT

of

Vietnam Veterans of America

Presented by

Richard F. Weidman
Director, Government Relations

Before the
House Committee on Veterans' Affairs

Regarding

Department of Veterans Affairs FY04 Budget

February 11, 2003

Mr. Chairman, on behalf of Vietnam Veterans of America (VVA) and our National President Thomas H. Corey, I thank you and your distinguish colleagues for the opportunity to present our views in regards to the President's proposed FY 2004 budget for the Department of Veterans Affairs (VA), and budget requests for other services that directly affect veterans' health care services and other vital services

Adequate Funding

Vietnam Veterans of America (VVA) holds that the purpose of the VA medical system is literally what is stated in their motto, which is "To care for he (or she) who hath borne the battle, his widow and his orphan." VVA continues to believe that the VA can and must do a better job of utilizing the funds they have more effectively and efficiently.

While the VA needs an increase of several billion to a level of at least $28 Billion in appropriated dollars for FY04 in order to accomplish their core mission, that vitally needed increase must be accompanied by additional management systems improvements, and much greater accountability from senior managers. By additional management tools, we mean a financial tracking system that works, statements of accounts that allow for tracking expenditures of specific fields and areas of interest (e.g., hepatitis). We also mean establishment of a real time Management Information System (MIS) that works to tell the Secretary and his top leaders exactly what resources they have where at any given time. If there is to be much more accountability demanded, then we must have the tools put in place to track essential data. There must also be much greater accountability for performance from GS 14, GS 15, and most especially from the Senior Executive Service (SES) and other "super grade" managers. A good place to start is very careful scrutiny of bonuses, which in FY 2002 averaged well over $11,000 per year for SES personnel at VA. In short, much more needs to be done in this area by the Executive branch, and possibly action by the Congress.

As steps are taken to accomplish greater accountability, and achieve better "bang for the buck," there must be a more steady and reliable flow of revenue than has been the case in recent years, at a level that is realistic given the needs of veterans seeking services from the Veterans Health Administration facilities. The best way to accomplish the needed stability that has been subject of discussion in the Congress and the veterans' community is to make funding for veterans health care mandatory. VVA also believes that whether funding is funded on the discretionary side of the ledger or on the mandatory side of the ledger, there must be adequate funding. As noted above that would mean a minimum of at least $28 billion for (exclusive of co-payments and third-party collections) for veterans' health care operations in FY 2004.

Most Americans believe that health care for veterans is a government obligation to those men and women who stepped forward to defend freedom and this nation. At a time when our President is asking a new generation of Americans our sons and daughters to bear the burden of defending this country, we must keep faith with their dedication by making the commitment to assure that the funds to care for their injuries and disabilities is not

relegated to a discretionary duty of the nation they have sworn to defend. Budgets are a reflection of the values and priorities of the administrators who design them and the legislators who approve them. What does "discretionary" funding for the care of men and women who defend this country say about America?

The President, with troops in the field requested $25.2 Billion in actual appropriated dollars for FY2004. Congress must soon act to provide at least $23.9 Billion for FY 2003 operations of the VA health care system. If Congress does not pass a FY 2003 budget soon, then it is incumbent on the President to ask for the difference between the continuing resolution currently in place and the $23.9 billion as an emergency appropriation that is vitally needed virtually immediately.

VVA points out that while we appreciate the proposal by the Administration to add about $1.4 Billion as an increase over the $23.9 Billion that will presumably (hopefully) be the final funding level for medical operations for FY 2003, it just simply is not enough to keep the system from further deteriorating.

The Secretary of Veterans Affairs took the only responsible action in light of the dire funding situation when he created a new Category 8 for priority of medical care at VA and suspended new enrollments of veterans in that category. Triage is hard. I had to do triage as an Army medic in Vietnam, and it was the hardest thing I have ever had to do. The Secretary had the courage to take the only proper choice under the circumstances. The question that we should now all be asking is why should it come to such a pass that Secretary Principi has to take such actions. It should not be that we have to triage American veterans in this way, but it will be this way increasingly until we catch up with funding and organizational capacity as to where we should have bee had it not been for the "flat lined years" and the increases less than the rate of medical inflation since, never mind the exploding population of veterans using the VA health care system.

As a Nation we can and must do better than we have done the past few years, despite tremendous efforts by the leadership on both sides of the aisle on this Committee, and many other friends in the Congress. We must have mandatory health care funding, and we need it now.

Veterans Health Initiative

To accomplish the proper mission of the VA as defined mission statement, one has to establish a "***Veterans*** Health Care System" that is focused on the needs the individual has as a veteran. One cannot possibly do this effectively if you do not take a complete military history, do a psychosocial work up where indicated, and test for such conditions and illnesses as the individual might well have been exposed because of the era of the military service, branch of service, duty stations (e.g., Vietnam theater of operations, Korea, Gulf War), military occupational specialty, etc. Perhaps the most glaring example of this is Hepatitis C for Vietnam veterans, but there are many more such conditions such as stronglioides and meliodiasis for those who served on the ground in Vietnam, other tropical diseases for World War II veterans who served in the South

Pacific, and "workplace hazards" specific to what the veteran did in military service to country, and when and where he or she did it.

This taking of a military and medical history is just plain common sense, and it is also good practice of medicine. It is absolutely necessary if we are committed to a "wellness" model of returning the individual to the highest degree of self sufficiency and autonomy possible. VVA holds that this not only makes sense, it is our duty as a Nation to do this right.

VVA also holds that it should be the explicitly stated goal of every veterans program to help the individual become as self sufficient as possible, and to us this means assisting the individual return to a state of readiness where he or she can obtain and sustain meaningful work. This may not be possible to achieve in every instance, but it should be the goal.

All of the medical experts will tell you that if one practices medicine in such a way as to help the person achieve "wellness" as opposed to just performing medical procedures for the immediate complaint reported by the patient, then it results in less overall cost to the system. The studies done at West Los Angeles VA Medical Center in regard to taking a true "holistic" approach would seem to bear out the cost savings that occur within the Fiscal Year alone, never mind the future years. If the system can be made to systematically concentrate on the needs of veterans as veterans in a rigorously holistic manner, then we will reduce "churning" and prevent many chronic problems from becoming so acute that repeated and/or prolonged inpatient care is required.

VVA looks forward to elaborating on these points next month, when we present our legislative agenda to you and to your distinguished colleagues from both the Senate and the House of Representatives. The point we wish to make here is that we do believe that VA can use the money it has more efficiently and (even more importantly) much more effectively.

Having noted all of the above, the question that confronts us today is how do we break out of the dilemma we are in as regard to securing enough resources to keep the system going long enough to discuss and debate how to make it work better to accomplish the goals we all share.

Some believe that the way to go with the delivery of care is to privatize it in some manner. That is an option that clearly worked to make the World War II GI Bill the most cost effective investment of a program ever enacted by our Nation's Congress. VVA would point out that VHA already contracts out more than one Billion in services already, and even has a pilot program in operation for contracting out compensation and pension exams. While this path holds promise in the view of some, it also is anathema in the view of others. The strongly held differences of opinion exist within the Domestic Policy Council and OMB, with the veterans' community, the public, and within the Congress. VVA would point out that the same sharp differences of opinion surrounded

the decision of General Bradley to affiliate VA Hospitals with the medical schools in the period immediately after World War II.

It is clear that the President and the Office of Management Budget (OMB) intend to contract out a great deal more of the services of the VA hospitals. Apparently much of the laboratory work is being contracted out already, and there are plans being executed not to greatly expand this and other contracting out to the private sector. VVA has reports that even the Pharmacy operation, the most efficient operation at the VA is soon slated for the contract table. OMB is currently preparing a new version of "A-76" to speed and enhance this process.

There must be a viable entity to discuss, and that requires sufficient resources. What is clear is that there will continue to be a need for a strong VA health care system as an anchor and central means of both delivering truly high quality care and ensuring the highest possible medical care to veterans as veterans. It is in everyone's interest who cares about the future of our country, and therefore cares about veterans, to ensure that there are enough resources available to maintain this activity, whatever form it may take in the future.

The ordinary processes of the Congress in the making of a budget may not be such as to allow for the adding of the $2.5 to $3 Billion in real appropriated taxpayer dollars it will take just to preserve current organizational capacity to deliver even the current state of medical care to America's veterans. There would be, in that figure funds for starting to restore specialized services, and enhancement of Fourth mission and preparations for treating the new combat wounded veterans, who may well be in hospitals here in the U.S. before there is an '03 budget appropriation enacted. While we seek to chart the ways to improve the delivery of the best possible medical care to veterans in the future. In the "business as usual" scenario, it is unlikely that much more than $1 Billion to will be added to the Administration's request for health care, inasmuch as the budget process is played as a "zero sum game." In a zero sum game any money not requested by the President must come from somewhere else.

Mr. Chairman, Vietnam Veterans of America urges that you join with Chairman Walsh of the Subcommittee on Appropriations, as well as the distinguished Chairmen of your respective Committees and your distinguished colleagues on both sides of the aisle to mobilize both the Republican and the Democratic leadership to find a way to fund the VHA at a level of at least $28 Billion.

We point out that funding VHA at more than $28 Billion would still be less of a percentage increase than that accorded to Medicare over the last decade, the Federal portion of Medicaid over the last decade, and significantly less than medical inflation over a similar period of time.

VVA also urges you to move forward legislation that would make per captita funding of the veterans health care system mandatory, at a figure for each veteran at the same level per capita as FY 1996, adjusted and compounded for medical

inflation for each year since. VVA's top two legislative priorities are mandatory funding for veterans' health care, and sharply increased accountability in government.

Guaranteed Transitional Housing Loans for Homeless Veterans

The VA Guaranteed Transitional Housing for Homeless Veterans Program, providing up to 15 loans for housing for homeless veterans, is confusing in its terminology. It is the loan program for multi-family housing. The veterans, who will use the facilities/housing that this loan program intends to establish, enter into a tenant/landlord relationship when they reside in this housing.

It has been VVA's understanding that this program was to provide a housing option for a period longer than two years...the normal length of time in a transitional living arrangement. The intended establishment was, in fact, to provide housing/residence as a long-term option.

In this regard, it is not "transitional" in the true and consistent use of this term, nor is it the definition of the word with which we in the grant arena are normally familiar. Being consistent with the terminology we find to be important so as not to cloud or confuse programs in the future. Additionally, multiple definitions may create a variety of criteria under which programs are held accountable and for which administrators are held responsible. It creates confusion when policies are written and legislation is sought. The change of title for this loan program may require legislative action. Perhaps, it would be more consistent with the intent of establishment of these residential options if they were viewed more as Community Intermediary Housing ... not Transitional.

I understand that you assert the VA intends to use certain language in the FY04 budget that would move this program from a loan program to a grant program and in the process change it from mandatory funding to discretionary. Because OMB is often the underlying obstacle to many of the problems with which we are faced, I suggest that VA may not necessarily be the initiator of this movement nor may they be in total agreement with it. This is to be seen, of course. However, VA has invested many months moving this program forward. I would assume, contractors, working in good faith with the VA, have been absorbed with the planning and procedures for the implementation of this program. If the VA changes in the middle of the road, it does not set an appropriate foundation for future involvement on the part of any future initiatives for this program. It undermines the creditability of the VA and its working relationship with any future concerns, corporations, investors, or non-profits that would consider an involvement with a project of this size.

In the past few years, Congress has lent their ears to the voice of homeless advocates and particularly to the resounding swell of heightened concern for homeless veterans. Historic legislation has been passed. Advocates for homeless veterans applaud this action. But we now ask for help in understanding why an innovative program by design will be

changed to a horse of a different color before it has had the opportunity to prove itself on the track.

If OMB believes this program has inherent flaws, what are they? How can they be addressed within the framework of its present structure? If the dollars are moved from mandatory to discretionary, how will the program dollars be protected for full utilization of the funding, originally set aside for this program? There are some who would suggest that this movement may have ulterior motives.

Compensation and Pension Perspectives

Even with the implementation of the Secretary's Claims Processing Task Force's recommendations concerning increased training and accountability of the VA Compensation and Pension (C&P) staff and management, progress in terms of demonstrated increases in proficiency (including timeliness and accuracy of decisions), reduced remanded claims and appeals, and professional accountability have been painfully slow and woefully inadequate. The Task Force essentially concluded that better training of new C&P hires and retraining of long-time staff members is paramount to overcoming the current institutional culture of indifference to benefits-related statutes, regulations and jurisprudence, acceptance of poor proficiency and performance, and the belief that staff and senior management are immune from disciplinary action as the result of erroneous and unnecessarily prolonged decision making. VVA wholeheartedly concurs with this conclusion.

The VA's budget submission for its C&P training and performance evaluation design programs contemplates too small of an increase ($2.1 million) to even hope to meaningfully affect the current situation, let alone accomplish its goals. Substantially increased funding is required in this respect to slow the momentum of years of low agency-wide expectations and effect significant changes in training, performance and accountability.

Proposed Legislation:

In its budget report, the VA has proposed legislation to reverse the decision of the United States Court of Appeals for the Federal Circuit in *Allen v. Principi*, 237 F.3d 1368 (Fed. Cir. 2001), which held that Title 38 U.S.C. § 1110 permits a veteran to receive compensation for an alcohol or drug abuse disability acquired as secondary to, or as a symptom of, a veteran's service-connected disability (including post-traumatic stress disorder (PTSD)). The Court concluded that section 1110 does not preclude compensation for an alcohol or drug abuse disability secondary to a service-connected disability, or use of an alcohol or drug abuse disability as evidence of the increased severity of a service-connected disability. The Court's analysis of the statute deemed that compensation is only barred for primary and secondary substance abuse disabilities that result from the veteran's willful misconduct or the primary abuse of alcohol or drugs (such as cirrhosis). The *Allen* decision overruled the Court of Appeals for Veterans

Claims' decision in *Barela v. West*, 11 Vet.App. 280 (1998) and VA General Counsel Opinions 2-98 and 7-99, which essentially decided that compensation may not be paid for a disability due to alcohol or drug abuse. Consequently, service connection may be granted for alcohol or drug abuse if it is clinically established that the condition is adjunct to a service-connected disability. A higher evaluation may be granted for such symptomatology if clinical evidence demonstrates that the symptomatology is part of a service-connected disability.

In rendering its opinion, the Federal Circuit did not find that Congress, in enacting 38 U.S.C. § 1110, intended to include secondary service connection for substance abuse-related disorders where a service-connected disability is the cause within the willful misconduct prohibition. Nowhere is this situation more prevalent than where a veteran has a service-connected psychiatric disorder, particularly PTSD. It cannot be disputed that the VA compensation scheme is designed to compensate veterans for disabilities incurred as the result of their military service. There is no substantive difference between any other secondarily service-connected disability and a substance abuse-related disability that is a consequence of alcohol or drug abuse caused by a service-connected disability. Federal courts have already recognized this. Essentially, what the VA proposes is cutting costs (*Allen*-related benefit payments are estimated at $127 million in FY 2004) by cutting entitlement to *bona fide* service-related disabilities. To do so flies in the face the VA's mission as well as being utterly unconscionable.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to answer any questions that you may have of me. Again, Vietnam Veterans of America thanks you and the distinguished Members of this Subcommittee for your tenacious leadership on so many veterans' health care issues and for considering our views on this issue of vital importance to veterans of every generation.

RICHARD WEIDMAN

Richard F. "Rick" Weidman serves as Director of Government Relations of Vietnam Veterans of America. As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam war, including service with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of New York Governor Mario M. Cuomo as statewide director of veterans employment & training (State Veterans Programs Administrator) for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans (NCHV) and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities-Subcommittee on Disabled Veterans, Advisory Committee on Veterans' Entrepreneurship at the Small Business Administration, and numerous other advocacy posts in veteran affairs. Among those other responsibilities, he is currently serving as Chairman of the Task Force for Veterans' Entrepreneurship and Chairman, Task Force for Veterans Preference & Government Accountability, both of which are mechanisms for veterans' organizations and other Americans committed to justice for veterans to coordinate efforts on these vital issues.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he also was active in community and veterans affairs. He attended Colgate University (B.A., (1967), and did graduate study at the University of Vermont.

He is married and has four children.

STATEMENT OF
PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE DEPARTMENT OF VETERANS AFFAIRS'
FISCAL YEAR 2004 BUDGET REQUEST

FEBRUARY 11, 2003

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to express the views of the 2.8 million members of The American Legion regarding the Department of Veterans Affairs' (VA) Fiscal Year (FY) 2004 budget request. As veterans' advocates, it is our job to ensure that VA is funded at a level that is adequate to fulfill the mandate "...to care for him who has borne the battle, his widow and his orphan."

With this budget request, President Bush and Secretary of Veterans Affairs Principi clearly state their objective: "a continued focus on the health care needs of VA's core groups of veterans – those with service-connected disabilities, the indigent, and those with special needs." The American Legion believes there are two ways to achieve this goal:

- rationing of health care by driving veterans away for the health care system designed to meet the health care needs of America's veterans or
- expand the health care system to meet the health care needs of America's veterans without compromising the quality of care.

For over a decade, The American Legion has advocated allowing veterans to spend their health care dollars on the health care system of their choice. The American Legion believes the Veterans Health Administration (VHA) can efficiently expand to meet the health care needs of the men and women who have honorably served this nation in its armed forces – in war and in peace.

The American Legion believes the level of funding proposed in the FY 2004 budget request may meet the President's goals, but will lead to over 1.2 millions veterans leaving the system. The American Legion also has reservations about the budgetary impact on other aspects of VA operations, to include the Veterans Benefit Administration (VBA).

When Congress opened access to the VA health care system, many veterans believed VA was their best health care option and voted with their feet. Since the Centers for Medicare and Medicaid Services (CMS), the nation's largest public health insurance program, does not offer its beneficiaries a substantive prescription program, many Medicare-eligible veterans chose to

enroll in VHA specifically to receive quality health care and access to an affordable prescription program. Since the Department of Defense (DoD), TRICARE, and TRICARE for Life require military retirees to make copayments or pay premiums, but does not provide for specialized care (like long-term care), many military retirees also chose to enroll in VHA.

Veterans continue to suffer as a result of a system that has been routinely under funded and is now ill equipped to handle the large influx of veterans waiting to use their services. Veterans continue to endure interminable waiting times for medical appointments, as well as, unacceptably long waiting times for claims adjudication.

VA essentially entered FY 2003 without a budget. Continuing to operate at an inadequate FY 2002 funding level has presented many challenges. The fallout, in part, has been the Secretary's decision to suspend enrollment of Priority Group 8 veterans for the foreseeable future. Clearly, the current system is fiscally tapped out.

The problems resulting from years of underfunding run even deeper within the VA health care system. In October 2002, National Commander Ronald F. Conley began an initiative to reach out to the hundreds of thousands of veterans who actually make up the VA health care backlog. Through surveys asking veterans for their comments regarding their experience with the local VA Medical Center (VAMC), The "I Am Not A Number" Campaign, as it has been dubbed, has allowed The American Legion to learn first-hand of the problems that exist when seeking health care through VA.

The problems described in these surveys, coupled with the information that has been gathered from Commander Conley's visits to over 25 Veterans Affairs Medical Centers (VAMCs), has been less than encouraging. VAMCs are expressing their concern over the significant increases in their Medical Care Collection Fund (MCCF) goals for FY 2003 and what impact the recent restrictions on enrolling any new Priority Group 8 veterans will have on their ability to meet those goals. Prohibiting the one Priority Group of veterans that, most likely, has an expendable income and has third-party health coverage to help VAMCs meet increased MCCF goals seems, at face value, illogical.

Many VAMCs are using capital improvement funds to pay for the delivery of health care. Facility improvements continue to be delayed due to budgetary shortfalls. Commander Conley is learning first hand of VAMC concerns over the outsourcing of services and the cost effectiveness of this initiative.

The growing shortage of medical specialty personnel, nurses in particular, is continuing to impact the delivery of quality health care. Exacerbating this shortage is the real possibility of National Guard and Reserve units being activated, since several thousand VA personnel are members of the Guard or Reserve and their activation would certainly have a negative impact on the operation of the VAMCs.

The American Legion believes these issues and others will continue to plague VA beyond FY 2003. As we turn to FY 2004, the picture is no brighter. The American Legion believes any budget for VA should be augmented by MCCF and not scored as an offset to a budget, because

these reimbursements are paid for the treatment of nonservice-connected medical conditions. When VA distributes its annual appropriations to each Veterans Integrated Service Network (VISN) it uses a Veterans Equitable Resource Allocation (VERA) formula. There are many components to this formula, to include the patient population of Priority Groups 1-6, but the number of enrolled Priority Group 7 and 8 veterans is not a funding or distribution factor. Therefore, a VISN is not funded to treat Priority Group 7 and 8 veterans, but must seek copayments and third-party reimbursements to cover the cost of care. These collects should be added to the discretionary appropriations, not subtracted from these limited resources.

MEDICAL CARE

The VA health care delivery system is not only the largest health care provider in the nation, but it has established itself as a formidable leader in the health care industry. Veterans receive quality health care and are choosing VA as their health care provider in record numbers. VA is currently struggling to meet their needs and, with VA's proposed FY 2004 budget, it will continue to struggle.

The FY 2004 budget request introduces several proposals to generate increased revenues from the pockets of veterans through an enrollment fee, copayments and third-party reimbursements. According to VA, these proposals will reduce the resource demand by $1.3 billion collectively and hopefully encourage 1.2 million veterans to leave the system. The budget request also seeks management savings of over $1.1 billion. This adds up to a $2.4 billion offset to the requested $25.4 billion budget for medical care.

The American Legion is concerned with several of the budget proposals:

- Limit enrollment – VA proposes to continue the suspension of enrollment of new Priority 8 veterans. These veterans have incomes above $24,644 for a single veteran and above the Housing and Urban Development (HUD) geographic means test level, to include noncompensable, 0 percent service-connected veterans. Although these service-connected veterans may seek health care for their service-connected disability, they are prohibited from enrolling for treatment of or prescriptions for any nonservice-connected medical conditions.

The American Legion continues to disagree with this recent decision. We believe denying veterans access to VA health care, particularly while we prepare to go to war, is unacceptable. Many recently separated veterans would fall into this Priority Group. By denying health care to Priority Group 8 veterans, VA is sending the message that these veterans are not welcomed, even if they have the expendable income or private health insurance coverage that VA can bill for the cost of their nonservice-connected medical treatment. Clearly, there are potential Priority Group 8 veterans with no health care coverage because they are self-employed or unable to afford premiums.

In order for more veterans to access VA health care, additional revenue streams must be generated to supplement the discretionary funding. The American Legion strongly advocates Congress authorize VA to bill, collect, and retain third-party reimbursements from CMS for treatment of Medicare-allowable, nonservice-connected medical conditions of Medicare-eligible veterans. Since Medicare is a Federally mandated, pre-paid health insurance program, The

American Legion believes Medicare-eligible veterans should be allowed to choose their health care provider.

To qualify for Medicare, most veterans make automatic monthly payroll deductions to CMS and cannot use the benefit until reaching age 65. Access to VHA health care is based on honorable military service not age; therefore, a veteran earns the right to enroll in VA, but is forced, by law, to participate in Medicare. There is a clear difference here: VA is a health care provider, while Medicare is a health insurer. If VA is a Medicare-eligible veteran's health care provider of choice, then VA should be reimbursed for providing quality health care services.

• Assess an annual enrollment fee - VA proposes a $250 annual enrollment fee for non-service-connected (NSC) Priority 7 veterans and all Priority 8 veterans. Priority 7 veterans have incomes above $24,644 for a single veteran and below the HUD geographic means test level, to include noncompensable, 0 percent service-connected disabled veterans. This annual enrollment fee would apply even if the veteran has third-party health insurance that reimburses VA for the treatment of nonservice-connected medical conditions. This annual enrollment fee would apply even if the veteran was willing to make copayments for treatment of nonservice-connected medical conditions, pharmacy, and specialized care (like long-term care). However, this annual enrollment fee does not guarantee timely access to quality health care. According to President Bush and Secretary Principi, these veterans are not their primary focus.

The American Legion cannot support this proposal because it is designed to discourage the enrollment of veterans based solely on their income and not their honorable military service. There are Priority Group 7 and 8 veterans with military awards and decorations for wartime service that, for the grace of God, were not seriously wounded. Many members of "The Greatest Generation" fall into these Priority Groups. Many veterans of the "Forgotten War" fall into these Priority Groups. This cannot be the intent of a grateful nation – to nickel and dime veterans out of their heath care system.

The American Legion would urge Congress to reject this proposal just as it did the Administration's plan last year to charge Priority Group 7 veterans a $1,500 deductible.

The American Legion will continue to work with Members of Congress to pass long-term funding solutions. We will continue to fight for Medicare reimbursement legislation that will allow Medicare to pay VA for the cost of health care it provides to all Medicare-eligible veterans. Further, we will continue to advocate mandatory funding legislation for the President's and Secretary Principi's core constituents.

Access to quality health care is a continuing struggle for veterans seeking care through VA. Continued budgetary shortfalls, combined with rising medical care costs and increased demand for care have resulted in unprecedented waiting times.

• Change the veteran's share of outpatient and pharmacy co-payments – This proposal entails reducing the pharmacy co-payment burden for Priority 2-5 veterans, while increasing Priority 7 and 8 pharmacy co-payments from $7 to $15. It also increases outpatient primary care co-payments from $15 to $20 for all Priority 7 and 8 veterans.

While The American Legion applauds the reduction of the pharmacy co-payment for veterans in Priority Groups 2-5, the recent increase in copayments from $2 to $7 was accompanied by a decrease in the outpatient copayment from $50 to $15. Obviously, this means the President and Secretary of VA miscalculated the reasonable charge for medications and treatment. The American Legion would rather VA seek reimbursements for CMS for all enrolled Medicare-eligible veterans being treated for nonservice-connected medical conditions, before trying to balance the budget on the backs of Priority Groups 7 and 8 veterans.

- Require reimbursement for services provided to health maintenance organization and preferred provider organization members - This proposal seeks to establish VA as a preferred provider for members of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) would obligate these organizations to reimburse VA for health care provided to their members.

The American Legion believes this change would help VA increase third-party reimbursements. The fact that VA currently cannot bill HMOs and PPOs is unfair considering VA treats many veterans who belong to these organizations. The American Legion would welcome this change; however, it seems odd to mandate private sector insurance plans to recognize VA as a preferred provider and not mandate CMS to recognize VA as a Medicare provider, especially since VA meets or exceeds most of CMS' own quality performance standards. If CMS' goal is to provide its beneficiaries with the best quality health care, VA should be a recognized Medicare provider. In fact, CMS Director Scully claimed before the Presidential Task Force To Improve Health Care Delivery for Our Nation's Veterans (PTF) that he encourages veterans to go to VA rather than private health care providers.

- Change the institutional long-term care services provided to veterans – This proposal would allow non-institutional, as well as, institutional workload in community and State Home Nursing programs along with VA Nursing to count toward the 1998 capacity level. VA would supposedly expand their total long-term care capacity by increasing non-institutional long-term care.

The American Legion believes the proposal will further stagnate long-term care services. The passage of the Veterans Millennium Health Care and Benefits Act (Public Law 106-117) on November 30, 1999, was the first step toward ensuring a comprehensive long-term care plan for veterans. The American Legion fully supported this insightful decision by Congress, especially with the aging veterans' population. It required the VA to bring the census back to 1998 levels. So far they have failed to do that. VA has the authority to establish copayments for nonservice-connected veterans in need of long-term care – a time in their lives when they and their families desperately need help from VA. The President and the Secretary want to reduce the number of long-term care beds without any recommendations from the PTF or the Capital Assets Realignment for Enhanced Services (CARES). In fact, the CARES process is currently not addressing either long-term care or mental health inpatient needs. The "market plans" currently being developed by each VISN will not be including institutionalized care involving long-term care or mental health. The American Legion cannot accept this recommendation.

The American Legion is committed to developing permanent solutions to preserve and improve the VA health care system. This goal includes providing a coordinated continuum of long-term cares to meet the needs of the individual veteran. With the ever-growing aging population of veterans, it is critical that VA positions itself to adequately care for all the needs of these veterans, to include long-term care.

The American Legion recommends $24.5 million for direct medical care in FY 2004; however, strongly recommend to add, rather than offset, MCCF and authorize VA to bill, collect, and retain third-party reimbursements from the nation's largest health insurance program – Medicare – for the treatment of nonservice-connected medical conditions on a fee-for-service basis.

MEDICAL AND PROSTHETIC RESEARCH

VA's Medical and Prosthetic Research Program (R&D) is the premier research initiative leading the nation's efforts to promote the health and care of veterans. The mission of R&D is to "discover knowledge and create innovations that advance the health and care of veterans and the nation." R&D has been instrumental in advancing treatments for conditions such as prostate cancer, diabetes, heart diseases, mental illnesses, spinal cord injury (SCI) and aging related diseases, conditions directly related to veterans.

The Quality Enhancement Research Initiative (QUERI) continues to be a top priority issue for R&D. QUERI is a multidisciplinary, data-driven national quality improvement program. There are eight QUERI groups that work to promote "putting research results to work" and to measure the impact of that research at all levels. These groups are chronic heart failure, diabetes, HIV/AIDS, ischemic heart disease (IHD), mental health, SCI, stroke and substance abuse. Additionally, The National Cancer Institute is funding a new Cancer QUERI. These initiatives focus on veterans' health issues and have already had a profound effect on improving the care and rehabilitation of the nation's veterans.

Two of the biggest challenges facing R&D are facility infrastructure and recruitment and retention. Like the rest of VHA's buildings, research facilities are in desperate need of repair. They have been neglected over the years due to budgetary constraints. Currently, R&D has nearly 30 facilities in varying states of disrepair. The condition of these facilities directly impacts the recruitment and retention of qualified researchers. The ability to maintain a state-of-the-art facility is vital to retaining talented and motivated researchers.

In the wake of the September 11th terrorist attacks and their aftermath, there has been a renewed focus on bioterrorism research and VHA's fourth mission, which is to support DoD during a national emergency.

The accomplishments of the VA research program cannot be overstated. The program has been recognized both nationally and internationally for its efforts toward the betterment of veterans' lives and advances in their health care. Without proper funding the program cannot possibly maintain its current level of success. The American Legion believes VA's budget request for $408 million is inadequate.

The American Legion recommends $445 million for medical and prosthetic research in Fiscal Year 2004.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

MAJOR & MINOR CONSTRUCTION

Over the past several years, The American Legion has testified on the inadequacy of funding for VA's major and minor construction programs. Buildings continue to be neglected and the persistent deterioration results in unsafe environments similar to conditions discovered last year at the VAMC in Kansas City, Missouri. Of course, those that pay the price of this neglect are the veterans who are receiving care at these facilities.

Year after year, needed projects are not funded, because the money is just not there. A 1998 study conducted by Price-Waterhouse recommended that VA fund 2 percent to 4 percent of Plant Replacement Value (PRV) per year and to reinvest in new facilities to replace aging facilities. The conclusion of this analysis was that VA's reinvestment rate of .84 percent was significantly lower than the benchmark of 2 percent. That equates to hundreds of millions of dollars that conceivably could be used for major construction projects. Private consultants have been warning for years that dozens of VA patient buildings were at the highest level of risk for earthquake damage or collapse, yet funding continues to be woefully short of what is actually needed to correct this problem. The President's budget request of $422 million falls well short of funds needed to ensure the safety of the nation's veterans.

The American Legion recommends $320 million for major construction and $240 million for minor construction to make a combined total of $560 million.

GRANTS FOR THE CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

The State Veterans Home Program is an important adjunct to VA's own nursing, hospital and domiciliary programs. The American Legion believes it must continue, and even expand, its role as an extremely vital asset to VA. This program has proven to be a cost-effective provider of quality care to many of the nation's veterans.

As many VA facilities reduce long-term care beds and VA has no plans to construct new nursing homes, state veterans' homes must absorb a greater share of the needs of an aging population. Title 38, United States Code (USC) authorizes VA to pay 65 percent of the total cost of building new veterans' homes.

The American Legion recognizes the growing long-term health care needs of older veterans and would like to reemphasize the essential service that the State Veterans' Home Program provides to these veterans. The program is a viable and important alternative health care provider to the VA system.

The American Legion recommends funding of $115 million for this program.

NATIONAL CEMETERY ADMINISTRATION (NCA)

The National Cemetery Administration (NCA) honors veterans with a final resting-place and lasting memorials that commemorate their service to the nation. More than two million Americans, including veterans of every war and conflict - from the Revolutionary War to the Gulf War - are honored by burial in VA's national cemeteries. Nearly 14,000 acres of land are devoted to this formidable mission.

As a result of the continuing increase in veterans' deaths, NCA is constantly seeking burial space. Total interments for NCA are projected to significantly increase over the next five years, peaking at 107,000 in FY 2008. NCA continues to strive to meet its accessibility goal of 90 percent of all veterans living within 75 miles of open national or state veterans' cemetery.

The Veterans' Millennium Health Care and Benefits Act (P.L. 106-117) required NCA to establish six new National Cemeteries. Fort Sill opened in 2001 under the fast-track program, while the remaining five, Atlanta, Detroit, South Florida, Pittsburgh, and Sacramento are in various stages of completion.

Maintaining cemeteries as national shrines is one of NCA's top priorities. This commitment involves renovating gravesites by raising, realigning and cleaning headstones and markers. The work that has been done so far has been outstanding, however, adequate funding is key to maintaining this very important commitment.

The American Legion recommends $150 million for the National Cemetery Administration in Fiscal Year 2004.

STATE CEMETERY GRANTS PROGRAM

The State Veterans Cemetery Grant Program continues to be a very popular and much needed program administered by VA. This program was designed to assist states in providing gravesites for veterans where NCA is unable to do so. This program is not intended to replace National Cemeteries, but to complement them. Grants for state-owned and operated cemeteries can be used to establish, expand and improve on existing cemeteries.

Under this program cemeteries must conform to the standards and guidelines prescribed by VA with regards to site selection, planning and construction. Like the NCA, these state cemeteries must be operated solely for the burial of service members who die on active duty, veterans, and their eligible spouses and dependent children.

The State Cemeteries accommodated over 15,000 burials in FY 2001. In light of the aging veteran population and with deaths expected to peak at 687,000 in 2006, it is necessary that this program remain viable. Now is the time to ensure that funding is commensurate with the mission of the program.

The American Legion recommends $37 million for the State Cemetery Grants Program in Fiscal Year 2004.

VETERANS BENEFITS ADMINISTRATION

The American Legion is gravely concerned by the proposed straight line staffing request for the Veterans Benefits Administration's (VBA) Compensation and Pension Service and for the Board of Veterans Appeals. There are long-term workload demands associated with the current backlog of pending claims that will extend well into FY 2004. VBA acknowledges there will also be a continued influx of new and reopened claims, based on the enactment of expanded benefit entitlements by the 107th Congress, including the Combat Related Special Compensation Pay Program, an expectation of additional presumptive diseases, and recent precedent decisions of the courts. Despite the fact that the present military build-up has been underway for a number of months, the budget request does not take into account the involvement of thousands of additional active duty personnel. VA must be able to provide these men and women timely, quality service upon their return to civilian life as veterans, in addition to its ongoing responsibility to current veterans.

Despite assertions of improved quality decision making, the number of appeals being filed continues to increase as does the number of appeals requiring further development either by the regional offices or the Board of Veterans Appeals. The American Legion believes these organizations will require additional personnel, if they are to achieve the ambitious service improvement goals promised the nation's veterans and their families in this budget request.

VETERANS BENEFITS ADMINISTRATION LEGISLATIVE INITIATIVES

VBA's net mandatory funding request reflects the enactment of several legislative proposals. These include:

- A two-percent COLA in compensation benefits. The American Legion supports an annual cost-of-living adjustment in disability compensation and DIC benefits.

- Legislation to overturn the decision of U.S. Court of Appeals for the Federal Circuit in *Allen v. Principi*, which held that VA must pay compensation for alcohol or drug-abuse disabilities, if they are secondary to a service-connected disability. The American Legion is opposed to any effort to eliminate or restrict a veteran's right to compensation for any disability or disabilities that are determined to be secondary to or a manifestation of the service connected disability. VA is responsible for administering the law not making moral judgment concerning what is or is not misconduct, as it did with the issue of tobacco-related illnesses. Such legislation would be an effort to punish certain disabled veterans for their service-related problems.

- Legislation to pay the full rate of compensation to certain Filipino veterans and their survivors. The American Legion continues to support this change in the law to recognize the military service performed by these veterans during World War II.

- Legislation to extend the operations of the Manila VA Regional Office for an additional five years. The American Legion favors the VA's continued presence in the Philippines, in order to provide timely service to these veterans and their families.

- Amend the law to extend the time limit for education benefits for members of the National Guard. Because the National Guard is now such an integral part of the armed forces, The American Legion believes this will be a much needed change in the law.

- Amendment of the Montgomery GI Bill to provide for on-the-job training for certain self-employment training programs. This will assist veterans in taking advantage of additional training through self-employment training programs.

- Legislation authorizing the extension of the Education Advisory Committee. This committee provides valuable input to VA officials.

- Terminate the Education Loan Program. If this program were, in fact, not being utilized as it was originally intended, The American Legion would not object to its termination.

- Convert the Homeless Veterans Guaranteed Transitional House Loan Program to grant program. The American Legion has been a strong supporter of the Homeless Veteran Transitional Housing Program. The American Legion would have no objection to making it into a grant rather than a loan guaranty program.

- Elimination of the 45-day rule for Death Pension. The American Legion has sought the elimination of this restriction, since enactment of OBRA 90.

- Authorize entitlement to government grave marker or headstone for a veteran's marked or unmarked grave, effective from November 1, 1990. This will enable the families of thousands of deceased veterans to obtain a government marker or headstone to reflect their honorable service to the nation.

- Authorize the payment of the burial plot allowance to state veterans' cemeteries. The American Legion has long favored this additional support for the State Veterans Cemetery Program.

Under the new budget format, the request for VBA provides for a total of $33.7 billion in mandatory funding for compensation, pension, education, vocational rehabilitation, and other benefit entitlements. Within this total, $26.3 billion will be required for the compensation program, $3.3 billion for the pension program, $1.9 billion for education, and $2.4 billion for the other veterans benefit programs. This represents an overall increase of $9.8 billion, over FY 2003. Compensation benefits will increase by $1.8 billion reflecting the proposed two-percent COLA, additional benefit payments as a result of *Allen v. Principi*, an increase in diabetes cases, and increases in the net caseload and benefit payments.

Discretionary funding for VBA's nine business lines totals $1.2 billion. While it provides for an additional 17 FTE for the Education Program, which is much needed, The American Legion is

deeply disturbed by the lack of any increase in staffing for compensation program. We believe this will constrain VBA's ability to address the many internal and external challenges emerging in FY 2003, which will have profound budgetary and operational implications for the FY 2004 budget.

Given the many and varied issues that VBA is faced with, it is imperative that Congress critically evaluate the level of discretionary funding requested and whether this will enable the regional offices to operate efficiently and provide timely, quality service that this nation's veterans expect and deserve. Individuals currently on active duty must also be assured that VA will not only be ready and willing to assist them, but have physical capacity to provide them the timely, quality service they too expect and deserve, without compromising current operations or benefits programs.

VBA is continuing with the implementation of its long-term strategic plan to hire and train a new cadre of adjudicators under its succession plan, continue the computer modernization program, and institute a variety of procedural and programmatic changes intended to improve the claims adjudication process. However, external forces, such as the enactment of legislation providing new benefits and medical care services, and precedent decisions of the courts continue to play a major role in changing VBA's plans, policies, and operations.

Over the course of FY 2002 and FY 2003, VBA has been able to make substantial progress toward realizing Secretary Principi's goal of a pending case backlog of 250,000 cases with an average processing time of 100 days by the end of September 2003. In March 2002, the regional office backlog peaked with over 423,000 pending cases requiring rating action. Some 40 percent of these cases were over six months old. There were also 147,000 case requiring some other type of action. Only 12 percent were six months or older. In addition, there were approximately 107,000 cases in appellate status. Of these, over 20 percent were cases that had been remanded by the Board of Veterans Appeals for further required development and readjudication. In human terms, there were over 670,000 claimants waiting and waiting for action on their case. Those with remanded appeals would have been waiting two to three years or longer.

According to VA data, by January 2003, the number of cases awaiting rating action had been reduced to 330,300 with only 32 percent older than six months and the number of cases requiring some other type of action was down to 81,500 but over 28 percent were older than six months. However, the number of cases in appellate status had grown to over 122,000. These statistics give a false impression of improvement. The drop in the claims backlog has been achieved largely at the expense of those whose claims were on appeal at the regional offices. VBA's efforts and resources were focused almost exclusively on pending claims, while appeals, including remands, were virtually ignored, since there was no work credit toward the station's production goals. In response to The American Legion's criticism concerning the lack of action on appeals and the hardship this imposed on disabled veterans, regional offices have, within the last several months, begun to address their appellate workload and pending remands, in particular.

The backlog of claims and appeals are, in our view, a symptom of unresolved systemic problems that have for years adversely affected the claims adjudication and appeals process. These

problems include frequent decision-making errors, lack of compliance with the VCAA's notice and development requirements, the absence of personal accountability, ineffective quality control and quality assurance, and inadequate training. The current work measurement system does not provide reliable, accurate data upon which to assess VBA's real resource needs. VBA is faced with a serious dilemma. While endeavoring to address these thorny quality-related issues, the regional offices are, at the same time, aggressively trying to process claims faster. From the results, it appears they still have not found a way to successfully balance these competing priorities. The American Legion remains concerned by the effects of VBA's emphasis on production rather than quality decision making, i.e., ensuring full and complete development with a decision that is fair and proper - the first time. This results in cases continuing to churn through the system, for the sake of an artificial goal.

The straight line staffing level requested for FY 2004 is based on the assumption that, with the realization of the Secretary's backlog reduction goal, VBA would be able to more effectively address the many quality-related problems as well other long-outstanding issues. Given past performance, The American Legion believes this is an unrealistic strategy and will not afford VBA the flexibility to cope with current workload demands, let alone some unanticipated contingency. As an example, a December 2002 decision by the United States Court of Appeals for the Federal Circuit determined that VA had used the wrong effective date for grants of service connection in Agent Orange-related diabetes claims. To date, action has been completed on over 88,000 Agent Orange-related diabetes claims. Some 17,000 are still pending. Data is not available on he number of cases that will have to be reworked, as a result of this decision. Considering the number of cases involved, this additional workload will be substantial and could significantly alter regional office production timelines and resource requirements. Another example of future workload demand will be VA's role in the Combat Related Special Compensation Pay program.

The American Legion believes that an increase in staffing in the compensation and pension programs for FY 2004 is both prudent and necessary. This reflects the increasingly complex nature of the claims and appeals process, the volume of additional work anticipated in FY 2003-2004, and the ongoing need to rebuild the core adjudication staff to replace the increasing number of experienced decision makers who are retiring within the next one to two years.

APPEALS

Staffing at the Board of Veterans Appeals in FY 2004 will decrease by 3 FTE from the FY 2003 level to 184 FTE. The proposed reduction in personnel is predicated on the expected lower volume of incoming new appeals and returning remands. However, given the number of appeals currently in the system and regional offices' continuing quality problems, The American Legion is concerned that the Board's new Development Program will require additional support both from the Board and from the C&P Service.

Beginning in February 2002, the BVA was given the authority to further develop appeal cases rather than remanding them to the regional office. The American Legion understands that 15 FTE were assigned to this unit. By the end of FY 2002, of the 17,231 appeals decided, the Board had remanded 3,328 or 19 percent. This figure is somewhat misleading, since, in addition

to the regular remands, the Board has undertaken development of over 9,000 cases that would have previously required a remand back to the regional office for further needed development and readjudication. Staffing for this unit is 32 FTE. The goal of the program is to ensure greater attention to full due process and quality decision-making, while providing claimants more timely action on the appeal. However, without a substantial improvement in the quality of regional office decisions, the BVA will have to assume more and more of the regional office's development and adjudication workload, which will require additional staffing resources.

The American Legion is concerned that regional office's focus on speed and production versus quality and propriety is directly contributing to the growth of the appellate backlog, which now tops 123,000 appeals. Each of these cases represents a veteran or a veteran's family who, after many months of waiting, is very dissatisfied with the decision they received on their claim for disability or death benefits. They will wait many more months before their case gets before the Board. In 2002, the average appeals resolution time was 731 days. This is projected to improve to 590 days in FY 2003 and to 520 days in FY 2004.

As noted earlier, The American Legion remains concerned by the problems arising from the regional offices' general lack of compliance with the duty to notify and duty to assist provisions of the Veterans Claims Assistance Act of 2001. This legislation was one of the most significant, pro-veteran changes in the VA claims adjudication system in the past decade. However, VBA continues to give only lip service to this law. While claimants receive what is termed a "VCAA" letter, it generally lacks essential information about the claim and what evidence is actually needed to grant the benefit sought in the particular case. Such letters are usually long and confusing, nonspecific, and full of bureaucratic language, which may or may not be accurate or appropriate to the claim. Rather than helping the individual with the development of the claim, these letters frequently generate more questions, phone calls, and correspondence to their representative or the regional office. In the end, the type of VCAA letter currently in use serves to delay rather than to facilitate the claims process. They set the stage for an appeal and, ultimately, additional work for the BVA and frustration and hardship for thousands of veterans and their families.

EDUCATION

The American Legion commends the increased-funding request for educational programs and support staff for the FY 2004 budget. The American Legion deeply appreciates Congress' attempts to provide for a stronger Montgomery GI Bill, (Chapter 30) including an increase in the monthly entitlement rate for active duty members from $900 to $985. However, due to the increased use of Reservists for homeland security and various overseas commitments around the world, there needs to be a significant increase in their monthly entitlement rates that are currently below $300 a month.

The American Legion also acknowledges the proposed increase in benefits to children and spouses of veterans who died of a service-connected disability or whose service-connected total disability is rated permanent, under Chapter 35 of title 38, United States Code. Having a stronger dependent/survivor educational benefit program is necessary to provide the nation with the caliber of individuals needed in today's all volunteer Armed Forces. Without providing

proper incentives, the military of the 21st century will be hard pressed to effectively carry out its mission.

VOCATIONAL REHABILITATION AND EMPLOYMENT

The American Legion is pleased with the funding level requested for the Vocational Rehabilitation and Employment program in FY 2004. The American Legion has always been a strong supporter of the services this program provides eligible service-disabled veterans. The training and education assist disabled veterans in becoming employable and helps them obtain and maintain suitable employment. The American Legion is pleased by the emphasis placed on the new Employment Specialist position as a means of redirecting the program toward the veteran's employment. During this time of economic uncertainty, meaningful employment should never be denied to veterans, especially those with a service-connected disabling condition.

CONCLUSION

Mr. Chairman and Members of the Committee:

The American Legion has outlined many issues in our testimony today. We believe all of these issues are important and we are fully committed to working with each of you to ensure that America's veterans receive the entitlements they have earned. Whether it is improved accessibility to health care, timely adjudication of disability claims, improved educational benefits or employment services, each and every aspect of these programs touches veterans from every generation. Together we can ensure that these programs remain productive, viable options for the men and women who have chosen to answer the nation's call to arms.

Thank you for allowing The American Legion the opportunity to appear before you today.

THE MILITARY COALITION

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STATEMENT
OF
THE MILITARY COALITION

before the

Committee on Veterans' Affairs

February 11, 2003

Presented by

Colonel Robert F. Norton, USA-Ret.
Co-Chairman, Veterans' Committee
The Military Coalition

Biography of Robert F. Norton, COL, USA (Ret.)
Deputy Director, Government Relations, MOAA
Co-Chair, Veterans' Committee, The Military Coalition

A native New Yorker, Bob Norton was born in Brooklyn and raised on Long Island. Following graduation from college in 1966, he enlisted in the U.S. Army as a private, completed officer candidate school, and was commissioned a second lieutenant of infantry in August 1967. He served a tour in South Vietnam (1968-1969) as a civil affairs platoon leader supporting the 196th Infantry Brigade in I Corps. He transferred to the U.S. Army Reserve in 1969 and pursued a teaching career at the secondary school level. He joined the 356th Civil Affairs Brigade (USAR), Bronx, NY and served in various staff positions from 1972-1978.

Colonel Norton volunteered for active duty in 1978 and was among the first group of USAR officers to affiliate with the "active Guard and Reserve" (AGR) program on full-time active duty. He specialized in manpower, personnel, and quality-of-life programs for the Army's reserve forces. Assignments included the Office of the Deputy Chief of Staff for Personnel, Army Staff; advisor to the Asst. Secretary of the Army (Manpower & Reserve Affairs); and personnel policy and plans officer for the Chief, Army Reserve.

Colonel Norton served two tours in the Office of the Secretary of Defense (OSD). He was responsible for implementing the Reserve Montgomery GI Bill as a staff officer in Reserve Affairs, OSD. From 1989 –1994, he was the senior military assistant to the Assistant Secretary of Defense for Reserve Affairs, where he was responsible for advising the Asst. Secretary and coordinating a staff of over 90 military and civilian personnel. During this tour, Reserve Affairs oversaw the call-up of more than 250,000 National Guard and Reserve component troops for the Persian Gulf War. Colonel Norton completed his career as special assistant to the Principal Deputy Asst. Secretary of Defense, Special Operations / Low Intensity Conflict and retired in 1995.

In 1995, Colonel Norton joined Analytic Services, Inc. (ANSER), Arlington, VA as a senior operational planner supporting various clients including United Nations humanitarian organizations and the U.S. Air Force's counterproliferation office. He joined MOAA's national headquarters as Deputy Director of Government Relations in March 1997.

Colonel Norton holds a B.A. in philosophy from Niagara University (1966) and a Master of Science (Education) from Canisius College, Buffalo (1971). He is a graduate of the U.S. Army Command and General Staff College, the U.S. Army War College, and Harvard University's Senior Officials in National Security course at the Kennedy School of Government.

Colonel Norton's military awards include the Legion of Merit, Defense Superior Service Medal, Bronze Star, Vietnam Service Medal, Armed Forces Reserve Medal, Army Staff Identification Badge and Office of the Secretary of Defense Identification Badge.

Colonel Norton is married to the former Colleen Krebs. The Nortons have two grown children and reside in Derwood, Maryland.

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE, on behalf of The Military Coalition, a consortium of nationally prominent uniformed services and veterans' organizations, I am grateful for this opportunity to express the Coalition's views on issues affecting the entire uniformed services community. This testimony provides the collective views of the following military and veterans' organizations, which represent approximately 5.5 million current and former members of the seven uniformed services, plus their families and survivors.

- Air Force Association
- Air Force Sergeants Association
- Air Force Women Officers Associated
- AMVETS (American Veterans)
- Army Aviation Association of America
- Association of Military Surgeons of the United States
- Association of the United States Army
- Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
- Commissioned Officers Association of the U.S. Public Health Service, Inc.
- Enlisted Association of the National Guard of the United States
- Fleet Reserve Association
- Gold Star Wives of America, Inc.
- Jewish War Veterans of the United States of America
- Marine Corps League
- Marine Corps Reserve Officers Association
- Military Chaplains Association of the United States of America
- Military Officers Association of America
- Military Order of the Purple Heart
- National Guard Association of the United States
- National Military Family Association
- National Order of Battlefield Commissions
- Naval Enlisted Reserve Association
- Naval Reserve Association
- Navy League of the United States
- Non Commissioned Officers Association
- Reserve Officers Association
- The Retired Enlisted Association
- The Society of Medical Consultants to the Armed Forces
- United Armed Forces Association
- United States Army Warrant Officers Association
- United States Coast Guard Chief Petty Officers Association
- Veterans of Foreign Wars
- Veterans' Widows International Network

The Military Coalition, Inc., does not receive any grants or contracts from the federal government.

VETERANS HEALTH CARE

Full Funding for Enrolled Veterans. Demand for VA health care far exceeds the capacity to provide timely, quality services to enrolled veterans. Under the VA's open enrollment program (which was suspended in January) approximately seven million veterans have enrolled in VA care and nearly five million veterans sought care in the system in 2002. Last year, some 315,000 veterans were on unacceptably long waiting lists ranging from six-months to one-year for initial or specialty appointments. Although there has been some progress in reducing the wait times, there are many parts of the country where veterans still are forced to wait many months for appointments. The demand - resources gap is having an adverse impact on veterans' health because many simply can't get care when it is needed. The Coalition believes very strongly

that once the VA has agreed to accept a veteran for care there is an absolute obligation of the government to provide high quality care in a timely manner.

TMC strongly supports full funding for all enrolled veterans to ensure timely, high-quality access to VA health care services.

Dual-Eligible Veterans. Veterans who have completed a full career in the armed forces, the Public Health Service or the NOAA Corps have earned lifetime entitlement to health care benefits provided by the Department of Defense in the TRICARE program and eligibility for VA health care services. Dual-eligible veterans constitute about 13% of all enrolled veterans, but they represent 30% of all disabled, Purple Heart, and POW enrollees in Priority Groups 1-3 as shown in the table below.

Military Retired VHA Enrollees

Priority:	**1**	**2**	**3**	**4**	**5**	**6**	**7A**	**7C**	**Total**
Under 65	137,001	96,808	126,883	777	27,835	9,474	8,877	60,715	468,370
Over 65	77,126	43,731	68,816	2,918	40,528	9,128	9,538	81,066	332,851
unknown:	7	13	21	1	1	2	0	5	50
Total	**214,134**	**140,552**	**195,720**	3,696	68,364	18,604	18,415	141,786	**801,271**
% Of **All** Enrollees	36%	34%	24%						12.6%

Military Retired VHA Patients

Priority:	**1**	**2**	**3**	**4**	**5**	**6**	**7A**	**7C**	**Total**
Under	108,986	55,002	57,414	638	14,512	3,315	4,707	19,724	264,298
Over	66,659	31,256	44,430	2,163	24,041	3,620	5,472	28,465	206,106
Unknown:	3	3	1	1	0	0	0	0	8
Total	175,648	86,261	101,845	2,802	38,553	6,935	10,179	48,189	470,412

Source: VHA. Dual-eligible enrollment and user data as of 30 September 2002. The table does not reflect a recent VA decision to transfer about two-thirds of PG 7 veterans to a newly established PG-8 category.

The table also illustrates that a significant number of disabled military retirees (PG 1-3) use VA health care for at least some of their care. For example, 82% of dual-eligibles with disabilities rated at 50% or greater use VA care.

TMC urges the Committee to fully fund specialty care including medical research and needed facilities upgrades for all enrolled veterans who rely on these unique VA services.

No "forced choice". TMC is most appreciative of Congress' action to protect dual-eligible veterans access to all earned health care benefits provided by DoD and VA. As we noted in testimony before the House Armed Services Military Personnel Subcommittee and the House Veterans Affairs Subcommittee on Health hearing last year, the government should not force military retirees to relinquish any earned health care benefit. We are encouraged that the DoD and VA Health Council has developed reimbursement rates to support better coordination-of-care activities between TRICARE and VA health care. Agency-level coordination mechanisms must be designed in ways that foster budget coordination and reconciliation without limiting dual-eligibles' access to earned health care benefits for the convenience of the government.

TMC appreciates Congress' continued support in opposing "forced choice" proposals that would compel dual-eligible veterans to relinquish access to either DoD or VA-sponsored health care services.

DoD – VA Health Systems' Collaboration. Representatives from TMC have actively participated in the Presidential Task Force (PTF) to Improve Health Care Delivery for Our Nation's veterans. The PTF is expected to issue a final

report on its findings and recommendations in the next few months. For servicemembers and veterans, a lasting legacy of the PTF could be the creation of a "seamless, transferable lifetime medical record." A lifetime service medical record could help veterans to obtain early, accurate and fair VA disability ratings, facilitate access to needed specialty care in either system, and enable collaborative medical research between DoD and the VA. Such a project requires considerable investment in information management and technology in both federal departments and the commitment of senior leaders to a strategic vision that places veterans at the heart of DoD – VA collaborative activities.

TMC strongly recommends Congressional support for funding the development of a "seamless, transferable, lifetime medical record" for all servicemembers; strategic planning at the highest levels of DoD and VA; investment in information management / technologies between the two departments; and closer collaboration between the TRICARE and VA 'CARES' planning processes.

VA Medicare Subvention. Over 40% of enrolled veterans are eligible for Medicare. VA Medicare Subvention may enhance some older veterans' access to VA health care and potentially reduce overlapping spending by Medicare and the VA for the same services. TMC is encouraged by the VA's recent announcement to create a Medicare + Choice Plan for certain Medicare-eligible Priority Group 8 veterans. But we offer two cautionary observations. "Medicare + Choice" plans have not been well received in the private sector; and, if VA must meet Medicare access standards for those who agree to participate in the "VA + Choice" HMO, it should also establish Medicare access standards for all enrolled veterans. TMC continues to endorse the concept of authorizing Medicare reimbursement – VA subvention – in VA facilities.

TMC recommends Congress endorse the "VA + Choice" plan and provide the funding for the entire VA system to meet Medicare access standards for all enrolled veterans. TMC continues to support Medicare reimbursement for non-service connected care for all enrolled Medicare-eligible veterans.

VETERANS BENEFITS

Disability Claims Backlog and Process Improvement. By late 2002, backlogged VA claims had dropped from 600k to 463k, including 97k claims on appeal. VA's goal is a steady state of 250k claims pending. However, despite commendable improvements in the "numbers", the reality is that the system has significant challenges in ensuring consistent, fair, and high-quality claims' ratings across the system. The key to long-term progress is the hiring, professional training, and support of a high-quality workforce of claims workers supported by investment in information management and technology. ***TMC strongly recommends adequately funding the Veterans' Benefits Administration to meet its manpower, training, and IM / IT requirements and to sustain recent improvements in reducing the claims backlog.***

Concurrent Receipt of Military Retired Pay and VA Disability Compensation. The Coalition was disappointed that agreement could not be reached last year to provide unconditional concurrent receipt to disabled military retired veterans, but appreciates the "first ever" provisions that were provided to eliminate the disability offset for certain retirees with combat- or operations-related disabilities. Congress' action to establish a "beachhead" in law is very significant in recognizing that military retired pay and veterans disability compensation are paid for different purposes, and one should not offset the other.

The Coalition has long held that retired pay is earned compensation for completing a career of arduous uniformed service, while veterans disability compensation is paid for loss of function and future earning potential caused by a service-connected disability.

Previous attempts to fix this inequity have all been met with the same response-the cost is too large. But the cost to men and women in uniform who have been injured while serving this Nation is far greater, as the government now deducts every dollar of this cost from disabled retired veterans' paychecks – imposing a heavy financial penalty on top of their service-connected health loss. The new special compensation authority will help several thousand in a very select group injured by combat, or related operations. But there are many, many more thousands of deserving disabled retirees who have been left behind.

The Coalition is particularly concerned that, during last-minute final negotiations on the FY 2003 Defense Authorization Act, changes in eligibility language inadvertently omitted three classes of disabled retirees who otherwise fall within the criteria enacted into law.

First, technical language effectively excluded virtually all National Guard and Reserve retirees with 20 years of creditable service and combat-related disabilities. There are many retired reservists who were awarded Purple Hearts and have combat-related disabilities. Their Guard and Reserve status did not protect them from being wounded on the battlefield, and they should not be discriminated against by this legislation.

Second, there are a very limited number of retirees who received nondisability retirements with 15 to 19 years of service during the drawdown of the early 1990s and who also have otherwise-qualifying combat-related disabilities. These members earned their military retirement independently of their disability and should be eligible to receive the special compensation if their disabilities would otherwise qualify.

Finally, enlisted retirees who were awarded one of the top two decorations for valor are authorized an extra 10 percent in retired pay (within the maximum limit of 75 percent of basic pay). The Coalition believes strongly that the modest extra retired pay awarded these members for their combat heroism should not be subject to the disability offset.

The Coalition is aware of concerns expressed by some that enactment of concurrent receipt legislation could lead to additional applications for initial award of disability ratings or increases in existing ratings. But we cannot accept any contention that government workload concerns should be used as an excuse to resist treating disabled retirees fairly.

The Coalition was particularly distressed by a proposal in the FY2003 VA-HUD Appropriations Bill reported by the House Appropriations Committee last year that was generated by just such a concern. The proposal would have barred the VA from processing any new disability applications by disabled retired veterans eligible for payments under any new concurrent receipt legislation Congress might pass. The Coalition was stunned that some in the same Congress that authorized a payment to a retiree with a service-connected disability would seek to simultaneously bar any newly disabled retirees from applying for it.

The Coalition hopes the Committee shares this concern and will ensure that the Department of Veterans Affairs is adequately funded to address the issue of timely claims processing.

The Military Coalition urges the Committee to support ultimate elimination of the disability offset for all disabled retirees, expansion of

eligibility for the new special compensation, and funding as necessary to ensure timely processing of any expected increase in disabled veterans' claims for this or other reasons.

Education Benefits for Career Servicemembers. Active duty career servicemembers who entered service during the VEAP-era (1 January 1977 - 30 June 1985) but who declined to take VEAP are the only group of currently serving members who have not been offered an opportunity to enroll in the Montgomery GI Bill (MGIB). There are about 110,000 servicemembers in this situation. Many actually were discouraged by service officials from signing up for VEAP, as it was acknowledged to be a grossly inadequate program compared to the Vietnam-era GI Bill and the subsequent MGIB, which started on 1 July 1985. As the backbone of today's force, these members – now with 17 to 25 years of service -- are critical to the success of ongoing and pending military operations. Before they complete their careers, they should be afforded at least one opportunity to say "yes" or "no" to veterans' education benefits under the MGIB.

TMC recommends Congress support an increase to MGIB program funds and endorse a sign-up window for career servicemembers who declined VEAP when they entered service.

Benchmarking MGIB Benefits. TMC is one of the original founding group of organizations within *The Partnership for Veterans Education*. Altogether, there are 52 military, veterans, and higher education organizations in the Partnership, which collectively represent more than 11 million members. The Partnership strongly advocates the establishment of a benchmark for MGIB benefits so that they keep pace with the average cost of a four-year public college education. The "Veterans Education and Benefits Expansion Act of 2001" (P.L. 107-103) signaled Congress' commitment to restoring the educational buying power of the MGIB. The final increase authorized in the law goes into effect on 1 October this year, raising basic MGIB rates for full-time study to $985 per month, a $313 per month increase, or 46%, over the past three years.

But even with the 1 October increase, MGIB benefits will account for only about 67% of the average cost of a four-year public college or university for academic year 2003-2004. Next year, a veteran can expect to pay on average about $1470 per month for full-time study at a four-year public college or university but receive just $985 in MGIB benefits. Since many veterans are married when they separate, it is increasingly difficult for them to achieve their educational and training goals with benefits that do not keep pace with the rising cost of education.

TMC supports the Partnership's goal of tying future benefit increases to a recognized government index the cost of higher education.

National Guard and Reserve Montgomery GI Bill Benefits. Tens of thousands of Guard and Reserve servicemembers have been mobilized over the past year and a half to support the war on terror at home and abroad. When these citizen-soldiers are demobilized they become eligible for veterans benefits. However, reserve MGIB benefits – authorized under Chapter 1606 of 10 USC -- have not kept pace proportionately with Chapter 30 (Title 38) benefits. Only two benefit increases have been legislated in the reserve program since its inception in 1985 (other than cost-of-living increases). In 1985, reserve MGIB rates were set at 47% of active duty MGIB rates. On 1 October this year, the reserve MGIB benefit will fall to about 27% of the Chapter 30 rate, $276 compared to $985 per month for full-time study. To synchronize this program with the Chapter 30 program, TMC supports transferring the Chapter 1606, Title 10 reserve MGIB program to Title 38 so that future increases in basic benefits can be reflected proportionately in the reserve program.

TMC recommends Congress support rate increases and funds for the reserve MGIB program so that National Guard and Reserve servicemembers can see an educational return on their voluntary service to country.

Retention of Dependency and Indemnity Compensation (DIC) if remarried after age 55. In U.S. government agencies, all survivor benefits are retained if a beneficiary remarries after a certain age. The only exception is the military DIC widow or widower. Many widows refrain from remarrying because they cannot afford to lose their DIC.

TMC urges Congress to provide funds to permit a DIC widow(er) who marries after the age of 55 to retain DIC status and benefits.

Conclusion

The Military Coalition greatly appreciates the opportunity to present our views on funding priorities for the administration's budget submission for the Department of Veterans Affairs. We look forward to working with the Committee leadership and members to ensure full funding for veterans health care and benefits programs.

STATEMENT

BY

CMSGT (RET.) JAMES D. STATON
EXECUTIVE DIRECTOR
AIR FORCE SERGEANTS ASSOCIATION

FOR THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

VETERANS ADMINISTRATION BUDGET FOR FISCAL YEAR 2004

FEBRUARY 11, 2003

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CURRICULUM VITAE

CMSgt (Ret.) James D. Staton is Executive Director (CEO) of the Air Force Sergeants Association. In his position, he manages the daily operations of AFSA International Headquarters near Washington, D.C., on behalf of more than 136,000 Air Force, Air National Guard, and Air Force Reserve enlisted personnel, active duty and retired, and their families, who are AFSA and AFSA Auxiliary members. He is also the Chief Executive Officer and Chairman of the Board for the Airmen Memorial Foundation and the Airmen Memorial Museum. He served 27 years in the United States Air Force before his military retirement in 1982. He has served at AFSA's Executive Director since October 1983.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Air Force Sergeants Association (AFSA) does not currently receive, nor has the association ever received, any federal money for grants or contracts. All of the association's activities and services are accomplished completely free of any federal funding.

Mr. Chairman and distinguished committee members, on behalf of the 136,000 members of the Air Force Sergeants Association (AFSA) and the enlisted men and women serving this nation, I welcome this opportunity to comment on the Administration's FY 2004 budget plan as it pertains to the Department of Veterans' Affairs (VA). This committee has always served in a singularly nonpartisan way to act as the conscience of this nation to ensure our veterans are viewed as a vital national resource rather than a financial burden. AFSA has always maintained, as has this committee, that the primary determinant for our decisions in regard to our veterans should not be on the bottom line, but what is right. *In recent years, your diligence and willingness to speak for the veterans has become even more important as the executive branch has increasingly focused on elimination of full-service veterans facilities, increased co-payments for service, and exclusion (by fiat or by adding onerous surcharges) of certain categories of veterans from service in veterans facilities.* It has become increasingly apparent that the executive branch's focus is not on increased funding as the veteran's pool increases, but rather on exclusion of some veterans because there have just become "too many of them." Once again we applaud this committee for working to fully honor those who we call upon (in increasing instances) to serve under unlimited liability–at the risk of their lives--to ensure the freedoms we enjoy. AFSA agrees with Chairman Chris Smith's assessment of the VA's FY2004 Budget plan as presented:

> "Although the budget contains a significant increase in health care appropriations, unfortunately, it also relies on unrealistic management efficiencies, steep new charges on veterans, the closure of thousands of VA-operated nursing home beds, and the disenrollment of more than a million veterans from the VA health care system to balance the books. . . .This budget proposal exposes systemic flaws in the current system of funding for veterans health that must be addressed with comprehensive, long-term solutions."

In this statement, AFSA asserts that we owe our veterans: (1) a solid educational program; (2) comprehensive short- and long-term health care to deal with any physical conditions that resulted from military service; (3) other programs such as home loans and employment support to enhance their post-military lives; (4) programs for their survivors; (5) full coverage for retired military veterans because they sacrificed a good portion of their lives at unlimited liability; and (6) full inclusion of the veterans of the Guard and Reserve into VA benefit programs.

Yours is not an easy job in deliberating how best to honor those who serve and, at the same time, protect the people's money. But we must always keep in mind that *veterans' programs speak about a nation's willingness to honor those who become our "shields" in maintaining liberty, and these programs also send a powerful message to those considering a military career.* This statement will be divided into three sections: education programs, health care, and "general issues."

EDUCATION PROGRAMS

An examination of the VA FY 2004 budget plan once again shows that any improvement in this area will need to come from Congress. In recent years, this committee singularly (with no initiated support from the Executive Branch) has done a masterful job of increasing the value of the Montgomery G.I. Bill (MGIB). As a member of the Partnership for Veterans' Education, we continue to ask that you transform the program to something similar to the post-WW II G.I. Bill. We ask that you *work toward funding a program that pays for books, tuition, and fees, and that the benefit be annually indexed to reflect the actual costs of education.* When our young men and women opt for military service, they should know that this "company" will provide them with a complete education, as do numerous companies in the private industry. Also we ask that you *work to overcome the exclusion of many servicemembers from these VA education programs.*

- *PROVIDE VETERANS WITH A FULL EDUCATION.* Despite the extremely commendable, recent increases in the MGIB which will bring the value up to $985 per month for 36 months by October 1 of this year, more needs to be done. If this nation is going to have a program that sincerely intends to satisfy the purpose of the program, it certainly should mirror civilian industry by providing a comprehensive educational program and not an insufficient one. According to the "College Report," an annual evaluative report published by the education "industry," average monthly educational costs are approximately $1,400 at this time. This figure reflects the cost of books, tuition, and fees at the average college or university for a commuter student. Of course, that average cost will increase in the future due to inflation. We ask that you fully fund the already-authorized increase, but look toward further increases in the program. Payment for full books, tuition, and fees for a four-year degree with annual indexing to maintain the value of the benefit, *at least, ought to be provided for those who make the military a career,*

- FUND AN ENROLLMENT WINDOW FOR MILITARY MEMBERS NOT CURRENTLY ENROLLED IN THE MGIB. There are well over 100,000 military members still serving who declined the opportunity to enroll in Veterans Educational Assistance Proram (VEAP)–the predecessor program to the Montgomery G.I. Bill (MGIB). VEAP was a relatively poor, two-for-one matching program, that was poorly advertized, incorrectly counseled, and which was actually discouraged because "something better" was coming along. Unfortunately, those who turned down VEAP were not allowed to convert to the MGIB. If this committee desires, we can provide ample "real life" examples of people who were so excluded with their reasons for declining VEAP enrollment. In the Air Force alone, over 35,000 currently serving members (DoD statistics) turned down VEAP enrollment and are now approaching retirement with no transitional educational program. Since the end of the VEAP program, tens of thousands more have declined enrollment in the MGIB–most did so because they are given a one-time, irrevocable enrollment opportunity at basic military training when they simply cannot afford to give up $100 per month for the first 12 months of their career. In fact, in the Air Force alone, there are now over 50,000 on duty who came in during the MGIB era who turned the MGIB down. Hundreds communicate with us that they want a second chance to get into the MGIB, now that they can afford to do so. As I said earlier, thanks to the fine work of this committee, the MGIB value has been increased each year for the past few years. Although more work needs to be done, the benefit is now a very "lucrative" benefit–a far cry from that which most VEAP and MGIB non-enrollees turned down. For that reason alone, fairness would dictate an enrollment opportunity for any military member not currently enrolled in the MGIB.

- *ELIMINATE THE $1,200 MGIB ENROLLMENT FEE.* This fee alone often causes young servicemembers to decline enrollment. They are given a one-time, irrevocable decision when they are making the least pay--under the pressure of initial training. Those who decline enrollment–many due to financial necessity–do not have a second chance to enroll in the program. This is one of the biggest complaints we get from many young airmen. They feel that, in a sense, it is a "dirty trick" to offer such an important program when it is clearly a financial burden to enroll in the program. This sends a very poor message to those who enter service expecting a world-class educational benefit. *We ask that you exercise your oversight role and eliminate the $1,200 enrollment fee. This alone will eliminate the non-enrollment problem. At the same time, it will reintroduce some honesty into the recruitment promises made concerning educational benefits.* Additionally, we have been told that a good case could be made to show that eliminating the fee will not be "pricey" since the administration of the fee costs nearly as much as the fee itself.

VETERANS' HEALTH CARE

While the $25.4 billion the Administration is requesting for VA health care in a positive

sign, the "baggage" that comes with it is certainly disturbing. *This budget plan once again reinforces the perception in the force that the Administration is going to deal with its funding challenges by the exclusion of more and more veterans from the system.* For example, the creation of a Priority Group 8 and the notion of charging a $250 enrollment fee is clearly designed to push people who served and put their lives on the line from this healthcare system. This is a "lite" version of the Administration's attempt (last year) to charge Priority Group 7 veterans a $1,500 deductible charge. Also, the VA plan to raise the pharmaceutical co-payments by more than 100 percent for some veterans is a further move to exclude some veterans by overpricing them. Last year, over 300,000 veterans seeking first or specialized medical care had to wait from 6 months to a year for an appointment. While the Administration claims that its "suppression of demand" will help to decrease these inexcusable waits for health care, the answer is not exclusion, but reasonable, realistic funding. Similarly, closing health care facilities and eliminating hundreds of veterans options for care is a poor way to manage the system. *Such moves communicate that the Administration is motivated by shrinking the system to manage the budget, rather than budgeting for the mission the VA is intended to provide.* The answer is to budget for the $2 billion shortfall in funding that this budget plan avoids. Other specific health-related situations that need to be addressed:

- *RESIST FORCED CHOICE AND PROHIBITIVE USER FEE APPROACHES OF THE ADMINISTRATION.* We applaud Congress' prohibition in the FY 2002 NDAA against a forced DoD-VA health care choice. Also, we are grateful that this committee stood fast in support of veterans by denying the Administration FY 2003 plan to charge a $1,500 annual deductible for care provided in VA facilities for Category 7 veterans. Once again, we ask you to prevent the $250 fee and pharmaceutical co-payment increases in the VA's FY 2004 plan. *It is apparent that, as this committee prevents each Administration plan to exclude or shift the burden to the veterans, an alternate approach is being formulated to be introduced as a countermove to your efforts.*

- *PROVIDE FUNDING FOR A FULL CONTINUUM OF CARE.* We ask you to provide funding for full access to VA health care for all veterans. All honorably discharged veterans must have the full continuum of care mandated by law. In the minds of many, the VA health care system is there to serve only paupers. This image and the underlying reality must be upgraded. AFSA believes there should be a full national commitment toward expanded health care opportunities for veterans. *This is one budget where this nation must be prepared to fund for full health care for the defenders of its freedoms.*

- *SUPPORT VA MEDICARE SUBVENTION.* AFSA offers full support for VA-Medicare subvention and applauds recent announcements that this approach will soon come to fruition. The VA has the infrastructure to handle this, so we anticipate the effort will be successful. Under this plan, Medicare would reimburse the VA for care it provides to non-disabled Medicare-eligible veterans at VA medical facilities. Just as in the case of DoD Medicare subvention, this is an opportunity to ensure that those who served are not lumped in with all those who never chose to do so. Because Medicare would reimburse the VA system, cost to the government would be minimal.

- *SUPPORT JUDICIOUS VA-DOD SHARING ARRANGEMENTS.* The enlisted force is pleased with judicious use of VA-DoD sharing arrangements involving network inclusion in the DoD health care program, and especially, the practice of consolidating physicals at the time of separation. This decision represents a good, common sense approach that should eliminate problems of inconsistency, save time, and take care of our veterans in a more timely manner. In that sense, these initiatives may actually save funding dollars. Our only caveat–albeit a crucial one--would be that DoD beneficiary participation in VA facilities must never endanger the scope or availability of care for our traditional VA patients, nor should any VA-DoD sharing arrangement jeopardize access and/or treatment of DoD health

services beneficiaries.

- *LONG-TERM CARE.* The VA must fully fund for long-term care, including nursing home care; care for chronically mentally ill veterans; and home care aid, support and services. While recent legislation took us a great deal closer to this end, it will only come about if adequate, earmarked, consistent funding is identified.

- *CARE FOR WOMEN VETERANS.* Another dimension of this nation's veterans' demographics that has significantly increased in recent years is the number of women who serve. The VA must be funded to provide the resources and legal authority to care for women to include obstetric services and after-birth care for the mother and child. AFSA applauds this committee's recent progress in this area and pledges to support further funding for this important, increasingly larger, group of veterans.

GENERAL ISSUES

- *SUPPORT EFFORTS TOWARD SPEEDIER PROCESSING.* Both this committee's chairman and the ranking member have often cited the inexcusably large number of rating cases awaiting a decision, many for six months to a year–and longer. The VA claims that by late 2002 the backlog of overdue claims had been reduced by 23 percent. We applaud Secretary Principi's pledge to further correct this problem and the progress that has been made to date during his tenure. We urge further efforts to provide full funding to, as Secretary Principi enunciated, "reduce claims processing time without sacrificing decision-making quality or VA's statutory duty to assist veterans develop their claims." *Such funding should include full manpower, training, and information management and technology requirements to further reduce and establish an acceptable claims adjudication situation.* We urge this committee to do all possible to push the VA to continue this progress and to fund initiatives that will make the system more efficient and user-friendly.

- *LEGITIMATE, SINCERE VETERANS PREFERENCE.* While over the last few years this committee has made progress toward making "Veterans' Preference" a reality. We urge this committees to continue to fund any improvement that will put "teeth" into such programs to give those who have served a "leg up" when transitioning back into the civilian workforce.

- *ELIMINATE HOME LOAN FEES.* The best way to attract new veterans to use this valuable benefit is to *eliminate fees and make the program as attractive a possible.* However, if other home loan programs are made available, liberal qualification criteria and the "no down payment" feature should be maintained for all sources.

- *INCLUDE THE GUARD AND RESERVE IN ALL VA PROGRAMS.* Those who serve in the Guard and Reserve deserve full, year-round benefits. The concept of "weekend warriors" is certainly an unfair, inaccurate misnomer. In fact, this nation's current war against terrorism, other worldwide commitments, protection of our homeland, and other impending military action simply could not succeed without the participation of the Guard and Reserve. Our nation owes them a great deal, the least of which is provision of a full benefits package for their service. To start, as an example, the Selected Reserve Home Loan Program should be permanently extended; continuing to revisit this issue and approve it for limited time periods sends a very poor signal to these patriots. Also, and more important, *AFSA urges this committee to call for an immediate study to result in full inclusion of the Guard and Reserve into the full range of VA benefits and programs.*

- *FULLY FUND PROGRAMS IN SUPPORT OF SURVIVORS.* Programs such as Dependency and Indemnity Compensation (DIC), pensions, and burial rights for the survivors of veterans is in keeping with highest traditions of the motto of the Veterans Administration. We ask you to fully support funding of programs for these family members

who also valiantly served. *As a start, we ask that you support that survivors who remarry after age 55 be entitled to continue receiving DIC, and to retain their burial entitlement.*

- *PROVIDE A WRITTEN GUARANTEE.* Many veterans are frustrated and disappointed because promises that were made during their careers are simply not being kept. *Due to an assault on many veterans programs, we are often told by veterans that they feel that the covenant between the nation and the veteran was one-sided, with the veteran always honoring his obligation, and hoping that the government does not renege on its.* We urge this committee to support a guarantee in writing of benefits to which veterans are legally entitled by virtue of their service. To refuse to do so is to say that this nation is not prepared to be honest with its servicemembers.

Mr. Chairman, in conclusion, I thank you and the members of this committee for this opportunity to comment on the Administration's FY 2004 Budget Plan and to present the views of the Air Force enlisted community. AFSA believes that the work of this committee is among the most important done on the Hill. *Your job is not only to protect and reward those who served; it is to demonstrate to those currently serving and who someday will serve that this nation is committed to honor those who give a portion of their lives to their nation.* After all, the nation's peace and current prosperity is in no small measure due to their noble efforts. On behalf of all AFSA members, we appreciate your efforts and, as always, are ready to support you in matters of mutual concern.

(end)

FOVA

Friends of VA Medical Care and Health Research

A coalition of national organizations committed to quality care for America's veterans

Statement for the Record
of the
Committee on Veterans Affairs
Hearing on the
FY 2004 Budget of the Department of Veterans Affairs
Submitted by
Friends of VA Medical Care and Health Research
February 11, 2003

The Friends of VA Medical Care and Health Research (FOVA), a coalition of 68 medical research, specialty, physician, academic, patient advocacy and industry organizations committed to quality care for veterans, is pleased to provide recommendations regarding FY 2004 funding for the Department of Veterans Affairs (VA) medical and prosthetics research program. **FOVA strongly encourages the Committee on Veterans Affairs to support an FY 2004 appropriation of at least $460 million for the direct costs of the VA research program and $45 million for research facility improvements.**

FOVA's FY 2004 recommendations build on the increase provided for the current year. FOVA thanks the members of the Committee for their leadership in ensuring a positive final outcome of $400 million for FY 2003.

We applaud the Bush Administration and Department of Veterans Affairs Secretary Anthony J. Principi for recognizing the invaluable contribution VA research makes to delivering high quality care for veterans and toward improving the health of veterans and the nation. However, the proposed $14 million (3.5%) increase in the direct costs of the program is inadequate to sustain the current level of effort or to accommodate new initiatives. FOVA's recommended funding level of $460 million allows overall growth of $60 million (15%) over FY 2003. Justification for an increase of this size is provided by the need to accommodate biomedical research inflation and federal pay increases as well as a major new initiative in deployment health research and expansion in areas such as terrorism, emerging pathogens, special populations, quality improvement, chronic diseases and diseases of the brain.

Three core needs justify the FOVA recommendation of $460 million:

1. **Investments in investigator-initiated research projects** at the VA have led to an explosion of knowledge that promises to advance knowledge of disease and unlock new strategies for prevention, treatment and cures. Attachment 1 is a list of just a few of VA's recent research achievements. However, many health challenges still confront the veteran community. Additional funding is needed to take advantage of the burgeoning scientific opportunities and to improve quality of life for our nation's veterans as well as the general public. FOVA urges the Committee to support additional funding for the following research priority areas identified by the VA for FY 2004

Terrorism:	Develop new immunization mechanisms for protection against parasites and pathogenic bacteria. Additionally, studies would investigate means to develop immunity to air-borne pathogens.
Deployment Health:	Study the potential long-term effects of exposures and risk factors among veterans of hazardous deployments, such as the Gulf War, Bosnia/Kosovo, and Afghanistan. This initiative recognizes five major research categories, including improvements in treatment of deployment-related illnesses and health risk communication for veterans and health care providers.
Emerging Pathogens:	Identify new natural agents that cause human disease (West Nile virus and hantavirus are recent examples) and elucidate the mechanisms of disease and possible treatments.
Special Populations:	Expand research to understand and address racial and ethnic disparities in health care as well as quality of care and health outcomes for female veterans.
Quality Improvement:	Fund the Quality Enhancement Research Initiative (QUERI) program and other efforts to support work to ensure appropriate, high-quality care for veterans with prostate cancer and dementias.
Chronic Diseases:	Continue, in part through its Research Enhancement Awards Programs (REAPs), work in understanding the prevalence as well as cost and outcomes of treatment for pulmonary, kidney, and heart diseases, diabetes, hepatitis C, and stroke.
Diseases of the Brain:	Study rehabilitation of stroke victims and increase support for researchers working on Alzheimer's disease and other dementias and Parkinson's disease.

2. The complexity of research combined with biomedical research inflation has increased the costs of research. The average cost of each VA research project is now $150,000, a 9% increase in just two years. As a result, **VA requires an increase of at least $15 million just to maintain a stable number of programs**.

3. **VA's career development programs** are a national resource for training the next generation of clinician scientists, those doctors who treat patients and address questions that have a direct impact on patient care. Additional funding is needed to address the growing national shortage of clinician-investigators.

Separate from its recommendations for the VA research appropriation, FOVA strongly encourages the Committee to address the increasingly urgent need for improvements in VA's research facilities by recommending a specific allocation of $45 million for these needs. FOVA applauds House appropriators for designating $25 million of the FY 2003 minor construction appropriation for research facility improvements. However, this funding was eliminated in the Omnibus bill deliberations.

During a hearing in April 2004, FOVA and the Association of American Medical Colleges made a compelling case for urgently needed upgrades to improve both patient and staff safety, and to accommodate state-of-the-art research.

Examples of urgently needed upgrades to ensure safety include the following:

- When an animal facility is too small, investigators bring the animals into their regular laboratories, exposing themselves and staff to occupational illnesses. OSHA inspectors have expressed concerns and in one case, said that if it were up to OSHA, the building would be shut down.
- During an annual inspection in Iowa City, a Fire Marshall recommended that research laboratories no longer be housed in one building because the building lacks fire sensors and a sprinkler system.
- Back up generators are needed to ensure safe temperatures in animal facilities on hot days in Milwaukee, Wisconsin.
- During a hazardous materials drill, the Philadelphia, Pennsylvania, fire department spread banana oil to mimic a toxic spill. Within 15 minutes, oil applied on the 4th floor of the research building was identified on the 2nd and 4th floors of the adjoining patient care facility.

Examples of improvements needed to accommodate research include:

- A researcher in Seattle, Washington, received for a grant that requires storing tissue samples in sub-zero freezers. Space was allocated, but the facility was unable to provide $30,000 to upgrade the electrical system to support the freezers.
- VA researchers in Gainesville, Florida are unable to conduct certain types of research because their "wet lab" countertops are made of particle board and Formica, rather than the standard stone, and are easily burned and stained from exposure to heat and chemicals.
- At the Southern Arizona VA Health Care System in Tucson, they spend precious resources outsourcing kennels for dogs because no funding is available to bring the existing VA kennels into line with AAALAC or FDA standards.

Substandard facilities make VA a less attractive partner in research collaborations with affiliated universities; reduce VA's ability to leverage the R&D appropriation with other federal and private sector funding; and make it difficult to attract cutting edge researchers, both clinician investigators and laboratory scientists, to pursue careers in VA. Facility R&D Committees regularly disapprove projects for funding consideration because the facility does not have the necessary infrastructure and has little prospect of acquiring it.

Under the current system, research must compete with other medical facility and clinical needs for basic infrastructure and physical plant support. Unfortunately, the minor construction appropriation is chronically inadequate to meet facility needs for clinical improvements much less research upgrades, and year after year the list of urgently needed research repairs and upgrades grows longer. VA has identified 18 sites in urgent need of minor construction funding to upgrade their research facilities. These sites, plus the many facilities with smaller, but no less important needs, provide more than sufficient justification for an appropriation of $45 million specifically for research facility improvements.

FOVA thanks the Committee for consideration of its views. For questions or additional information, please contact any member of the FOVA executive committee listed on this letterhead. Thank you for your consideration.

Organizations that have endorsed FOVA's FY 2004 recommendations (as of February 18, 2003):

Administrators of Internal Medicine
Alliance for Aging Research
Alzheimer's Association
American Academy of Child and Adolescent Psychiatry
American Academy of Neurology

American Academy of Orthopaedic Surgeons
American Association of Anatomists
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Neurological Surgeons
American College of Chest Physicians
American College of Clinical Pharmacology
American College of Physicians-American Society of Internal Medicine
American College of Rheumatology
American Dental Education Association
American Federation for Medical Research
American Gastroenterological Association
American Geriatrics Society
American Heart Association
American Hospital Association
American Lung Association
American Military Retirees Association
American Optometric Association
American Osteopathic Association
American Physiological Society
American Psychiatric Association
American Psychological Association
American Society for Bone and Mineral Research
American Society for Investigative Pathology
American Society for Pharmacology and Experimental Therapeutics
American Society of Hematology
American Society of Nephrology
American Thoracic Society
American Urological Association
Association for Assessment and Accreditation of Laboratory Animal Care International
Association for Research in Vision and Ophthalmology
Association of Academic Health Centers
Association of American Medical Colleges
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Schools and Colleges of Optometry
Association of Subspecialty Professors
Association of VA Chiefs of Medicine
Blinded Veterans Association
Clerkship Directors in Internal Medicine
Coalition for American Trauma Care
Congress of Neurological Surgeons
Gerontological Society of America
Independence Technology
Juvenile Diabetes Research Foundation International
Legion of Valor of the USA, Inc.
Medicine-Pediatrics Program Directors Association
National Alliance for the Mentally Ill
National Association for Uniformed Services
National Association of VA Dermatologists
National Association of Veterans' Research and Education Foundations

National Mental Health Association
National Multiple Sclerosis Society
National Organization of Rare Disorders
Nurses Organization of Veterans Affairs
Osteogenesis Imperfecta Foundation
Paralyzed Veterans of America
Partnership Foundation for Optometric Education
Society for Investigative Dermatology
Society for Neuroscience
Society of General Internal Medicine
Spinal Cord Research Foundation
Veterans Affairs Physician Assistant Association

Attachment 1

VA Research – Recent Achievements and Initiatives
October 1, 2002

Populations of infectious bacteria change constantly in the lungs of patients with **chronic obstructive pulmonary disease** (COPD). This study ends decades of controversy and may explain why healthy immune systems cannot prevent these recurring infections.
August 2002 – The New England Journal of Medicine – Buffalo VAMC

Patients undergoing mock surgery **for osteoarthritis of the knee** are just as likely to report pain relief as those undergoing actual surgery. These findings challenge the usefulness of such surgery, which costs Americans over $3 billion every year.
July 2002 –T he New England Journal of Medicine – Houston VAMC

A new blood test that can be administered in the emergency room **diagnoses heart failure** in 15 minutes. Conventional tests often require an overnight hospital stay to detect the hormones that show a heart attack occurred.
July 2002 – The New England Journal of Medicine – VA San Diego Health Care System

High-quality, non-prescription footwear is often adequate for typical **diabetic patients**. Footulcer rates among subjects wearing such shoes are the same as those wearing costly specialized footwear.
May 2002 -- Journal of the American Medical Association – Seattle VAMC

Gastric bypass surgery seems to help suppress the production of ghrelin, a recently discovered "hunger hormone." Patients undergoing the surgery to combat **obesity** had dramatically lower levels of ghrelin compared to those trying to lose weight by dieting alone.
May 2002 -- The New England Journal of Medicine – Seattle VAMC

Surgical repair of **abdominal aortic aneurysms** less than 5.5 centimeters wide does not improve survival rates. The common hazards of surgery may present greater risks than the aneurysms themselves. *May 2002 -- The New England Journal of Medicine* – Minneapolis VAMC

A specific molecule plays a key role in reducing **inflammation** of injured tissue. The discovery may lead to new treatments for slow-healing wounds and persistent inflammation. *April 2002 – Science* - VA Connecticut Health Care System

An oral **smallpox** drug found effective in lab tissue cultures and mice is now being studied for human application. The drug stops the virus' ability to replicate, and may prove effective in treating those already infected.*March 2002 – International Conference on Antiviral Research – VA San Diego Health Care System*

Epoetin, a **kidney** medication that stimulates the production of red blood cells, is safe and effective at reduced doses when administered by an injection rather than the standard intravenous method. This discovery could save the nation's Medicare system up to $142 million each year. *February 2002 – American Journal of Medicine* – Hines VAMC

Heart attack patients at VA hospitals are more likely than patients at private hospitals to get medications such as clot-busting drugs and aspirin. Nearly 71 percent of patients at VA hospitals had received such medications on discharge compared to 58 percent at private hospitals.
December 2001 -- Circulation - Houston VAMC

United States General Accounting Office

GAO

Testimony
Before the House Committee on Veterans' Affairs

For Release on Delivery
Expected at 10:00 a.m. EST
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VETERANS BENEFITS ADMINISTRATION

Better Staff Attrition Data and Analysis Needed

Statement for the Record by Cynthia A. Bascetta, Director
Education, Workforce and Income Security Issues

GAO-03-452T

GAO
Accountability·Integrity·Reliability

Highlights

Highlights of GAO-03-452T, a statement for the record to the Committee on Veterans' Affairs, House of Representatives.

February 2003

VETERANS BENEFITS ADMINISTRATION

Better Staff Attrition Data and Analysis Needed

Why GAO Did This Study

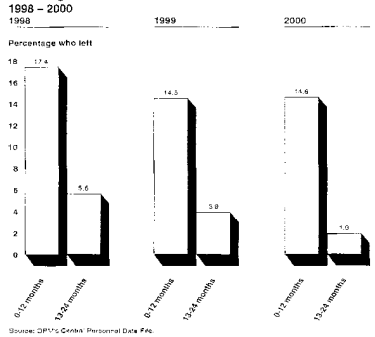
By the year 2006, the Veterans Benefits Administration (VBA) projects it will lose a significant portion of its mission-critical workforce to retirement. Since fiscal year 1998, VBA has hired over 2000 new employees to begin to fill this expected gap. GAO was asked to review, with particular attention for new employees, (1) the attrition rate at VBA and the soundness of its methods for calculating attrition and (2) whether VBA has adequate data to effectively analyze the reasons for attrition. To answer these questions, we obtained and analyzed attrition data from VBA's Office of Human Resources, calculated attrition rates for VBA and other federal agencies using a governmentwide database on federal employment, and interviewed VBA officials about their efforts to measure attrition and determine why new employees leave.

What GAO Found

About 15 percent of new examiners hired in fiscal year 2000 left VBA within 12 months of their hiring date, more than double the 6 percent rate of all VBA employees who left in fiscal year 2000. In general, new hire attrition tends to exceed the rate for all other employees, and VBA's 15 percent rate is similar to the attrition rate for all new federal employees hired between fiscal years 1998 and 2000, when as many as 17 percent left within 12 months of being hired.

VBA does not have adequate data on the reasons why employees, particularly new employees, choose to leave the agency. VBA has descriptive data on how employees leave the agency (whether through resignation, retirement, or transfer), but VBA does not have comprehensive data on the reasons employees resign. While VBA collects some data on the reasons for attrition in exit interviews, these data are limited because exit interviews are not conducted consistently, and the data from these interviews are not compiled and analyzed. Without such data, VBA cannot determine ways to address the reasons employees are leaving. Furthermore, VBA has not performed analysis to determine whether it can reduce its staff attrition. Improved collection and analysis of attrition data, including data on the reasons for attrition, could help the agency minimize the lost investment in training, particularly when new employees resign. A forthcoming report will explore options for improving VBA's collection and analysis of attrition data.

Percentage of Examiners Who Left VBA within 2 Years of Their Hiring Date, Fiscal Years 1998 – 2000



Source: OPM's CHRIS Personnel Data File.

Note: Data for fiscal year 2000 do not reflect a full 24-month time period.

www.gao.gov/cgi-bin/getrpt? GAO-03-452T

To view the full report, including the scope and methodology, click on the link above. For more information, contact Cynthia Bascetta, Director, Education, Workforce and Income Security, 202-512-7101.

Mr. Chairman and Members of the Committee:

We are pleased to have the opportunity to comment on efforts undertaken by the Veterans Benefits Administration (VBA) to ensure it has a sufficient workforce to process veterans' claims for disability compensation and pension benefits. About 40 percent of VBA's employees work as examiners, who review and process veterans' disability claims at 57 regional offices throughout the country. VBA projects that, of its examiners who are eligible to retire, 21 percent will do so by the year 2006. Acknowledging the implications of these retirements for the quality of services provided to veterans, VBA hired over 2,000 new examiners between fiscal years 1998 and 2001. While VBA recognizes the importance of retaining its new employees, until 2001 it was not regularly calculating an attrition rate for its newly hired employees.

In response to a request from Representative Lane Evans, Ranking Democratic Member, we examined (1) the attrition rate at VBA, and the soundness of its methods for calculating attrition and (2) the adequacy of data VBA has on the reasons for attrition. We focused our analysis on new employees because of the investment in training they need to reach full productivity. To do our work, we obtained and analyzed attrition data from VBA's Office of Human Resources and interviewed VBA officials. We performed calculations of VBA's attrition rates and compared them to those for other federal claims examiners, using a governmentwide database on federal civilian employment. We also interviewed Office of Personnel Management (OPM) and GAO human capital officials to identify generally accepted methods of calculating attrition and to determine how federal agencies develop and analyze data on attrition and the reasons for attrition. We conducted our work between October 2002 and January 2003 in accordance with generally accepted government auditing standards. This statement for the record is an interim product that summarizes the results to date based on our ongoing review of staff attrition at VBA.

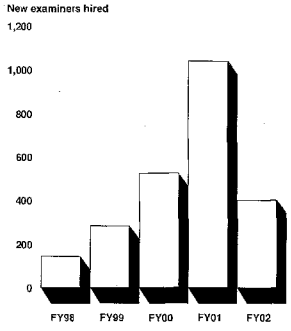
In summary, for fiscal years 2000 and 2001, the attrition rate at VBA for all employees was about 6 percent. The rate for newly hired examiners was more than twice as high in fiscal year 2000, the most recent year for which comparable data were available. Specifically, about 15 percent of new examiners hired in fiscal year 2000 left the agency within 12 months of being hired. This is similar to the attrition rate for all new federal employees hired between fiscal years 1998 and 2000, when as many as 17 percent left within 12 months of being hired. It is typical for new hire attrition to exceed overall attrition, but the new hire attrition rate was much higher in certain VBA regional offices located in major urban areas than it was in other regional offices. While VBA has descriptive data on how employees leave the agency (whether through resignation, retirement, or transfer), it does not have analytic data on the reasons why employees, particularly new employees, leave the agency. Without such data, VBA cannot determine ways to address why employees are leaving. Furthermore, VBA has not performed the types of analysis on its data that would help the agency determine whether it can reduce attrition. Such analyses can help an agency determine the extent to which an attrition problem may exist and provide needed information for effective workforce planning. We will be reporting in more detail in a forthcoming report on these issues and options for improving VBA's collection and analysis of attrition data.

Background

VBA provides benefits to about 2.7 million veterans and about 579,000 surviving spouses, children, and parents. Some of these benefits and services include disability compensation and pension, education, loan guaranty, and insurance. VBA employs about 5,000 examiners,[1] and they represent about 40 percent of the agency's entire workforce. Most examiners are located at 57 regional offices and are responsible for reviewing and processing veterans' disability claims. Typically, they begin service at GS-5 or GS-7, grades that have starting salaries for 2003 of about $23,400 to $29,000.[2] Examiners can be promoted to GS-10.[3]

Between 1998 and 2001, VBA hired about 2,000 new examiners (see figure 1). According to VBA officials, this was the first time VBA had the authority to hire significant numbers of examiners. These examiners were hired in anticipation of a large number of future retirements. For example, in 2000, VBA was expecting the retirement of 1,100 experienced examiners in the next 5 years. In addition, the hiring of these new examiners coincided with a growth in the backlog of claims awaiting decisions. Between 1998 and 2001, the backlog increased by 74 percent from about 241,000 to about 420,000. VBA has since implemented an initiative to reduce this backlog.[4]

Figure 1. Examiners Hired by VBA, Fiscal Years 1998-2002



Source: VBA.

According to VBA, it takes 2 to 3 years for a newly hired examiner to become fully productive. After being hired, new examiners receive a combination of formal training in a central location and on-the-job training

[1]According to VBA, these positions carry the title of Veterans Service Representative (VSR). VSRs and similar positions, such as rating specialists, are classified as job series 996, veterans claims examiner. For our analysis, GAO focused on the 996 job series. For the purpose of this statement for the record, we are referring to jobs in this series as examiners.

[2]According to a VBA official, in some cases, they can also start at GS-9, with a starting salary in 2003 of about $35,500.

[3]VBA is planning to extend competitive promotion potential for this job series to GS-11.

[4]VBA began to implement this initiative, called Claims Process Improvement, at all its regional offices in July 2002. For more information, see *Veterans' Benefits: Claims Processing Timeliness Performance Measures Could Be Improved*, GAO-03-282 (Washington, D.C.: December 19, 2002).

in one of VBA's regional offices. Once on the job, these workers perform a variety of critical tasks, including compiling medical evidence, assessing the extent of the disability, determining the level of benefit, handling payment, and considering appeals.

Workforce planning is a key component to maintaining a workforce that can carry out the tasks critical to an agency's mission. Strategic workforce planning focuses on developing and implementing long-term strategies—clearly linked to an agency's mission and programmatic goals—for acquiring, developing, and retaining employees. Collecting data on attrition rates and the reasons for attrition are one part of conducting workforce planning. Other types of data that can be used in workforce planning include size and composition of the workforce, skills inventory, projected retirement rates and eligibility, and feedback from exit interviews.[5] This data can be analyzed to identify gaps between an agency's current and future workforce needs, which can in turn become the basis for developing strategies to build a workforce that accommodates future needs.

Attrition At VBA Is Higher For Newly Hired Examiners Than For The Agency Overall

In fiscal year 2000, the attrition rate for new examiners at VBA was about 15 percent, more than twice as high as the 6 percent rate for all employees who left that year. About 15 percent of the new examiners hired in fiscal year 2000 left the agency within 1 year of being hired. VBA calculates attrition by counting employees who leave the agency and comparing that number to either total employees or a sub-group of total employees. The methods VBA uses to calculate attrition are consistent with those used by OPM and other federal agencies.

Attrition for New Employees at VBA Is More Than Twice as High as the Agency's Overall Rate of About Six Percent

Attrition rates for new VBA examiners were generally higher than those for all VBA examiners and other employees. As shown in table 1, in fiscal years 2000 and 2001, overall attrition rates for VBA examiners and other VBA employees ranged from about 4 percent to about 6 percent. However, among all new examiners hired in fiscal year 2000, about 15 percent left the agency within 12 months, as shown in figure 2. These attrition rates reflect all types of attrition—including resignation, retirement, and termination.[6] However, for new hires, attrition consists predominantly of resignations.

[5]For more information, see *A Model of Strategic Human Capital Management, Exposure Draft*, GAO-02-373SP (Washington, D.C.: Mar. 15, 2002).

[6]We did not include in our analysis of new hire attrition staff who left the examiner position but remained in VBA, nor did we include transfers within VA.

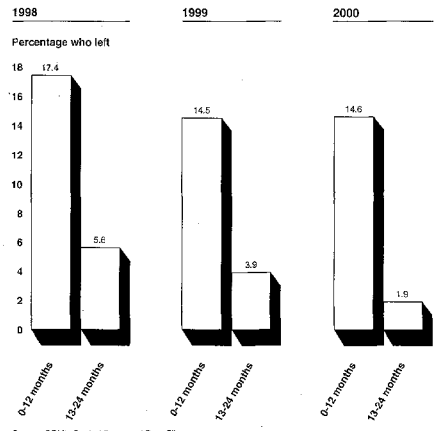
Table 1: Overall Attrition Rates for VBA Examiners, Other VBA, Other Department of Veterans Affairs (VA), and Other Federal Employees, Fiscal Years 2000-2001

	VBA				
Fiscal year	Examiners	All other white-collar employees	Agencywide	All other VA	All other federal government
2000	4.6	6.9	6.0	8.2	7.4
2001	6.0	6.6	6.4	7.8	7.0

Source: OPM's Central Personnel Data File.

Note: GAO performed these calculations by dividing separations by an average of the total workforce on board at the beginning and end of each year. The averages could only be calculated for the two years shown.

Figure 2: Percentage of Examiners Who Left VBA within 2 Years of Their Hiring Date, Fiscal Years 1998-2000



Source: OPM's Central Personnel Data File.

Note: Data for fiscal year 2000 do not reflect a full 24-month time period. A comparable analysis could not be done for fiscal year 2001 because comparable data were not available to reflect a full 24-month time period.

According to human capital experts, in general, new employees tend to leave at higher rates than all other employees. This has been the experience for federal agencies historically and, according to our analysis of OPM's data, is generally the case governmentwide. Attrition rates for all federal employees, both new hires and senior staff, were about 7 percent in fiscal year 2000. [7] However, for all new federal employees—those hired in fiscal year 1998, 1999, and 2000—as many as 17 percent left within 12 months of being hired. [7]

VBA calculations show that attrition for newly hired examiners is particularly high or particularly low in certain locations. [8] VBA officials

[7]These attrition rates represent employees at all federal agencies except VA.

[8]According to VBA officials, attrition rates could also be calculated for certain subgroups of newly hired examiners such as veterans or minorities. VBA has not calculated attrition rates for these subgroups.

acknowledge that, in certain regional offices, attrition has been high for newly hired examiners. For example, VBA found attrition rates of 38 percent to 49 percent for new examiners hired over a 3-year period at four regional offices—Baltimore (38 percent), Chicago (39 percent), Newark (41 percent), New York (49 percent). By contrast, some offices—such as Phoenix, Arizona; Louisville, Kentucky; Huntington, West Virginia; and Wichita, Kansas—experienced no attrition among new examiners hired during this period.

VBA Uses Accepted Methods to Calculate Attrition

The two basic methods VBA uses to calculate attrition are consistent with methods used by OPM and other federal agencies. Both methods, the "annual calculation" and the "cohort calculation," compare employees who leave the agency to either total employees or a sub-group of total employees. They provide different ways of looking at attrition trends. The annual calculation indicates broad attrition patterns from year to year. In contrast, the cohort calculation tracks attrition over a period of time for a specific group, and the timeframe and group can vary to suit the needs of the analysis. Using this method, VBA reported attrition rates similar to those found by GAO. The following are the two methods VBA uses:

- **Annual calculation**. This method calculates attrition by dividing all employees who left in a given year by an average of employees working at the agency at the beginning of the year and at the end of the year.

- **Cohort calculation**. This method calculates attrition by tracking a specified group or "cohort" of employees. The cohort can be defined as all those hired (new hires only) during a specific timeframe. These new hires are tracked for selected intervals (3 months, 6 months, etc.). This method can be adapted by defining the cohort differently (for example, to track attrition among a subgroup of new hires) and by using different timeframes for the tracking (e.g., 12 months, 18 months, etc.). This calculation differs from the annual calculation in that it does not take an average of the total workforce. VBA used this method to determine the attrition rate of certain newly hired examiners for a presentation in 2001 and for additional, more comprehensive calculations in 2002. VBA plans to use this method to calculate attrition rate for new examiners at least annually starting in 2003.

According to OPM officials, the annual method is a generally accepted method used to calculate attrition by federal agencies. OPM officials also recognized the value of the cohort method for calculations that require specific time frames or groups of employees, and added that tracking the attrition of new employees is an important practice. OPM does not mandate the use of a particular method for the calculation of attrition, but officials stated that any method used should be clearly explained.

VBA Lacks Adequate Data On Reasons Employees Leave And Analysis Of Staff Attrition

While VBA has descriptive data on how employees separate from the agency (whether through resignation, termination, retirement, or transfer), it does not have adequate analytic data on the reasons why employees, particularly new employees, leave the agency. VBA collects some data on the reasons for attrition in exit interviews. However, these data are not systematically collected in a consistent manner and not compiled or

analyzed. Furthermore, VBA has not performed the types of analysis on its data that would help the agency determine whether it can reduce its attrition rate. VBA is taking steps to ensure that attrition data will be available to guide its workforce planning.

VBA Collects Some Data on Types of Separations, but Data on Reasons Are Limited

While VBA systematically collects descriptive data on how employees leave the agency, the data on the reasons employees leave is not systematically collected or analyzed. As at other federal agencies, when employees leave VBA, a standard federal "Form 52" is filled out.[9] This form records whether the employee is leaving due to a resignation, termination, retirement, or transfer. Because this information appears on the form in discrete fields, VBA human resources staff can easily enter it into the agency's computer system to aggregate information on the types of separations.

The Form 52 also includes a blank space for narrative comments on the reasons for leaving. This space is primarily intended to be used in the case of resignation and its use is optional on the part of the employee. However, according to VBA officials, this area is frequently left blank. When this area is filled out, it is up to a human resources employee to decide how to label an employee's reason for leaving in the computer system. Several "quit codes" exist to help in this labeling process. For example, reasons for leaving can be coded as relating to pay and benefits, supervisory relationship, opportunity for advancement, or personal reasons, including family responsibilities, illness, or household relocation. All forms are sent to one of four human resource centers to be entered into the agency's computer system. Human resources employees in these centers are instructed to code the reasons for leaving to the best of their ability. However, these staff members cannot clarify reasons when the information is blank or ambiguous because they do not have access to either the separated employee or the regional human resources staff who actually processed the employee's separation. Therefore, VBA officials do not consider the Form 52 to be a complete or reliable source of information on the reasons employees resign from VBA.

While VBA conducts exit interviews to collect information on the reasons employees resign, it does not have a standard process for these interviews, nor are they conducted consistently for all separating employees, according to VBA officials. Exit interviews with separating employees are conducted at regional offices. However, no standard process exists for such interviews, according to the results of an internal VA assessment. VBA officials state that the downsizing of human resources staff in regional offices is at least partly responsible for the inconsistency with which exit interviews are conducted. In addition, the data from the interviews that are conducted are not forwarded to national headquarters to be aggregated and analyzed. Despite VBA's inconsistent use of exit interviews, VA policy recognizes the importance of exit interviews for determining the reasons an employee leaves.

Some offices and staff members within VBA have made special efforts to compile or collect information on the reasons examiners leave the agency by producing special studies or reports. These include the following:

[9]The Form 52, Request for Personnel Action, is used by all federal agencies, including VBA.

- **High-Performing Young Promotable Employees (HYPE).** In September 2002, a group of employees, representing six regional offices, prepared a report based on 72 exit interviews conducted at seven regional offices. The exit interviews had been conducted over 3 fiscal years: 1999, 2000, and 2001.

- **Loss of New Hires in Veterans Service Centers.** At the request of the head of VBA, the newly organized Office of Performance Analysis and Integrity (OPAI) issued a report in September 2002 that examined new hire attrition rates for regional offices individually. The report also looked at reasons for leaving, based on interviews with the directors of two regional offices.

- **Review of attrition data at certain regional offices.** At least two regional offices have investigated the reasons for attrition on their own initiative. For example, in October 2002, senior management at the Newark regional office compiled information on the attrition of examiners over a 3-year period and the reasons given for why these examiners left. This study was prompted by concern about high attrition rates at the Newark office. Portland did a similar review in September 2001.

These special efforts had several common findings. For example, three reported that inadequate opportunity for training was one of the reasons examiners left VBA. Two reported workload as a reason for leaving. Two also identified instances in which examiners resigned as a result of pending termination for poor performance or conduct. Reports associated with these efforts touched on other reasons for resignation, including inadequate opportunity for full utilization of skills, insufficient pay, and various personal reasons.

The other source of information on reasons examiners left VBA was anecdotal information provided by regional and other senior human resources officials. For example, senior human resources officials stated that reasons for leaving included factors such as inadequate work space and computer equipment as well as insufficient pay. In addition, these officials reported that some newly hired examiners left when they discovered that the job tasks were not what they had expected. According to a VBA official, certain regional offices are aware of the types of employers with whom they are competing. For example, some regional offices report losing employees to a range of employers in both the public sector, including other federal agencies (such as SSA and DOL), and the private sector, including firms in the information technology sector.

VBA has begun to address some of the findings from these special studies or reports. For example, the HYPE report included several recommendations. The report recommended that the agency develop a comprehensive strategic plan that addresses attrition and retention; the report also recommended that the agency improve and centralize its exit interview process. Both of these recommendations are in the process of being implemented at VBA. In addition, according to a VBA official, certain regional offices have taken steps to offer job candidates opportunities to observe the work place before being hired. This effort was undertaken partly in response to information about employees' expectations of their duties and work environment.

VBA Has Not Fully Analyzed Data to Determine Whether Attrition Can Be Reduced

VBA has not performed the types of analysis on its data that would help the agency determine whether it could reduce attrition or identify the extent to which an attrition problem may exist. To better understand its own attrition, an agency can take advantage of a range of analyses. These include the following:

- **Comparisons.** To understand the degree to which its attrition is a problem, an agency can compare its own attrition to the attrition of other federal agencies, especially to the attrition of agencies with employees who do similar work. While one of VBA's special reports did some broad comparisons of VBA's attrition to the attrition at other federal agencies, VBA has not compared, as we have done, the attrition of newly hired examiners to the attrition of employees in other parts of the federal government with comparable job series.

- **Attrition modeling.** To understand the degree to which attrition is a problem, an agency can estimate the attrition rates it expects in the future, providing a baseline against which to measure the actual attrition it experiences.[10] This allows officials to determine if attrition rates are higher or lower than expected. While VBA has projected retirement rates for planning purposes, according to VBA officials, there was no formal or informal process to estimate the expected attrition rates of the examiners who joined the agency since 1998. In 2002, VA projected future attrition trends for examiners in a restructuring plan submitted to the Office of Management and Budget, and officials expect to compare these projections to actual attrition rates for examiners in the future.

- **Cost analysis.** To understand the degree to which attrition is a problem, an agency can estimate the cost of recruiting and training new employees who leave and their replacements. While VBA's human resources office conducted a partial estimate of attrition costs in 2001, this estimate did not include all associated costs (including one of the most important and potentially expensive, the investment lost when a trained employee leaves).

- **Labor market analysis.** To understand the degree to which its attrition is a problem, an agency can evaluate labor market conditions in locations where it operates. Such an evaluation can provide context for understanding if an attrition rate is higher than might be expected in those locations. Using general labor market data, VBA has identified several locations where it faces significant competition from other employers, both public and private. This information could be used to better understand its attrition rate in those locations in the future. However, this information is not based on the actual employment plans of separating employees, and VBA does not routinely collect or document this information. According to a VBA official, collecting data on where VBA's separating employees find employment after VBA would be useful for developing a more accurate understanding of the employers with whom VBA is competing.

[10]For more information on attrition modeling, see *Air Traffic Control: FAA Needs to Better Prepare for Impending Wave of Controller Attrition*, GAO-02-591 (Washington, D.C.: June 14, 2002). For additional information on how attrition data can be used by federal agencies, see *Human Capital: A Self-Assessment for Agency Leaders*, GAO/OCG-00-14G (Washington, D.C.: Sept. 2000) and, for the importance of valid and reliable data in assessing an agency's workforce requirements, see *A Model of Strategic Human Capital Management, Exposure Draft*, GAO-02-373SP (Washington, D.C.: Mar. 15, 2002).

VBA is taking steps to ensure that attrition data will be available to guide workforce planning. First, VBA intends to develop a workforce plan, following a workforce policy approved by VA in January 2003.[11] In a related document, VA stated its expectation that, in the current economy, attrition among examiners may stabilize. Continued monitoring of attrition rates and improved data on reasons for attrition would allow VBA to test that assumption. Second, VBA has recently designated an official to head strategic planning efforts. While these efforts will include human capital issues, and according to VBA officials, will address attrition, VBA's human resources office is expected to assume primary responsibility for human capital issues and to coordinate with the strategic planning office. Obtaining better attrition data and conducting adequate analysis of attrition and the reasons for attrition could help VBA target future recruitment efforts and minimize attrition. For example, VA's new automated exit survey, which VA officials expect to be available in spring 2003, has the potential to aid VBA in its attrition data gathering and analysis. Separating employees will be able to answer a series of questions about the reasons they decided to leave the agency. The survey will provide confidentiality for the employee, potentially allowing for more accurate responses. It will also facilitate electronic analysis that could be broken down by type of job and region.

Concluding Observations

VBA's ability to effectively serve veterans hinges on maintaining a sufficient workforce through effective workforce planning. While attrition data are just one part of workforce planning, the data are important because they can be used to anticipate the number of employees and the types of skills that need to be replaced. The agency currently lacks useful information on the reasons new employees leave and adequate analysis of its staff attrition. In addition, some offices experience much higher or lower rates. Continuing monitoring of attrition data by region may point to regions that need special attention. Sustained attention to both the reasons for attrition and attrition rates, particularly for new employees, is needed so VBA can conduct effective workforce planning. Understanding the reasons for attrition could help the agency minimize the investment in training lost when a new employee leaves. Furthermore, the new workforce planning efforts under way at VBA offer an opportunity to improve data collection on the reasons for attrition and attrition rates.

GAO Contacts and Staff Acknowledgments

For future contacts regarding this statement, please call Cynthia A. Bascetta at (202) 512-7101. Others who made key contributions to this statement are Irene Chu, Ronald Ito, Grant Mallie, Christopher Morehouse, Corinna Nicolaou, and Gregory Wilmoth.

[11]The new VA policy requires workforce plans from all three of VA's administrations—VBA, the Veterans Health Administration, and the National Cemetery Administration. VA first identified the need for a workforce policy following a workforce analysis required of all executive branch agencies by the Office of Management and Budget in May 2001.

Related GAO Products

General Human Capital Reports

Human Capital: Effective Use of Flexibilities Can Assist Agencies in Managing Their Workforces. GAO-03-2. Washington, D.C.: December 6, 2002.

Air Traffic Control: FAA Needs to Better Prepare for Impending Wave of Controller Attrition. GAO-02-591. Washington, D.C.: June 14, 2002.

A Model of Strategic Human Capital Management, Exposure Draft. GAO-02-373SP. Washington, D.C.: March 15, 2002.

Federal Employee Retirements: Expected Increase Over the Next 5 Years Illustrates Need for Workforce Planning. GAO-01-509. Washington, D.C.: April 27, 2001.

Human Capital: A Self-Assessment Checklist for Agency Leaders. GAO/OCG-00-14G. Washington, D.C.: September 2000.

Department of Veterans Affairs

Major Management Challenges and Program Risks: Department of Veterans Affairs. GAO-03-110. Washington, D.C.: January 2003.

High-Risk Series: An Update. GAO-03-119. Washington, D.C.: January 2003.

Veterans Benefits Administration

Veterans' Benefits: Claims Processing Timeliness Performance Measures Could Be Improved. GAO-03-282. Washington, D.C.: December 19, 2002.

Veterans' Benefits: Despite Recent Improvements, Meeting Claims Processing Goals Will Be Challenging. GAO-02-645T. Washington, D.C.: April 26, 2002.

Veterans' Benefits: Training for Claims Processors Needs Evaluation. GAO-01-601. Washington, D.C.: May 31, 2001.

Veterans Benefits Administration: Problems and Challenges Facing Disability Claims Processing. GAO/T-HEHS/AIMD-00-146. Washington, D.C.: May 18, 2000.

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WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN SMITH TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Christopher H. Smith, Chairman
Committee on Veterans' Affairs
February 11, 2003
Hearing on the Department of Veterans Affairs
Budget Request for Fiscal Year 2004

1. Please provide the Committee a detailed explanation, including supporting data, of VA's assertion that long-term care, institutional nursing home beds in this country is becoming "obsolete" as indicated in the budget presentation?

Response: VA recognizes that there is and will continue to be a need for nursing home care, both for post-hospital rehabilitation and treatment and for long-term maintenance care for frail elderly and disabled individuals who cannot be cared for in the community. VA does not believe that nursing home care is becoming obsolete but rather that the counting of nursing home beds as a measure of health care capacity is becoming obsolete given the increased availability of alternatives to nursing home care that did not exist 10 to 15 years ago. Recent studies demonstrate that non-institutional care provides outcomes that are as good or better than nursing home care and at a lower cost. Although most individuals prefer to be cared for at home rather than in an institution, VA has in the past invested most of its long-term care resources in nursing home care. Our plan is both to maintain a level of nursing home care for veterans in VA, contract community and State veteran nursing homes, and expand home and community-based care. This approach was recommended by the Federal Advisory Committee on the Future of Long-Term Care in VA in its report published in June 1998 and is also supported by numerous studies (both VA and non-VA) in the medical and scientific literature in this area.

Attachment A provides a listing of relevant studies on the effectiveness of home and community-based care.

2. In the past several weeks the Committee has received communications from many veterans stating that both the medical and administrative staffs at their local medical centers were not aware of the service-connected priority care regulation you announced last year. Please explain what is being done to ensure all VA facilities are implementing the new regulation?

Response: VHA facilities were made aware of this regulation on January 17, 2003, the day it was implemented. On the same day, an implementing directive was published, and announcements were made on the VHA-wide conference call. An announcement about the forthcoming regulation and directive were made on the Network Director conference call on January 16, 2003. A number of occupation-specific calls to orient the staff to this new regulation have been held. Within a short period of time, staff at all levels of the organization were made aware of this change and over the past 3 months, frequent reminders have been sent to the field.

3. While attending a VA conference on long-term care in January, one of our Committee staff heard a DOD official announce that in the event of a war, DOD medical facilities plan to treat only active duty military members and refer all other military patients to VA health facilities. Is there a formal agreement in place to execute this type of large-scale referral procedure? Please provide the agreement and descriptive information so that the Committee will have a clear understanding of its nature and scope.

Response: We are unaware of a DoD plan or any formal agreement under which DoD would treat only active duty military members and refer all other military patients to VA facilities. However, we will bring the issue up at the next meeting of the Executive Council.

4. VA is requesting a 2 percent increase in funding in fiscal year 2004 for the Medical and Prosthetic Research Appropriation. Does this increase correspond with the Administration's commitment to increase research funding at the National Institutes of Health, National Science Foundation and the Centers for Disease Control and Prevention?

Response: The Administration's recommended two percent increase in VA research funding for FY 2004 is consistent with the proposed increases for the National Institutes of Health (1.8 percent) and the Centers for Disease Control and Prevention (2.4 percent).

5. VA recently reported improved coordination between VA and DOD in its fiscal year 2002 Performance Plan. What is the status of your joint vision statement and strategic planning effort with DOD for fiscal year 2004? Will these achievements be reported in the 2003 Performance Plan?

Response: The VA/DoD Joint Executive council (JEC) established a Joint Strategic Planning Committee (JSPC) at its September 12, 2002, meeting. The committee has been meeting regularly since that time. A joint vision, mission statement, guiding principles and six strategic goals were developed and approved by the JEC at the January 23, 2003, meeting. Currently, the committee is developing strategic elements and performance measurements for each of the six strategic goals and plans to present them to the JEC for review and approval at the April 15, 2003, meeting. While VA anticipates reporting on its achievements in VA/DoD coordination in the 2003 Performance Plan, the Department will not be in a position to address the specific performance elements in the joint strategic plan until 2004.

6. Please provide the Committee a report within 60 days of this transmittal of the status of implementation of the VA-DOD sharing provisions in Public Law 107-314, Title VII, Subtitle C, sections 721 through 726.

Response: On December 18, 2002, the VA/DoD Health Executive Council (HEC), co-chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs, reviewed the VA/DoD collaboration provisions included in Public Law 107-314. Following review of the provisions, the co-chairs directed the establishment of a new work group and assigned specific provisions to existing work groups for action as outlined below:

Section 721 amends Section 8111 of title 38, United States Code, and revises coordination and sharing guidelines:

1. Requires the Secretary of Veterans Affairs and the Secretary of Defense to enter into agreements and contracts for the mutually beneficial use of VA and DoD health care resources with the goal of improving the access to, and quality and cost effectiveness of, the health care provided by VHA and the Military Health System to the beneficiaries of both Departments.

2. Develop and publish a joint strategic plan and incorporate into departmental plans and give priority to efforts that improve intra-regional and national sharing and improve ability to both departments to provide coordinated health care.

Status: The Joint Executive Council, Co-Chaired by the VA Deputy Secretary and the Under Secretary of Defense (Personnel and Readiness), charged the development of a Joint Strategic Planning Executive Steering Committee, which is developing a strategic plan for VA/DoD collaboration. Health care is a major goal identified in the joint strategic plan and subsequent planning and implementation will be assigned to the HEC following approval of the new joint plan.

3. Establishes an interagency committee known as the VA-DoD Health Executive Committee composed of the Deputy Secretary of the VA and the Under Secretary of Defense for Personnel and Readiness and such other officers and employees of the two departments as the Secretary may designate.

Status: The VA/DoD Joint Executive Council, co-chaired by the officials identified in legislation, has committed to implementing this provision through a review of the VA/DoD committee structure, requiring the development of new Executive Council charters, and reviewing current membership and roles to ensure the appropriate identification of changes in policies and procedures to promote mutually beneficial coordination of health care resources. The Health Executive Council, co-chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense (Health Affairs), is expected to be re-chartered by July 2003.

4. Establishes a joint incentives fund.

Status: The VA/DoD HEC has assigned responsibility to the Financial Management Work Group to develop guidelines and implementation plans for a joint incentives fund consisting of $15 million contributed from each agency. The work group is expected to provide an initial report in June 2003.

5. Joint issuance of guidelines and policies.
   Status: The Financial Management Work Group has proposed and the VA/DoD HEC has approved a national standardized reimbursement rate for VA/DoD sharing agreements. The work group is completing development of joint implementation guidelines and has been assigned responsibility for ensuring full implementation by October 2003. Additionally, the HEC will work with the JEC in developing the annual report to Congress including summaries of sharing agreements and planning activities; recommendations for legislation to facilitate sharing; and status reports on initiatives mandated by Congress.

Section 722 directs VA and DoD to conduct a health care resources sharing and coordination project to serve as a test for evaluating the feasibility, and the advantages and disadvantages, of measures and programs designed to improve the sharing and coordination of health care.

Status: The co-chairs of the VA-DoD Health Executive Council assigned the Joint Facility Utilization and Resource Sharing Work Group with responsibility for coordinating pilot project requirements and developing an implementation plan for Section 722. The work group has augmented representation and begun deliberations on criteria for site selection and is expected to provide an update at the June 2003 HEC meeting.

Section 723 directs DoD and VA to report on improved coordination and sharing of health care and health care resources following domestic acts of terrorism or domestic use of weapons of mass destruction.

Status: The VA/DoD HEC assigned this provision to the Deployment Health Work Group to complete. The required report to Congress is still in preparation and will be submitted in the near future.

Section 724 directs interoperability of VA and DoD pharmacy data systems.

Status: The VA/DoD HEC jointly assigned this provision to the Pharmacy and Information Management/Information Technology Work Groups to develop an implementation plan for interoperability by achieving real-time interface, data exchange, and checking of prescription drug data of outpatients, and using national standards for the exchange of outpatient medication information. The work groups are expected to brief the HEC on the status of their deliberations during the summer of 2003.

Section 725 directs VA and DoD to establish a joint pilot program for providing graduate medical education and training for physicians.

Status: To comply with this provision, the VA/DoD HEC co-chairs directed the establishment of a new work group on graduate medical education. A major assignment for this work group will include the development of a joint pilot program.

Section 726 repeals certain limits on VA resources. The repeal of VA bed limits does not require additional action to implement.

7. The Military Coalition's testimony strongly supports a particular VA-DOD sharing initiative: creating a seamless and transferable lifetime medical record for every veteran. Please inform the Committee what progress has been made in achieving this goal.

Response: The Department of Veterans Affairs (VA) and the Department of Defense (DoD) are closely collaborating to improve veterans' and military beneficiary health care. A key element of this effort is the development of the ability to share medical information electronically between VA and DoD. Recently, the VA/DoD Joint Executive Council and Health Executive Council approved the adoption of the Joint VA/DoD Electronic Health Records Plan. This Plan provides for the exchange of health data and development of a common health information infrastructure and architecture supported by common data, communications, security and software standards, and high performance health information systems. Key initiatives included in the Electronic Health Records Plan are the Federal Health Information Exchange (FHIE) and HealthePeople (Federal).

The Departments have made significant progress toward achieving the goals provided for by the Electronic Health Records Plan. Since June 2002, the Departments have been sharing electronic medical information successfully. FHIE (formerly known as GCPR) provides historical data on separated and retired military personnel from the DoD's Composite Health Care System (CHCS) to the FHIE Data Repository for use in VA clinical encounters and potential future use for aggregate analysis. Current patient data that are being sent from DoD to VA via secure messaging include laboratory results, radiology reports, outpatient pharmacy information, and patient demographics. This first phase of FHIE, the Near Term Solution, is fully deployed and operational at VA medical centers nationwide. The next phase of FHIE is currently being deployed and includes admission discharge transfer (ADT) data, discharge summaries, allergies, and consult tracking.

HealthePeople (Federal) is a strategy to achieve full interoperability among Federal health information systems starting with the ability to provide a two-way exchange of health related information between VA and DoD. Providers of care in both Departments will be able to access relevant medical information to aid them in patient care. HealthePeople (Federal) was initiated to:

- Improve sharing of information

- Adopt common standards for architecture, security, communications, data, technology, and software
- Seek joint procurements and/or building of applications where appropriate
- Seek opportunities for sharing existing systems and technology
- Explore convergence of VA and DoD health information technology applications where feasible and within mission requirements
- Develop interoperable health records and data repositories

The initiative will provide interoperability between the two health information systems by 2005.

The Departments have made significant progress in moving toward HealthePeople (Federal). To date, the Departments are collaborating on several important health information applications. Together, these applications and initiatives form the electronic framework that will permit the Departments to offer a seamless electronic medical record. Progress within each of these projects is as follows:

- Clinical Data Repository/Health Data Repository (CHDR): This project seeks to ensure the interoperability of the DoD Clinical Data Repository with the VA Health Data Repository by FY 2005. The Departments have formed an active working group to lead this effort and have made significant progress toward building a prototype.

- Consolidated Mail-Out Pharmacy: The Departments are Beta testing a system that supports VA's refilling of outpatient prescription medications from DoD's Military Treatment Facilities at the option of the beneficiary.

- Lab Data Sharing and Interoperability: The Departments are conducting Beta testing of an application that supports the ability of VA and DoD to combine resources and provide laboratory services to one another. A blood specimen can be collected at one facility and sent to the other where the laboratory test is performed. The laboratory results are then returned electronically, using secure encryption services, to the original facility, where the patient is receiving treatment, for inclusion in the patient's electronic health record.

- Credentialing: An integrated project team has identified the common credentialing data elements to be exchanged between the DoD and VA credentialing systems and has identified three test sites. Current work includes development on the joint software and plans to begin testing by the fourth quarter of FY 2003. This will decrease the time and resources needed to credential providers who need to practice in both VA and DoD health care settings.

- Scheduling: The Departments are sharing technical requirements to ensure interoperability between the DoD scheduling application and the VA outpatient scheduling application. This will allow providers to see all

appointments a patient might have scheduled at both VA and DoD facilities and, where authorized, to schedule appointments in each other's clinics.

- E-portal Systems: The Departments are collaborating on a joint acquisition of health content for their electronic web portal systems. This will provide uniform patient health information to the beneficiaries of both Departments.

8. How is VHA notifying newly separated servicemembers of their two-year eligibility for VA health care after leaving active duty? Are those recently separated veterans in priority 8 exempt from the January 17th decision to bar new VA enrollees?

Response: VHA has incorporated information concerning the two-year enhanced enrollment priority assignment and treatment authority for recently discharged veterans who served in combat (38 U.S.C. 1710(e)(1)(D)) in a variety of communication products. It is identified on the VHA Eligibility website (http://www.va.gov/elig/), it is incorporated into the Enrollment Priority Fact Sheet and it is included in a variety of Frequently Asked Question documents that are widely distributed. VHA has also initiated contact with VBA to incorporate information concerning this treatment authority into the Transition Assistance Program (TAP) briefing program and in the Veterans Assistance at Discharge mailing program. We anticipate that these two programs will include notification of this program within 60 days.

Recently discharged veterans who meet the combat veteran definition and whose income would normally place them into enrollment priority group 8 are eligible for placement into priority group 6. VHA has published a policy directive providing guidance concerning the processing of such applicants. At this time, VHA staff must use manual procedures to provide this benefit since VHA has not yet implemented computer enhancements to integrate this benefit into its information systems.

9. The Committee has received several letters from incarcerated veterans who have been told by local VA homeless coordinators that they are not eligible to receive any information regarding services and programs until they have secured release from incarceration. Have the provisions of Public Law 107-95 dealing with prison, jail and institutional outreach and coordination demonstration projects (sections 2022 and 2023 of the Act) been implemented? Please report to the Committee within 30 days of this transmittal.

Response: Staff members from VA, the Department of Labor, and the Department of Justice formed an interagency work group to identify locations for the institutional outreach and coordination demonstration projects. This work group expects to

identify three of the six demonstration projects in the next few months and plans for implementation of these initial projects by the end of the fiscal year.

Several Health Care for Homeless Veterans Programs at VA medical centers conduct outreach to incarcerated veterans to provide them with information about benefits and assist them with pre-release planning. Well-developed programs exist in Los Angeles, New York City, and Columbia, South Carolina.

Training for the new 20 full-time VA regional office Homeless Veterans Coordinators is being planned for May. Several VA medical center homeless veterans program staff are expected to attend this training program also. Outreach to incarcerated veterans will be discussed as part of the training program.

10. The President's budget recommended legislation to convert the direct loan program for Guaranteed Transitional Housing for Homeless Veterans from a mandatory program to a discretionary grant program. Please explain the intent of this proposal within the context of implementing the authority we provided in 1998 in Public Law 105-368.

Response: VA is seeking legislation to convert the current guaranteed loan program for transition housing into a grant program because VA has found that many potential sponsors of transitional housing for homeless veterans are in need of a cash grant or other sources of funds that do not require regular repayment. Based on numerous discussions with potential developers, VA has concluded that a grant would be of more benefits to such developers than a loan. In addition, numerous representatives of government, private, and public lending institutions, and real estate developers of multi-family housing projects have advised VA of the high risk involved and high rates of defaults by borrowers.

Nevertheless, pending enactment of this proposal, VA is carefully proceeding to implement the existing loan guaranty program. VA has been negotiating with several established organizations with a solid record of developing hosing for homeless individuals and other low income groups. VA's goal is to have at least conditional commitments issued for three to five pilot projects under the current law by the end of the current fiscal year. VA's legislative proposal would allow loans for any project for which VA has issued a commitment prior to the enactment of the legislation converting the loan program into a grant program.

11. During a CARES briefing with VA staff this past fall, the Committee staff was told that a long-term care planning model projected that approximately 17,000 new nursing beds would be needed in the next decade to meet the needs of aging veterans. How does this compare with VA's decision to curtail approximately 5,000 nursing home beds in fiscal year 2004? Please inform the Committee when any new VA nursing home bed projections are made.

Response: Projections of need for nursing home care based on VA's Long-Term Care Planning Model are utilized to determine capacity required by VA-supported nursing home care programs (VA-operated, contract community, and State veterans nursing homes). Future expansion in nursing home beds will primarily be in State homes in accordance with the recommendations of the Federal Advisory Committee on the Future of VA Long-Term Care (VA Long-Term Care at the Crossroads, June 1998). This is expected to continue because of the sustained level of approximately $100 million appropriated annually for the State Home Construction Grant Program and the ongoing VA support of veterans care in State homes through the State Home Per Diem Grant Program. Although the CARES process primarily addresses VA capital assets, the bed capacity for veterans in State homes is a major consideration when planning for nursing home bed needs.

VA's Long-Term Care Planning Model is derived from the Medical Expenditure Panel Survey conducted in 1996 for estimating the need for nursing home care and the National Home and Hospice survey conducted in 1998 for the estimating the need for home care by the enrolled veteran population. There is evidence that rates of disability among elderly people have diminished since 1996. In addition, non-institutional alternatives to nursing home care have become more available in VA in recent years. Because the patient population and utilization rates for nursing home care have likely changed since 1996 and the next national nursing home survey to document such changes is just in the planning stages, VA is currently analyzing its Long-Term Care Planning Model to determine what refinements could be made in the near future to better reflect enrolled veterans needs and utilization patterns. VA will be pleased to share with the Committee the results of that effort when completed.

12. One of the high-priority initiatives identified by the VA and DOD Joint Executive Council (JEC) for improved VA and DOD coordination is the establishment of a joint consolidated mail out pharmacy pilot project. What is the status of development for a collaborative mail out pharmacy pilot program?

Response: The pilot continues to advance successfully and expand through the three designated military treatment facilities (Balboa Naval/San Diego (CA); Darnell Army/Fort Hood (TX); and Kirtland AFB/Albuquerque (NM)) and the Consolidated Mail Outpatient Pharmacy (CMOP) facility at Leavenworth, KS. The combined workloads of the three military treatment facilities are approaching 40,000 prescriptions per month and continuing to increase. Patient acceptance and satisfaction rates are constantly monitored and are receiving excellent scores.

The VA/DoD CMOP interface is operating well but will need to become more robust to be expanded beyond the pilot phase. Discussions and planning meetings between VA, DoD, and Science Applications International Corporation on future interface design are ongoing.

VA commissioned the Center for Naval Analysis to study the CMOP program and that report was completed in February 2003. The findings of that report validated current CMOP planning and indicated the need to establish two CMOP facilities to support expanding the DoD workloads beyond the pilot.

DoD has indicated that they will be commissioning a review of the pilot and that a report from the review is due by July 2003.

13. During the Committee hearing on February 11, 2003, the Under Secretary for Health stated, "What we have done, though, is create a new care coordination office that this year will actually add 17,000 veterans to a care coordination program using interactive technologies." Please provide the Committee details about the administration and funding of the announced plan, including the enrollment of veterans by each VISN and the participation of veterans in assisted living facilities.

Response: The VHA's Office of Care Coordination is being established as an expansion of the pre-existing Telemedicine Strategic Healthcare Group within the Office of Patient Care Services (PCS). It is being established with the specific purposes of:

- advising the VHA's Undersecretary for Health's Office on the strategy for care coordination;
- implementing aspects of the VHA care coordination strategy, as required;
- overseeing the monitoring and evaluation of care coordination programs in all VISNs;
- recommending the appropriate professional development of care coordinators;
- ensuring the appropriate accreditation of all VHA care coordination programs;
- coordinating clinical input into the VHA's patient held record My Health-eVet; and
- coordinating clinical input into Web-based e-health and outcomes information for veterans.

The mission and vision of the new office require it to have a crosscutting role and to work in a collaborative manner to achieve its goals and objectives. The new office will remain within PCS. It will work closely with all the Strategic Healthcare Groups in PCS. A steering committee convened under the chairmanship of the VHA Deputy Undersecretary for Health will decide the office's strategic direction and work prioritization.

Five VISNs are currently funded to provide care coordination services. These VISNs are collaborating to deploy best practices identified in the Sunshine Network in Florida/Puerto Rico. A minimum of 800 veterans per VISN is the target set for the expansion in each VISN. An additional $10 million in fiscal year 2003 has been designated to expand to 6 more VISNs and funding will be identified for fiscal year 2004 to include the remaining 10 VISNs.

Care coordination is being provided at the site of residence for the veteran, including assisted living facilities (private and state-owned). Each VISN will address the unique needs of its population and use care coordination to provide services to help meet its performance targets.

14. Attached is a list of recommendations contained in the June 1998 Report of the Federal Advisory Committee on the Future of VA Long-Term Care entitled "VA Long-Term Care At The Crossroads." The Chairman of this panel was Dr. John Rowe, who is the author of numerous works related to the care of older persons. In particular, your attention is called to the following recommendations:

"VA should retain its core of VA-operated long-term care services while improving access and efficiency of operations. Most new demand for care should be met through non-institutional services, contracting, and, where available, State Veterans Homes."

"VA needs to maintain its three nursing home programs. *Home and community based services cannot substitute for nursing home care for most of the veteran population.* VA should use its own hospital-based nursing home beds to provide care to post-acute patients, patients who cannot be cared for in other nursing home programs, and those patients who can be cared for more efficiently in VANHs."

Please clarify whether there is any recommendation or inference in this report that veterans who do not have a service-connected disability rated greater than 70 percent should be denied access to VA nursing home care. Please also provide a status report within 30 days of this transmittal on VA's progress in implementing the recommendations contained in this report.

Response: The Federal Advisory Committee Report includes the following statements and recommendations:

- "VA should retain its core of VA-operated long-term care services . . . Most new demand for care should be met through non-institutional services, contracting, and, where available, State Veterans Homes."
- "To meet the needs of veterans who are eligible for, and use, VA for their healthcare needs, planning for long-term care should be based on Category A veterans."
- "In an era of limited budgetary resources, VA should not seek funding for any new nursing home beds . . ."

In response to the recommendation that most new demand for care should be met through non-institutional services and specifically that VA triple its investment in home and community-based care (H&CBC), VHA set a target to triple the services provided in H&CBC as measured by Average Daily Census (ADC) in these programs: Home-Based Primary Care, Contract Home Health Care, Homemaker/Home Health Aide, VA Adult Day Health Care, and Contract Adult Day

Health Care. The Federal Advisory Committee recommendations were based upon FY 1997 data, and for that year the combined ADC in these programs was 11,433. The VHA strategic target for expansion was set at 34,500 ADC, and a plan was implemented to reach this target by 2007. In FY 2002, the ADC in these H&CBC programs was 17,465, or a 52.7percent increase above the FY1997 baseline. The target for FY 2003 is to expand these programs by 22 percent to an ADC of 21,308.

Action has similarly been taken on other recommendations contained in the report. VA continues to target the demand for services using recent refinements of the Long-Term Care Planning Model. In November 1999, the recommendation became policy that veterans who had been long-term residents of a VA nursing home would be allowed to remain in the VA nursing home for as long as they require such care, regardless of their service connection status. Patients admitted after November 1999 are treated in VA nursing home care units as long as they need the specialized care. Effective November 1999, respite care provision was broadened to include non-institutional settings. The assessment of all VA nursing home residents through RAI/MDS has been implemented nationwide. (Note: RAI/MDS stands for Resident Assessment Instrument/Minimum Data Set. This is a data source used to identify ways of improving patient outcomes. Its overall purpose is to allow VA to enhance patient care, monitor improvement, prevent avoidable decline whenever possible, and obtain objective data for quality assurance and other studies.)

15. In a May 8, 2002 letter from the Secretary to Chairman Smith (copy enclosed), the Secretary pledged to reopen VA nursing home beds if additional funding was provided by the Congress. The Congress recently passed and the President signed Public Law 108-7 on February 20, this omnibus appropriations measure provides $1.1 billion in additional funds for VA medical care over those the President requested in the budget for fiscal year 2003. Please provide the Committee a detailed network-by-network plan for reopening nursing home care beds in order to comply with the provisions of section 1710B(b) of title 38, United States Code.

Response: The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, requires the Secretary to ensure that the staffing and level of extended care services provided nationally in facilities of the Department during any fiscal year are not less than the staffing and level of such services provided during fiscal year 1998.

From FY 1999 to FY 2002, 469 VA nursing home beds were closed and 749 nursing home beds were opened, for a net gain of almost 300 authorized beds. In addition, from FY 1998 to FY 2001, the number of veterans served in VA nursing home beds increased from 48,878 to 49,406. However, the average daily census (ADC) in VA nursing home beds decreased from 13,391 in 1998 to 11,672 in 2001 due to shorter lengths of stay.

The target ADC for VA Nursing Home Care Units (VANHCU) was set for each VISN using VA's Long-Term Care (LTC) Planning Model. Each VISN is graded on its performance in providing veterans access to all VA-sponsored LTC services, including Nursing Home Care (NHC) and Home & Community Based Care (H&CBC). VISNs with relatively poor access scores, called Reliance Levels, were assigned a greater proportion of the ADC to be added. VISNs with high reliance level scores were assigned relatively fewer additional ADC to add. In no case would the workload increase result in new construction of VANHCU beds. The following chart summarizes VISN performance in FY2002 and the established VISN targets for FY 2003.

VA Nursing Home Care
FY 2002 Performance
FY 2003 Target

VISN	1998 Baseline ADC	FY 2002 ADC	FY 2002 Target ADC	% of Target Met in FY 2002	FY 2003 Planned ADC
1	619	579	658	88.0%	658
2	548	416	436	95.4%	436
3	988	786	876	89.7%	876
4	1185	1104	1140	96.8%	1140
5	431	437	468	93.4%	468
6	748	740	804	92.0%	804
7	713	693	687	100.9%	687
8	934	848	864	98.1%	864
9	411	276	313	88.2%	313
10	657	510	608	83.9%	608
11	644	564	597	94.5%	597
12	674	622	673	92.4%	673
15	382	311	343	90.7%	343
16	755	699	755	92.6%	755
17	603	587	594	98.8%	594
18	440	341	395	86.3%	395
19	386	220	247	89.1%	247
20	354	272	284	95.8%	284
21	627	659	682	96.6%	682
22	540	424	441	96.1%	441
23	787	678	685	99.0%	685
Total	**13,426**	**11,766**	**12,550**	**93.8%**	**12,550**

Note: FY 2003 Targets remained at FY 2002 levels, pending resolution of FY 2004 budget.

16. A 1985 VA report entitled "Caring For The Older Veteran" estimated that VA should provide non-institutional care to 760,000 veterans in 2000 and institutional care to 100,000 to 140,000 veterans daily. In the fiscal year just completed, VA provided non-institutional care to 24,000 veterans and institutional care to 43,000 veterans daily (including care for almost 12,000 veterans in domiciliaries and sub-acute beds). There is a large gap between the 1985 projection and the current level of care. Why has VA not requested additional funding to provide care to more of the aging veteran population?

Response: The 1985 VA report entitled "Caring For The Older Veteran" utilized a method for determining "real need" that combined the veteran users at the time

and the estimated number of veterans who were sick and would use VA care if they were aware and had access. The report provided estimated numbers of veterans for whom VA would provide care in 2000 if VA were to meet 100 percent of the "real need." The VA health care system, however, was never designed to meet 100 percent of all veterans health care needs. In fact, until recently, access to the system was limited by statute to indigent veterans and those with service-connected disabilities. The Veterans Eligibility and Reform Act of 1996 greatly expanded eligibility for medical care in VA, and VA has since that time requested additional funding to provide care to more veterans, including more elderly veterans. As noted in the question above, the average daily census in FY 2002 for non-institutional long-term care was 24,000 and for institutional long-term care was 43,000, but the actual number of individual veterans treated was over 60,000 in non-institutional care and over 115,000 in institutional care. VA anticipates being able to serve yet more veterans in the future with expanded use of telemedicine technology and care management.

17. Please provide the Committee a table showing the growth in the number of VA outpatient facilities since 1990. Please provide any analysis of the savings which have occurred since VA began to focus on providing care in the most appropriate setting in the mid-1990s.

Response: VHA's shift in delivering health care services in outpatient settings is consistent with health care delivery trends to provide care in the most appropriate settings. The following table shows the growth in the number of non hospital-based outpatient facilities from December 1989 to December 2002.

Non Hospital-Based Clinics (CBOC, Independent, Mobile Clinics)*
December 1989-December 2002

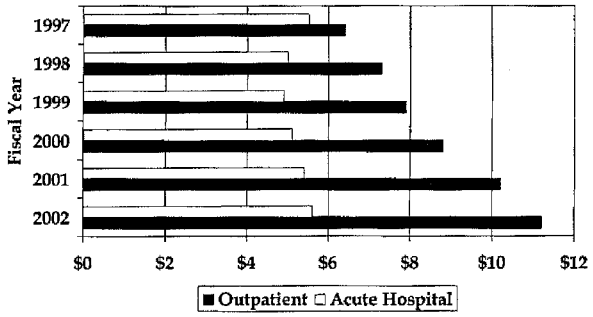
	1989	1990	1991	1992	1993	1994	1995
Clinics	167	167	173	191	182	194	219

	1996	1997	1998	1999	2000	2001	2002
Clinics	226	268	379	527	637	696	692

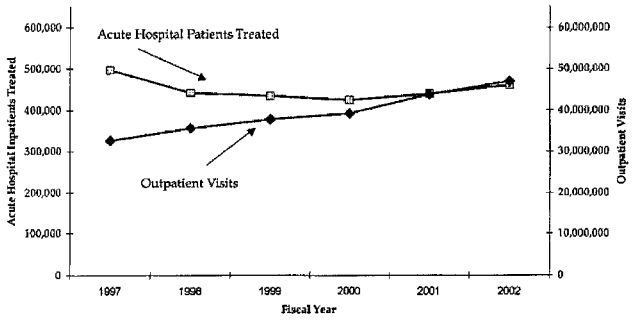
* The numbers include multiple sites for contract clinics.

Since 1997, the cost per unique patient has decreased by over 10 percent, whereas, the number of unique patients treated by VA has increased by over 48 percent. The following two charts show the shift both in resources and in workload towards inpatient alternatives, such as outpatient care. Greater emphasis towards these programs has resulted in more appropriate and more cost-effective care for many patients. In the "VA's Shift to Outpatient Care" chart, over 66 percent of the total resources expended in 2002 on VA acute hospital care and outpatient care were spent for outpatient care.

VA's Shift to Outpatient Care
Expenditures in Billions



Workload Changes
Acute Hospital and Outpatient Care
Fiscal Years 1997 - 2002



18. Please comment on the effect on veterans seeking VA care of the change in eligibility for outpatient care made in 1996 and of the increase in the number of outpatient facilities.

Response: The Veterans Health Care Eligibility Reform Act of 1996 and the Veterans Millennium Health Care Act of 1999 allowed VA to provide comprehensive health care services to all veterans. The national reputation and public perception of VA as a leader in the delivery of quality health care services has steadily risen, due in part to widespread acknowledgement of VHA's major advances in quality and patient safety. Access to health care has greatly improved with the opening of hundreds of community-based outpatient clinics. VA now has nearly 1,300 sites of care and provides health care services at locations much closer to where our patients live. Eighty-seven percent of VA's patient population now lives within 30 minutes of a VA medical facility.

Because of the success in transforming VA health care and because of problems of coverage and availability of some services in the private sector, VA is experiencing an unprecedented demand for health care services. Our patient population is growing older and this has led to an increase in veterans' need for health care services. VA has favorable pharmacy benefits compared to other health care providers, especially Medicare, and this has attracted many veterans to our system. In FY 1996, VA provided care to 2.7 million veterans. In FY 2002, VA enrolled approximately 1.1 million additional veterans, bringing the enrollment in the veterans health care system to nearly 6.2 million veterans. The number of veterans who received VA care increased to nearly 4.3 million. For FY 2003, VHA currently projects that it will provide care to approximately 4.6 million veteran patients.

This growth in demand for VA health care services has put a severe strain on VA's ability to continue to provide timely, high-quality health care, and it is clear that continued workload growth of the magnitude seen in recent years is unsustainable. At one point, almost 300,000 veterans were on waiting lists for appointments to get primary care and required specialty services.

VA has taken several measures to address this challenge and is achieving success in decreasing the time veterans must wait for an appointment.

- VHA has moved aggressively to make its primary care resources more efficient by increasing provider panel sizes and implementing a series of advanced access principles. Delivering care more efficiently and more effectively has resulted in "new" capacity at "marginal costs." Essentially, VHA is providing care to more patients with few or no additional staff at relatively little additional expense other than the cost of diagnostic services and medications. However, this approach to increasing capacity has reached its limits in many areas.
- During the past year, the Secretary took steps to assure that VA would afford priority access to veterans with service-connected disabilities.

- In January 2003, the Secretary announced that additional steps were necessary for the system to adequately serve all its patients and, in particular, to ensure that VA has capacity to care for veterans for whom our Nation has the greatest obligation: those with service-connected disabilities, lower-income veterans, and those needing specialized care. Enrollment of new Priority Group 8 veterans was suspended effective January 17, 2003. This suspension allows VA to apply limited resources in accordance with the priorities established by Congress.
- VHA is using technology to provide home care to more patients, monitoring them through telephone contacts, telemedicine units and use of the Internet. The program, which has been tested in VISN 8, not only decreases the need for face-to-face outpatient visits, it also decreases the cost of care by approximately 65 percent, primarily as a result of fewer emergency room visits and hospital admissions.

These actions will ensure VA continues to provide the best care possible to our highest priority veterans.

19. Please provide a detailed analysis of the kinds and savings from management efficiencies that will have been achieved by the end of fiscal year 2003. Please include a comparison of 2003 efficiencies with those achieved in 2001 and 2002.

Response: We are estimating that we will achieve management savings of $316 million by the end of FY 2003. They will result from management actions that include improved standardization policies and compliance in the procurement of supplies, pharmaceuticals, equipment, and other capital purchases. Resource savings are also anticipated from adherence to national criteria established to promote operational efficiencies in current and new Community-Based Outpatient Clinics (CBOCS). Likewise, resource savings are expected to result from improved guidance and control of centrally managed programs. Additional information on standardization in procurement and improved programmatic efficiencies are as follows:

Standardization and compliance in procurement – Standardization is expected to facilitate best-value product pricing through volume purchasing and should facilitate the delivery of high-quality health care. It is VA policy to standardize, to the maximum extent possible, the types and kinds of supplies and equipment it purchases, consistent with clinical and practitioner needs. The types of items considered for national standardization are only those that are not limited by geographic differences in availability and for which technology is mature enough that they are unlikely to change dramatically within a 1-year period. Standardized items establish an equal standard for veterans across the system.

Program Efficiencies – VHA has developed a new CBOC directive that calls for increased scrutiny of clinic proposals. Proposals that do not meet the criteria outlined in the directive will not be approved. Program evaluations will also be made of centrally managed programs (called specific purpose programs) to promote cost effectiveness. These are programs that are neither considered widely dispersed nor funded on a workload-related basis like the programs normally funded under general purpose allocations to the VISNs.

The following table provides a dollar comparison of estimated management and program efficiencies for FYs 2001 through 2003.

Management Efficiencies
(Dollars in Millions)

Fiscal Year	Estimate
2001	$360
2002	$300
2003	$316

20. At page 13 of their written testimony, The American Legion states with respect to the Veterans Claims Assistance Act of 2001 that "such letters are usually long and confusing, nonspecific, and full of bureaucratic language, which may or may not be accurate or appropriate to the claim."
a. What is VA's response to The American Legion's Statement?
b. Please furnish sample VCAA letters VA sends to claimants.

Response: The Veterans Claims Assistance Act of 2000 outlines the notice that VA must provide to claimants. The U.S. Court of Appeals for Veterans Claims has focused on this notice requirement and VA's implementation of it. See e.g., Quartuccio v. Principi, 16 Vet. App. 183, 186-87 (2002). VA has also received input from veterans and veterans' service organizations concerning the information provided in VCAA notice letters.

The difficulty VA faces is in providing a notice format that complies with the law while giving regional office staff the ability to readily and consistently provide the notice. The law governing VA claims and the different ways in which benefits can be granted of necessity make the required notice more complex than most individual claimants anticipate. For example, there are three different ways in which a condition may be service connected (directly, on a secondary basis, or through the application of a presumption). Therefore, we can certainly understand why some claimants consider the notice information confusing, bureaucratic, and irrelevant to their individual claims. A copy of the template of the current VCAA notice is marked as Attachment B.

Having said that, VA is responding to input it has received and is rewriting the information provided in the notice letter to make it more understandable. The rewritten letter will focus on the actions that the claimant needs to take regarding

his or her claim. The revised notice letter is also being tested with veterans in several regional offices to ensure its readability. The revised notice will be deployed as part of the MAP-D application. We expect to deploy the revised notice nationwide by the end of this fiscal year.

21. Volume 3, page 1B-23 of the Administration's FY 2004 budget submission states: "The statutory 3 percent procurement goal for service-disabled veteran-owned business concerns, as well as the increasing goal for HUBZone business concerns continues to be a concern due to the scarcity of these firms. OSDBU is developing outreach initiatives in each of these important areas."

a. How many service-disabled veteran-owned businesses exist?

Response: The Federal Acquisition Regulation (FAR) interim rule, implementing the Veterans Entrepreneurship and Small Business Development Act of 1999 was published in the October 11, 2000 Federal Register. Part B, the Regulatory Flexibility Act section, stated that there are "100,000 to 300,000 small businesses owned and controlled by service-disabled veterans." This figure was restated in the final rule for this FAR Case #2000-302, published on October 22, 2001. A subsequent correction to the FAR case appeared in the January 14, 2002 Federal Register, but the population estimates were unchanged.

b. Please describe outreach efforts to such businesses.

Response: The Secretary of Veterans Affairs dedicated the Center for Veterans Enterprise, an organizational component of the Office of Small and Disadvantaged Business Utilization on February 14, 2001. Full-time staff within the Center promotes business ownership and expansion for veterans and service-connected disabled veterans. A Fact Sheet describing the work of the Center in its 2-year existence is provided for information purposes.

In an effort to improve VA's HUBZone accomplishments, OSDBU launched an outreach initiative, whereby OSDBU obtained from VA's Financial Management System a record of all contractors and vendors paid during the preceding 18-month period. Using this information and the National Bureau of Standards and Technology's web site to obtain named places by state and zip code, OSDBU wrote to each vendor with a zip code that was potentially located in an eligible non-metropolitan county or census tract to alert the firm of the possibility that they may be HUBZone-eligible.

Approximately 182,000 HUBZone outreach letters were sent to vendors. Nearly 20,000 of these letters were returned as undeliverable, with 89% reaching the addressees. During the six-month period between January 14, 2002 and June 14, 2002, 643 new firms were HUBZone-certified by SBA, bringing the total to 5,187 firms, an increase of approximately 12%.

Of the 643 newly certified HUBZone small businesses, 46 companies, approximately 7%, received letters from VA alerting them to their HUBZone eligibility and may be attributable to the outreach effort.

OSDBU partnered with Veterans Industries at the Washington, DC, VA Medical Center for this initiative. Veterans Industries photocopied and assembled letters and envelopes for mailing. Total cost of the outreach initiative, including first-class postage was nearly $78,000. OSDBU will have to assess the feasibility of future HUBZone Outreach Initiatives given the return of the original efforts.

22. The administration's FY 2004 budget submission requests an increase in FTEE for educational assistance claims processing from 952 to 969. Page 115 of VA's fiscal year 2002 Performance and Accountability Report states quality assurance data for education claims: "Of the 1,541 cases reviewed, there were 110 decisions with payment errors and 340 with service errors (some cases had more than one service error)." A 22 percent service error rate is disappointing. How does the Department plan to address this matter?

Response: Service errors are those errors that do not directly affect payment. They include errors in obtaining evidence, inadequate due process notification, and incorrect communications (internal or external) not involving due process. The service error rate was 20 percent in fiscal year 2001, 22 percent in fiscal year 2002, and is 21 percent for fiscal year 2003 to date.

Over the previous two fiscal years, pending workload was very high, and a large proportion of our Education claims processors were newly hired. Overall quality suffered as a result. The reduction of pending work in the current fiscal year and the increasing experience of the workforce are two factors that should contribute to quality improvement. Results thus far have shown some progress and we expect that progress to continue and accelerate through the rest of this year.

Many of the service errors involve correspondence. To improve the quality of correspondence, Education Service has an ongoing program producing standardized pattern letters. These letters are generated by an application on claims processing workstations, and help to avoid problems in composition that might otherwise occur. In addition, the Regional Processing Offices (RPOs) have recently established regular correspondence reviews to identify problems as they occur.

Education Service conducts quarterly reviews of claims processing for each RPO. The report of the review identifies error trends and recommends refresher training targeted to those trends. Follow-up is done to ensure that appropriate training was given. In addition, RPOs conduct local quality reviews monthly, using the results of the reviews to identify and correct error trends. Education Service also conducts annual appraisal and assistance visits to each RPO, during which the areas of quality and training are reviewed. Where appropriate, recommendations for

improvement are made and then monitored to ensure that they have been put into practice.

Nationwide performance standards for Education claims processors, including a quality element, are currently being tested, and will be implemented during the current fiscal year. Education Service is in the first stages of a project that will result in standardized training and certification for employees.

Education Service is also engaged in a multi-year transition to an automated claims processing system, which will not only speed processing but also help to eliminate errors. Although only a small proportion of claims are now processed automatically, the quality of these actions is very high. We anticipate that expansion of automated processing will improve quality significantly.

23. The FY 2004 budget submission requests 1,204 FTEE for vocational rehabilitation, an increase of 147 over the FY 2002 level and a decrease of one FTEE over last fiscal year. Page 115 of the 2002 Performance and Accountability Report noted an 81 percent accuracy rate for both vocational rehabilitation and employment evaluation, planning, and services, and for accuracy of outcome decisions. Please define in more detail these two categories and explain the significance of the accuracy rate for the vocational rehabilitation participant.

Response: Accuracy for evaluation, planning, and services addresses three important aspects of developing a program of rehabilitation that meets a veteran's individual requirements. Evaluation refers to the assessment of the disabled veteran's physical, medical, psychosocial and employment needs. Planning is the process of developing a course of rehabilitative services based on identified needs. Service delivery refers to the range of assistance provided to the veteran as outlined in the rehabilitation plan.

The accuracy measure in this area is intended to ensure successful rehabilitation programs are developed for the veteran, and that those services and benefits delineated in the rehabilitation plan are appropriately and effectively delivered.

Accuracy of the outcome decisions focuses on the classification of closing a veteran's case. Outcome decisions are of two types: rehabilitated and discontinued. Rehabilitated outcomes occur when veterans have obtained and maintained suitable employment or, in cases where veterans are determined to be unemployable, or they have attained independence in daily living and an improved quality of life. Discontinued outcomes occur when veterans do not initiate or continue the rehabilitation process or, more infrequently, as a result of unsatisfactory conduct and cooperation during the rehabilitation process.

The accuracy measure in this area is intended to ensure that all necessary rehabilitation services have been provided and all efforts have been expended to assist veterans in completing their rehabilitation programs. This measure is also

designed to ensure that successful rehabilitation outcomes comply with statutory requirements for providing vocational rehabilitation benefits to veterans.

24. Question: Page 129 of the FY 2002 Performance and Accountability Report states a "blocked" and "abandoned" telephone call rate of a combined 16 percent.

a. What factors led to this degradation in service?
b. How can VA reduce this percentage?

Response: The number of new and reopened claims pending in the regional offices increased significantly in FY 2001 and through the middle of FY 2002, largely due to the enactment of the Veterans' Claims Assistance Act of 2000 and the addition of type II diabetes as a presumptive disability for veterans with service in Vietnam. The number of phone calls to regional offices therefore increased as well. From FY 2000 to FY 2002, the number of calls went from 20,800,000 to 23,200,000. Our resources were stretched as we worked to reduce the pending inventory, improve timeliness in processing claims, and respond to the increased number of claimants and others calling us for assistance.

VBA's strategy to improve telephone service nationwide is through the deployment of Virtual Information Centers (VIC). VICs network a group of regional offices to allow the transfer of an incoming call to another RO in the VIC if the contacted RO is unable to take the call within 30 seconds.

The economies of scale in a VIC call environment allow VBA to improve service using fewer personnel. During FY 2002 there were two operational VICs that comprised a total of 11 regional offices. The blocked call rate for regional offices operating in a VIC was one percent and the abandoned call rate was five percent. Both performance measures are significantly better than the national average of seven percent blocked and nine percent abandoned. In January 2003, VBA implemented a third VIC in the Central Area that currently includes nine ROs, bringing the national total to 20 regional offices in VICs. Plans are underway for a fourth VIC. VBA will also expand existing VICs between FY 2003 and FY 2008. By the end of FY 2006, 93% of telephone calls to VBA service centers will be answered in a VIC environment.

Attachment A (Response to Question 1)

Literature on Effectiveness of Home and Community-Based Care

I. Non-VA Studies

A. Studies have shown that in-home primary care, skilled nursing, rehabilitation and other services (pharmacy, respiratory therapy, etc.) prevent initial hospitalization or hospital readmissions and reduce overall hospital length of stay in elderly patients with a variety of medical conditions. Outcomes of home-based care were equal or better, and costs were equal or lower, compared to patients treated in-hospital.

Kane, RL, Chen, Q., Finch, M., Blewett, L., Burns, R., Moskowitz, M. The optimal outcomes of post-hospital care under Medicare. Health Services Research. 2000;35(3):615-61. Consecutive patients with one of 5 diagnoses (CVA, COPD, CHF, hip procedures, and hip fracture, discharged from 52 hospitals in 3 cities to one of the following post-hospital settings (rehabilitation facility, nursing home, home with home health care) were followed for 1 year. **FINDINGS**: In general, patients discharged to nursing homes fared worst and those sent home with home health care or to rehabilitation did best. Because the cost of rehabilitation is high, greater use of home care could result in improved outcomes at modest or no additional cost.

Kuisma, R. et. al. A randomized, controlled comparison of home versus institutional rehabilitation of patients with hip fracture. Clinical Rehabilitation 2002;16(5):553-61. This randomized, controlled clinical equivalence trial was conducted at the Queen Elizabeth Hospital in Hong Kong. Forty (40) study group patients were discharged directly home from the acute hospitalization for hip repair and visited by a physiotherapist an average of 4.6 times. The control group of 41 patients were discharged to a rehabilitation center for further treatment lasting on average 36.2 days and they received physiotherapy daily. The mean age of the subjects was 75 year old, 60 percent were female and the majority were retired or homemakers. **RESULTS**: Both groups of patients improved their ambulation ability during their rehabilitation period but neither group achieved their pre-ambulatory status by the time of completion of the study. The study group achieved statistically significant higher ambulation scores for community and household ambulation compared with the control group by the end of the study, a year after hip repair surgery.

Intrator, O., Berg, K. Benefits of home health care after inpatient rehabilitation for hip fracture: health service use by Medicare beneficiaries, 1987-1992. Archives of Physical Medicine and Rehabilitation. 1998;79(10):1195-9. This study examined the Medicare claims from 1 percent of 1986 beneficiaries followed until 1992 who were hospitalized with hip fracture at 70 years or older and who had no major Medicare claims during the year prior to hospitalization and who were discharged home after inpatient rehabilitation. Claims were reviewed for any re-hospitalization and any non-skilled nursing home admission during the 12 months after hospital discharge for hip fracture repair. **RESULTS:** Patients who received additional home health services were less likely to be hospitalized (27.2%) than those who received rehabilitation only (31.1%). They were also less likely to have a non-skilled nursing home admission (11.3% vs. 23.3%) and more likely to survive the year with no subsequent Medicare claims (65% vs. 55%). Further analysis showed that home health was associated with a significantly lower risk of nursing home admission.

Levi, SJ. Posthospital setting, resource utilization, and self-care outcome in older women with hip fracture. Archives of Physical Medicine and Rehabilitation. 1997;78(9):973-9. This was a prospective cohort study to compare post-hospital rehabilitation resource utilization and self-care outcome of women with hip fracture discharged after surgery to three types of settings (home, inpatient rehabilitation, or skilled nursing home). The study sample consisted of 130 community-dwelling women, aged 65 and over, with hip fracture treated at one of 4 hospitals (2 general community hospitals and 2 teaching hospitals). **RESULTS:** For patients discharged to home, inpatient rehabilitation, and skilled nursing home, respectively, mean post-hospital institutional days were 1, 16, and 50; mean sessions of physical therapy were 15, 35, and 50; mean sessions of occupational therapy were 0, 11, and 16; mean 2-month Barthel Activities of Daily Living (ADL) Index (total possible score is 100 = independent in all ADLs) was 93, 89, and 80; and mean 6-month Barthel Index was 89, 88, and 86. Differences in post-hospital institutional days and physical and occupational therapy sessions, but not 2- and 6-month Barthel Indes, were statistically significant after controlling for patient characteristics. It was concluded that type of post-hospital setting is associated with resource utilization but not self-care outcome after hip fracture.

Nauffal, D., Domenech, R., Martinez Garcia, MA., Compte, L., et al. Non-invasive positive pressure home ventilation in restrictive disorders: outcome and impact on health-related quality of life. Respiratory Medicine 2002;96(10):777-83. This study conducted in Spain was designed to investigate the long-term effects of noninvasive positive pressure home ventilation (NIPPHV) upon dyspnea, health-related quality of life (HRQL), lung function and hospitalization rate in 35 patients with kyphoscoliosis and 27 patients with several neuromuscular disorders. Dyspnea, HRQL, lung function and nocturnal oxygen saturation (SaO2) were measured before and after 3, 6, 9, 12, and 18 months of NIPPHV use. **RESULTS:** NIPPHV improved dyspnea, SaO2 and quality of life and reduces PaCO2 in patients with kyphoscoliosis and the improvements persisted for 18 months after the start of HIPPHV. Neuromuscular patients showed only an improvement pm SaO2 and quality of life that disappeared in the long-term follow-up. Hospitalization rate decreased for both groups.

Cotton, NM., Bucknall, CE., Dagg, KD., Johnson, MK., et. Al. Early discharge for patients with exacerbations of chronic obstructive pulmonary disease: a randomized controlled trial. Thorax 2000;55(11):902-6. This is a controlled trial to compare early discharge with home treatment supported by respiratory nurses with conventional hospital management of patients admitted with exacerbations of chronic obstructive pulmonary disease (COPD). The study was conducted in the United Kingdom and included 81 patients (41 in the study group; 40 in the control group) with COPD who were admitted to the hospital as emergencies and identified for the study the next working day. If patients had other medical conditions or acidotic respiratory failure requiring inpatient management, they were excluded from the study. The study group was discharged early from the hospital and continued treatment at home under the supervision of specialist respiratory nurses. The control group received conventional care. **RESULTS:** On an intention to treat basis, the mean inpatient hospital stay for the study group was 3.2 days compared to 6.1 days for the control group. Twelve patients (29.3% study group; 30% control group) were re-admitted to the hospital from each group. For these re-admitted patients, the study group spent a mean of 7.83 days in the hospital compared to 8.75 for the control group. There was one death in the study group and 2 deaths in the control group. It was concluded that patients with acute exacerbations of COPD uncomplicated by acidotic respiratory failure of other medical problems can be discharged home earlier than is current practice with support by visiting respiratory nurses.

Sommers, LS., Marton, KI., Barbaccia, JC., Randolph, J. Physician, nurse, and social worker collaboration in primary care for chronically ill seniors. Archives of Internal Medicine. 2000;160(12):1825-33. A concurrent, controlled cohort study of 543 patients in 18 private office practices of primary care physicians was conducted. The intervention group received care from their primary care physician working with a registered nurse and a social worker, while the control group received care as usual from their primary care physician. **RESULTS**: From 1992 (baseline year) to 1993, the two groups did not differ in service use or in self-reported health status. From 1993 to 1994, the hospitalization rate of the control group increased from 0.34 to 0.52 while the rate in the intervention group remained at baseline (P=. 03). The proportion of intervention patients with readmissions decreased from 6% to 4% while the rate in the control group increased from 4% to 9%. Mean office visits to all physicians fell by 1.5 visits for the intervention group compared to a 0.5 visit increase in the control group. With fewer hospital admissions, average per-patient savings for 1994 were $90 inclusive of the intervention's cost but exclusive of savings from fewer office visits.

Stoddart, H., Whitley, E., Harvey, I., Sharp, D. et. Al. What determines the use of home care services by elderly people? Health & Social Care in the Community 2002;10(5):348-60. The objective of this study was to investigate the determinants of use of statutory and private home care services by older people living in the community in a British city. A questionnaire was distributed to a stratified random sample of 2000 elderly people, equal numbers of men and women, age 65-74, and 75 years or over. The outcome measures were the use of statutory or private home care services in the previous 3 months. The response rate was 79 percent. **FINDINGS:** Increasing age, not owning a car and being a widow(er) were associated with greater use of both statutory and private home care services, as was worse self-reported overall health. Worse physical functioning, worse emotional health, problems with cognition, foot problems and a greater number of falls were also determinants of use of home care services. Problems with eyesight were determinants for both types of home care services for women, but only private services for men. For women, leakage of urine was associated with greater use of private services. Older age on leaving full-time education was associated with increased use of private home care services. Social networks and social support were not generally associated with use of these services after controlling for demographic factors. Understanding the determinants for the use of both statutory and private home care services is important because of the increasing numbers of elderly people in the United Kingdom and the policy to maintain older people in their own homes. Purchasers and providers should be able to address at least some of the modifiable predictors.

Harjai, KJ., Mehra, MR., Ventura, HO., Lapeyre, YM. et. al. Home inotrpic therapy in advanced heart failure: Cost analysis and clinical outcomes. Chest 1997;112(5):1298-1303. This was a retrospective analysis of 24 patients (13 men; 11 women; age, 61 + or –12) with left ventricular ejection fraction <30% and heart failure refractory to oral agents requiring home IV inotropic therapy for at least 4 consecutive weeks between May 1994 and April 1996. Inotropic agents included dobutamine or milrinone. Costs of care and clinical outcomes were compared during the period of inotropic therapy (study period) and the immediate preceding period of equal duration (control period). **FINDINGS:** Compared to the control period, the study period (mean 3.9 mos.) was associated with a 16% reduction in cost, amounting to a calculated savings of $5,700 per patient or $1,465 per patient month. Concomitantly, a decrease in the number of hospital admissions from a mean of 2.7 to 1.3 and length of stay from 20.9 to 5.5 days was observed with improvement in New York Heart Association (NYHA) functional class from a mean of 4 to 2.7. Eight (8) patients (38%) died after 2.8 months of home IV inotropic therapy.

Von Koch, L., de Pedro-Cuesta, J., Kostulas, V., Almazan, J., Widen Holmqvist, L. Randomized controlled trial of rehabilitation at home after stroke: one-year follow-up of patient outcome, resource use and cost. Cerebrovascular Diseases: Basel, Sweden 2001;12(2):131-8. Eighty-three (83) patients, moderately impaired 5-7 days after acute stroke, were included in a randomized controlled trial, 42 in the intervention group and 41 in the rehabilitation group. The intervention group discharged early from the hospital into a home rehabilitation program including occupational, physical, and speech and language therapists. All patients were independent in toileting and in feeding. One-year follow-up of patient outcome included mortality, motor capacity, dysphasia, activities of daily living, social activities, perceived dysfunction, and self-reported falls. Resource use over 12 months included inpatient hospital care, outpatient health care, use of health-related services, informal care, and cost of health care. **RESULTS:** On univariate analysis there was no difference in patient outcome. Multivariate analysis showed that the intervention had a significant effect on independence in activities of daily living. A significant difference in inpatient hospital care, initial and recurrent, was observed, with a mean of 18 (intervention) versus 33 (control) days. The control group registered more outpatient visits to hospital occupational therapists, private physical therapists and day hospital attendance while the intervention group registered more visits to nurses in primary care and home rehabilitation. No other significant differences in outcome or resource utilization were found. It was concluded that in Sweden, the early supported discharge with continued rehabilitation at home proved no less beneficial as a rehabilitation service and provided care and

rehabilitation for 5 moderately disabled stroke patients over 12 months after stroke onset for the cost o 4 in routine rehabilitation.

Anderson, C., Rubenach, S., Mhurchu, CN., Clark, M., Spencer, C., Winsor, A. Home or hospital for stroke rehabilitation? results of a randomized controlled trial: health outcomes at 6 months. Stroke: A Journal of Cerebral Circulation 2000;31(5):1024-31. This was a study conducted in South Australia comparing early hospital discharge and home-based rehabilitation with usual inpatient rehabilitation and follow-up care. The trial was carried out in 2 affiliated teaching hospitals and included 86 patients with acute stroke (mean age of 75 years old) who were admitted to the hospital and required rehabilitation. Forty-two (42) patients received early hospital discharge and home-based rehabilitation (median duration, 5 weeks) and 44 patients continued with conventional rehabilitation. The primary end point was self-reported general health status (SF-36) at 6 months after randomization. A number of secondary outcome measures were also assessed. **RESULTS:** Overall, clinical outcomes for patients did not differ significantly between the groups at 6 months, but the total duration of hospital stay in the experimental group was significantly reduced (15 versus 30 days). Caregivers among the home-based rehabilitation group had significantly lower mental health SF-36 scores.

Talcott, JA., Whalen, A., Clark, J., Rieker, PP., Finberg, R. Home antibiotic therapy for low-risk cancer patients with fever and neutropenia: a pilot study of 30 patients based on a validated prediction rule. Journal of Clinical: Official Journal of the American Society of Clinical Oncology 1994;12(1):107-14. Newly admitted outpatients with fever and neutopenia were evaluated for home therapy during 2 days of inpatient observation. To evaluate enrolled patients' acceptance of home care, patient attitudes and quality of life before and after home therapy were assessed. To assess economic effects, medical charges of patients treated at home were compared with those of medically eligible patients who remained in the hospital. **RESULTS:** The 30 patients treated at home were neutropenic for a median of 6 days. Four (4) of these patients had medical complications and 5 others were readmitted for observation. Patients' quality of life improved during home therapy and favorable attitudes toward home care persisted after treatment. Medically eligible patients not enrolled in the home care program had briefer neutropenia than patients treated at home but had 44% higher daily medical charges and equivalent overall charges despite treatment half as long as those in home care.

Grayson, ML., Silvers, J., Turnidge, J. Home intravenous antibiotic therapy. A safe and effective alternative to inpatient care. Medical Journal of Australia 1995;162(5):249-53. Patients with serious bacterial

infections requiring parenteral antibiotic therapy were enrolled in a pilot program to receive treatment at home. Antibiotics were premixed in the hospital pharmacy and administered by the Royal District Nursing Service in Melbourne, Australia, and medical back-up was provided. **RESULTS:** Twenty (20) patients (mean age 58, range 19-84 years) received 21 courses of intravenous antibiotics at home (mean duration 26 days, range 11-44 days). Conditions treated included osteomyelitis (10 pts.), endocarditis (5 pts.), vascular graft and pacemaker sepsis (4 pts.) and chronic cellulitis (1 pt.). Treatment at home was well tolerated with no significant complications and cure was achieved in 18 of 20 patients. A mean benefit in treatment costs between home and the equivalent inpatient therapy was calculated at a minimum of $112 per day for the 538 days that home therapy was provided. The reduced bed use by the patients treated at home was determined to allow an additional hospital throughput of between 86 and 107 patients annually.

Jordhoy, MS., Fayers, P., Saltnes T., Ahlner-Elmqvist, M., Jannert, M., Kaasa, S. A palliative-care intervention and death at home: a cluster randomized trial. Lancet 2000;356(9233);888-93. The Palliative Medicine Unit at University Hospital of Tronheim, Norway, started an intervention program aimed at enabling patients to spend more time at home and die there if they prefer. Close cooperation was needed with the community health-care professionals, who acted as the principal formal caregivers, and a multidisciplinary consultant team who coordinated the care. This study assesses the intervention's effectiveness compared with conventional care. Four hundred and thirty-four (434) patients (235 assigned intervention and 199 conventional care) who had incurable malignant disease and an expected survival of 2-9 months were enrolled in the study. Main outcomes were place of death and time spent in institutions in the last month of life. **FINDINGS:** Of the 395 patients who died, significantly more intervention patients than controls died at home (54(25%) vs. 26 (15%)). The time spent at home was not significantly increased, although intervention patients spent a smaller proportion of time in nursing homes in the last month of life than did controls (7.2% vs. 14.6%). Hospital use was similar in the two groups.

Strauss, MJ., Gong., Gary, BD., Kalsbeek, WD., Spear, S. The cost of home air-fluidized therapy for pressure sores. A randomized controlled trial. Journal of Family Practice 1991;33(1):52-9. One hundred twelve (112) patients with 3rd or 4th stage pressure sores were randomly assigned to 36 weeks of either 1) home air-fluidized bed therapy (CLINITRON Therapy Unit) that included the services of a visiting nurse specialist as long as the patient had 3rd or 4th stage pressure sores, or 2) home conventional therapy (alternating pressure pads, air-support mattresses, water mattresses or high-density foam pads). **RESULTS:**

Compared with patients in the control group, patients receiving air-fluidized bed therapy spent significantly fewer days in the hospital (11.4 days vs. 25.5 days) and used fewer total inpatient resources, as reflected both in charges ($13,263 vs. $25,736) and in Medicare Diagnostic Related Group (DRG) and physician payments ($6,646 vs. $12,131). Total cost of healthcare resources used (inpatient and outpatient) was only slightly lower for patients treated with air-fluidized bed therapy ($29,016 vs. $34,747), primarily due to the cost of the air-fluidized therapy for the treatment group. Clinical outcomes were similar.

B. Studies have shown that more intensive therapy in institutional settings provides improved outcomes when patients are more severely impaired, demonstrating that there is a role for institutional services and that patient management must be individualized to the patient's circumstances.

Chiu, L., Shyu, WC., Liu, YH. Comparisons of the cost-effectiveness among hospital chronic care, nursing home placement, home nursing care and family care for severe stroke patients. Journal of Advanced Nursing 2001;33(3):380-386. Three hundred and thirteen (313) hospitalized stroke patients followed from discharge from a Taipei metropolitan area hospital until 3 months post-discharge. **RESULTS**: Caring for patients in their own homes was not only more expensive (considering cost of family labor) but also less effective in improving Activities of Daily Living (ADL) scores than caring for patients in nursing homes and in chronic care units of hospitals.

Ozdemir, F., Birtane, M., Tabatabaei, R., Kokino, S., Ekuklu, G. Comparing stroke rehabilitation outcomes between acute inpatient and nonintense home settings. Archive of Physical Medicine and Rehabilitation. 2001;82(10):1375-1379. Randomized clinical trial of 60 stroke patients (30 in inpatient rehabilitation, 30 in home-based rehabilitation comprised of conventional exercises with family caregiver and limited professional supervision) between the ages of 43-80 years. All patients referred to the study were medically stable. Both groups were similar on baseline demographic, physical and medical characteristics. The home-based rehabilitation group and their family caregiver were visited and instructed by a rehabilitation physician and physiotherapist for 2 hours each week. RESULTS: Patients rehabilitated in acute inpatient setting had better motor, functional and cognitive outcomes with relatively low complications than did those in non-intense rehabilitation efforts in home settings.

Andrew, T., Moriarty, J., Levin, E., Webb, S. Outcome of referral to social services department for people with cognitive impairment. International Journal of Geriatric Psychiatry. 2000;15(5):406-14. The objective of this cohort study was to determine how the entry into long term care (NHC)

of people assessed by their local social services departments under the National Health Service and Community Care Act of 1990 (United Kingdom) is predicted by the severity of their cognitive impairment, care provided by family members, and the receipt of community care services. The study included 141 people with cognitive impairment aged 65 and older who were followed for 11/2 years after referral. **FINDINGS**: The receipt and intensity of community care services increased the probability of remaining at home. People with mild to moderate cognitive impairment were more likely to remain at home if they had a spouse or daughter as carer. Analysis of the interaction between the 3 main effects predicting entry into long term care (NHC) suggests that while carers are central in determining whether older people with cognitive impairment are able to remain living in the community, there are limits to the care they can provide.

Kelly, MH., Ackerman, RM. Total joint arthroplasty: a comparison of postacute settings on patient functional outcomes. Orthopaedic Nursing/National Association of Orthopaedic Nurses. 1999;18(5):75-84. This descriptive comparative study used a convenience sample of 96 patients having total joint arthroplasty performed by one physician within one institution. The post-acute care setting (subacute rehabilitation unit versus home with home physical therapy) was self-selected by the patients after information was provided on both options. **FINDINGS**: All patients improved significantly over time in all subscores and in total functional score. The mean total cost of the joint replacement for the subjects who went to the subacute unit was $24,144 compared to $16,918 for those who received therapy at home. The groups were significantly different demographically with the subacute being older (>75), likely to have comorbidities and to live alone.

C. There is evidence that home health care decreases nursing home lengths of stay and/or improves outcomes:

Kane, RL, Chen, Q., Finch, M., Blewett, L., Burns, R., Moskowitz, M. The optimal outcomes of post-hospital care under Medicare. Health Services Research. 2000;35(3):615-61. Consecutive patients with one of 5 diagnoses (CVA, COPD, CHF, hip procedures, and hip fracture, discharged from 52 hospitals in 3 cities to one of the following post-hospital settings (rehabilitation facility, nursing home, home with home health care) were followed for 1 year. **FINDINGS:** In general, patients discharged to nursing homes fared worst and those sent home with home health care or to rehabilitation did best. Because the cost of rehabilitation is high, greater use of home care could result in improved outcomes at modest or no additional cost.

Intrator, O., Berg, K. Benefits of home health care after inpatient rehabilitation for hip fracture: health service use by Medicare

beneficiaries, 1987-1992. Archives of Physical Medicine and Rehabilitation. 1998;79(10):1195-9. Medicare claims were reviewed for persons hospitalized with hip fracture at 70 years or older who had no major Medicare claims during the year before hospitalization and who were discharged home after inpatient rehabilitation. **FINDINGS**: Patients who received additional home health services were less likely to be hospitalized (27.2%) than those who received rehabilitation only (31.1%), were also less likely to have a non-skilled nursing home admission (11.3% vs. 23.3%), and were more likely to survive the year with no subsequent Medicare claims (65.6% vs. 55%).

Jordhoy, MS., Fayers, P., Saltnes T., Ahlner-Elmqvist, M., Jannert, M., Kaasa, S. A palliative-care intervention and death at home: a cluster randomized trial. Lancet 2000;356(9233);888-93. The Palliative Medicine Unit at University Hospital of Tronheim, Norway, started an intervention program aimed at enabling patients to spend more time at home and die there if they chose. Close cooperation was needed with the community health-care professionals, who acted as the principal formal caregivers, and a multidisciplinary consultant team who coordinated the care. This study assesses the intervention's effectiveness compared with conventional care. Four hundred and thirty-four (434) patients (235 assigned intervention and 199 conventional care) who had incurable malignant disease and an expected survival of 2-9 months were enrolled in the study. Main outcomes were place of death and time spent in institutions in the last month of life. **FINDINGS:** Of the 395 patients who died, significantly more intervention patients than controls died at home (54(25%) vs. 26 (15%)). The time spent at home was not significantly increased, although intervention patients spent a smaller proportion of time in nursing homes in the last month of life than did controls (7.2% vs. 14.6%). Hospital use was similar in the two groups.

Andrew, T., Moriatry, J., Levin, E., Webb, S. Outcome of referral to social services departments for people with cognitive impairment. International Journal of Geriatric Psychiatry 2000;15(5):406-414. The objective of this study was to determine how the entry into long-term care of people assessed by their local social services department (SSD under the National Health Service and Community Act of 1990 – United Kingdom) is predicted by the severity of their cognitive impairment, care provided by family members, and the receipt of community care services. The study included a cohort of 141 people with cognitive impairment and aged 65 and over, followed for over one and a half years after referral from three SSDs (county council, metropolitan and inner London boroughs). **FINDINGS:** The receipt and intensity of community care services increased the probability of remaining at home. People with mild or moderate cognitive impairment were more likely to remain at

home if they had a spouse of daughter carer. Analysis of the interaction between three main effects predicting entry to long-term care (severity of cognitive impairment, access to a carer, and the receipt of home care or day care) suggests that while carers are central in determining whether older people with cognitive impairment are able to remain living in the community, there are limits to the care they can provide.

D. Impact of case management/care management

Poole, PJ., Chase, B., Frankel, A., Black, PN. Case management may reduce length of hospital stay in patients with recurrent admissions for chronic obstructive pulmonary disease. Respirology. 2001;6(1):37-42. Case control study of a total of 32 patients with at least 4 admissions for COPD in the previous 2 years to hospitals in New Zealand. Case management by a clinical nurse specialist introduced for 16 of the patients. **RESULTS**: In first year of case management, the number of hospital bed days fell to 8 per patient from 22 per patient the previous year, mainly due to reduction in LOS from 5.6 to 3.5 days. Control group had no change in LOS. Case managed patients had a significant improvement in their quality of life scores.

Murtaugh Christopher, M., Litke, A. Transitions through postacute and long-term care settings: patterns of use and outcomes for a national cohort of elders. Medical care. 2002;40(3):227-36. A 2-year longitudinal study of utilization of short-stay hospitals and postacute and long-term care settings by 4.9 million elders who responded in 1992 to the National Long Term Care Survey published in 1994. Indicators of potential transition problems include emergency room visits, potentially avoidable hospital stays, and return to an institutional setting following discharge to the community. **RESULTS**: Nearly 18% of elders were admitted to or discharged from a study setting between 1992 and 1994. Of these, 22.4% had subsequent health care use, suggesting a transition problem. Transitions from acute care hospitals to paid home care represented 20.8% of all transitions that were followed by relatively high rates of potential problems. Care coordination strategies for improving outcomes of transitions through postacute and long-term care settings are suggested.

E. Telehomecare

Dansky, KH., Palmer, L., Shea, D., Bowles, KH. Cost analysis of telehomecare. Telemedicine Journal and E-Health: the Official Journal of the American Telemedicine Association. 2001;7(3):225-32. A descriptive study on the clinical outcomes and costs associated with a telehomecare intervention in a large, urban, home health agency. **RESULTS**: While telehomecare imposes additional expenses for care

delivery, it contributes substantial savings without compromising quality. The financial benefit increases exponentially as the duration of the patient care episode increases.

Hoskins, LM., Clark, HM., Schroeder, MA., Walton-Moss, B., Thiel, L. A clinical pathway for congestive heart failure. Home Healthcare Nurse. 2001;19(4):207-17. This was Part II of a study that compared two groups of elderly home health patients with congestive heart failure (CHF). One group's plan of care was guided by a clinical pathway while the other group's was not. In the first part of the study, the rehospitalization rate in the group not on the clinical pathway was 22.9% versus 12.5% in the clinical pathway group. Part II of the study included 67 patients on the clinical pathway and 140 patients in the usual care group and describes intermediate patient outcomes and analysis of selected variables for their impact on rehospitalization. **FINDINGS:** The most important single factor contributing to the risk of rehospitalization was a declining ability to demonstrate tolerance to gradual activity increase. Second in importance was the ability to stat 2 complications of CHF (consequences of noncompliance). Use of telehealth is recommended as one mechanism for addressing the impact of Prospective Payment System on home health care and to ensure improved care beyond those focusing on the use of the pathway.

Johnston, B., Wheeler, L., Deuser, J., Sousa, KH. Outcomes of the Kaiser Permanente Tele-Home Health Research Project. Archives of Family Medicine. 2000;9(1):40-5. A quasi-experimental study of newly referred patients diagnosed as having congestive health failure, chronic obstructive pulmonary disease, cerebral vascular accident, cancer, diabetes, anxiety, or need for wound care. Intervention group of 102 had home health care and access to a remote video system allowing nurses and patients to interact in real time. Control group of 110 had routine home health care and telephone contact. **RESULTS**: No differences were found between the two groups in the quality indicators, patient satisfaction, or use of services. Although the average cost for home health services was $1830 in the intervention group and $1167 in the control group, the total mean costs of care, excluding home health care costs, were $1948 in the intervention group and $2674 in the control group.

Kobza, L., Scheurich, A. The impact of telemedicine on outcomes of chronic wounds in the home care setting. Ostomy/Wound Management. 2000;46(10):48-53. A descriptive study comparing the utilization of telemedicine in situations where wound specialists consulted with the home health nurse in the patient's home regarding care of chronic wounds with like data collected as a baseline prior to the telemedicine intervention. **RESULTS**: The telemedicine intervention group had

improved healing rates, decreased healing time, decreased number of home health visits, and a decreased number of hospitalizations related to wound complications.

II. VA Studies

A. Studies have shown that In-home primary care, skilled nursing, rehabilitation and other services (pharmacy, respiratory therapy, etc.) prevent initial hospitalization or hospital readmissions and reduce overall hospital length of stay in elderly veterans with a variety of medical conditions. Outcomes of home-based care were equal or better, and costs were equal or lower, compared to patients treated in-hospital.

Ritchie, CA., Thomas, DR. Home-based primary care in the VA setting, with a focus on Birmingham, Alabama. Journal of Long-Term Home Health Care: The PRIDE Institute Journal. 1998;17(4):18-25. This is a descriptive study of VA's Home-Based Primary Care (HBPC) Program, which provides comprehensive primary care to homebound veterans. Unlike Medicare-funded home care, it is not oriented to episodic provision of skilled nursing care, but rather to long-term primary care in the home by an interdisciplinary team including a physician. **FINDINGS**: Outcomes assessment of care provided through HBPC has been positive, suggesting an overall improvement in patient function and decrease in health care costs among those enrolled in the program. The HBPC Program offers a tested model of primary home care within a "managed care" model and should be considered by those initiating managed primary home care within the private sector.

Hughes, S., Cummings, J., Weaver, F., Manheim, L., Braun, B., Conrad, K. A randomized trial of the cost effectiveness of VA Hospital-Based Home Care for the terminally ill. Health Services Research. February 1992, (26.6);801-817. All admissions to a 1,100 bed Veterans Affairs (VA) hospital were screened to identify 171 terminally ill patients with informal caregivers who were then randomly assigned to VA HBHC (N=85) or customary care (N=86). Patient functioning, and patient and caregiver morale and satisfaction with care were measured at baseline, one month and six months. Health services utilization was monitored over the six-month study period and converted to cost. **FINDINGS:** There were no differences in patient survival, activities of daily living, cognitive functioning or morale but a significant increase in patient ($p=.02$) and caregiver ($p=.005$) satisfaction with care at one month in the HBHC group. Those in the HBHC group used 5.9 fewer VA hospital days resulting in a $1,639 or 47% per capita saving in VA hospital costs. As a result, total per capita health care costs, including HBHC, were $769 or 18 percent lower in the HBHC sample, indicating that expansion of VA HBHC to serve terminally ill veterans would increase satisfaction with care at no additional cost.

Cummings, J., Hughes, S. Weaver, F., Manheim, L., Conrad, K., Nash, K., Braun, B., Adelman, J. Cost-effectiveness of Veterans Administration Hospital-Based Home Care. Archives of Internal Medicine. June 1990, (150), 1274-1280. Patients (N=419) with two or more functional impairments or a terminal illness were randomized to hospital-based home care (HBHC) or customary care. Functional status, satisfaction with care, and morale were measured at baseline and at 1 and 6 months. **FINDINGS:** There was significantly higher patient and caregiver satisfaction with care at 1 month and lower VA and private sector hospital costs ($3,000 vs. $4,245) for the HBHC group. Net per person health care cost were also 13% lower in this experimental group.

Hughes, S., Cummings, J., Weaver, F., Manheim, L., Conrad, K., Nash, K. A randomized trial of Veterans Adminstration Home Care for severely disabled veterans. Medical Care, 1990, 28(2);135-145. This randomized study screened hospital admissions to all wards except Psychiatry and Spinal Cord Injured during a 3-year period to identify 233 severely disabled patients (2 impairments on the Katz Index of ADL) and caregivers who were willing to participate in a pretest-multiple posttest trial of the Hines VA Hospital-based Home Care (HBHC) Program. Patient functional status, morale, and satisfaction with care were measured at baseline, 1 month and 6 months post discharge. All health care services used by both groups were tracked over the 6-month period and converted to cost. **FINDINGS:** There was significantly improved 1-month satisfaction with care and improved 6-month cognitive functioning among HBHC patients and 1-month and 6-month satisfaction with care among their caregivers. A non-significant 10% decrease in net cost of care was found in the HBHC group, largely due to lower use of private sector hospital care.

West, JA., Miller, NH., Parker, KM., Senneca, D. et. Al. A comprehensive management system for heart failure improves clinical outcomes and reduces medical resource utilization. American Journal of Cardiology 1997;79(1):58-63. This study evaluated the feasibility and safety of MULTIFIT, a physician-supported, nurse-mediated, home-based system for heart failure management that implements consensus guidelines for pharmacologic and dietary therapy using a nurse manager to enhance patient adherence and to monitor clinical status by frequent telephone contact. Fifty-one (51) patients with the clinical diagnosis of heart failure were followed for a mean of 138 days. **FINDINGS:** Daily dietary sodium intake fell by 38% from 3,393 to 2,088 mg.; average daily medication doses increased significantly (lisinopril: 17-to 33 mg.; hydralazine: 140 to 252 mg.). Functional status and exercise capacity improved significantly. Compared with the 6 months before enrollment and normalized for variable follow-up, the frequency of general medical and cardiology visits declined by 23% and 31% respectively; emergency

room visits for heart failure and for all causes declined 67% and 53% respectively. Hospitalization rates for heart failure and for all causes declined 87% and 74%, respectively, compared with the year before enrollment. The MULTUFIT system enhanced the effectiveness of pharmacologic and dietary therapy for heart failure in clinical practice, improving clinical outcomes and reducing medical resource utilization.

Impact of case management/care management, and Telehomecare

Meyer, M., Kobb, R., Ryan, P. Virtually healthy: Chronic Disease Management in the Home. Disease Management, 2002; 5(2), 87-94. Beginning in April 2000, eight clinical demonstration projects were funded for 2 years within the Sunshine Network (Florida, Southern Georgia, Puerto Rico) of the Veterans Health Administration to test disease management principles, the care coordinator role, and the effective use of technology to maintain veterans in their homes. Five of these projects focused on complex medical/chronic disease populations. Seven hundred and ninety-one (791) veterans were recruited in these five projects and enrolled in the Community Care Coordination Service (CCCS), an "aging in place" model. The purpose behind the integration of the care coordinator role with technology was to improve health status, increase program efficiency, and decrease resource utilization. **FINDINGS:** Evaluation results to date have shown a 40% reduction in emergency room visits, 63% reduction in hospital admission, 60% reduction in hospital bed days of care, 64% reduction in VHA nursing home admissions, and 88% reduction in nursing home bed days of care. All Performance Improvement outcomes reached or exceeded the targeted goals and a functional assessment revealed five significant improvements out of 10 domains of the SF 36V.

CONGRESSMAN SIMMONS TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Rob Simmons, Chairman
Subcommittee on Health
Committee on Veterans' Affairs
February 11, 2003

Hearing on the Department of Veterans Affairs
Budget Request for Fiscal Year 2004

1. In reviewing the December 2002 GAO report entitled, "Managing for Results: Efforts to Strengthen the Link Between Resources and Results at the VHA," on page 16, GAO notes that certain VHA officials, such as network directors, sign an annual performance agreement with the Under Secretary for Health, called the Network Performance Plan, and that based on how they do in the course of a year, they may receive a bonus. Mr. Joseph Violante, of Disabled American Veterans, testified during the hearing that 85 percent of network directors received bonuses last year. What bonuses were paid last year and to whom? What are the criteria for receiving a bonus? Has anyone been penalized for not meeting performance standards?

Response: Bonuses are based on the network directors' performance, including their personal achievements, as framed in our eight core competencies, their VISN's performance as measured by the performance measures and monitors they were held accountable for, achievements on national assignments, and achievements in support of the President's Management Agenda. VHA has consistently improved performance over the past 5-6 years, to the point where many aspects of VHA healthcare are benchmarked against other private and public healthcare organizations. The Network Directors are largely responsible and accountable for those improvements. Since VHA implemented its new performance-contract-based senior executive performance system in 1996, top VA management have consistently awarded an annual performance bonus to network directors in recognition of the highest level of responsibilities Because of VISN and system-wide performance (with very rare exception), network directors receive either a performance bonus or a Presidential Rank Award every year under VHA's performance program. Attachment A contains a listing of bonuses paid in FY 2002.

2. One of the four primary missions of VA is to backup the Department of Defense health system in a time war or other emergencies. What has the VA done in support of DoD emergency preparedness, particularly in the area of bioterrorism?

Response: The Secretary of Veterans Affairs recently approved consolidation of VA's emergency preparedness responsibilities under the Office for Policy, Planning, and Preparedness. That office is coordinating a number of actions to prepare VA to respond to the requirements of the VA/DoD Contingency Hospital

System. VA carries out its responsibilities under PL 97-174 primarily by providing available beds at VA Primary Receiving Centers under a contingency plan to provide hospital care for DoD casualties as required. Under the VA/DoD Contingency Hospital System, VA could make available up to approximately 6,000 VA beds to treat DoD casualties.

With regard to terrorism, the Bay Pines, Florida, and Little Rock, Arkansas VA Medical Centers rolled out their "train the trainer" program. The goal is to train 300 teams from 75 VA facilities over the next 12 months on decontamination procedures. VA is contracting for personal protective equipment (PPE) and decontamination equipment that will enable the Department to better respond and continue the treatment of casualties in case of any weapons of mass destruction attack.

Under the requirements of 38 U.S.C. § 8111A and the associated Memorandum of Understanding (MOU) between VA and the Department of Defense (DoD), VA provides care for military patients during time of war or other national emergency. VA's responsibilities are carried out through development of contingency plans at each VISN and at VA medical Centers (VAMCs) identified as Primary Receiving Centers, Secondary Support Centers, and Installation Support Centers. The Plans address the process for receipt and care of casualties at the VAMCs and include features unique to each individual VAMC's role and required VA, DOD, and community resources. The Plans are reviewed and revised annually, if necessary.

In addition, an interagency partnership, the National Disaster Medical System (NDMS) exists among VA, DoD, the Public Health Service (Health and Human Services), and the Federal Emergency Management Agency. Under the NDMS, identified VAMCs and DoD Medical Treatment Facilities are designated as Federal Coordinating Centers (FCCs). The FCCs, through MOUs with civilian hospitals, coordinating the use of staffed hospital beds for use by civilian casualties of a disaster or other catastrophic event or by military casualties, in the event that DoD or VA beds are at capacity.

VA's Emergency Management Strategic Healthcare Group (EMSHG) is the internal executive agent for both VA-DoD contingency planning and for NDMS. EMSHG Area Emergency Managers serve as Coordinators at the VAMCs designated as FCCs. EMSHG assists the VISNs and VAMCs in carrying out the mission to provide care to DoD casualties through conducting routine bed reporting exercises, whereby they report numbers of available, staffed beds at VAMCs for VA-DoD contingency and at NDMS-enrolled civilian hospitals for NDMS FCCs. The bed numbers are reported to the Air Force Global Patient Movement Requirements Center, which manages patient/casualty transport for both programs. EMSHG also coordinates and assists the VISNs and VAMCs in the conduct of training and exercises, including those focused on issues involving biological and other weapons of mass destruction; reviewing and revising applicable plans; identifying, developing, and equipping patient reception team; interfacing with appropriate

community resources; obtaining required goods and services for Plan activation; and in other ways to ensure effectiveness.

3. Among other factors, income helps determine a veteran's priority status. Does this include an asset test?

Response: If a veteran's annual income is at or below the income threshold levels established under 38 U.S.C. §1722(b)(1), VA is required to consider the veteran's assets (commonly referred to as corpus of the estate or net worth). The asset determination is made in the same manner in which net worth determinations are made for pension benefits. The determination process based on income and assets establishes the enrollment priority groups to which certain veterans are assigned and which veterans must make medical care co-payments.

Attachment 1 (Response to Question 1)

VISN/ HQ ORG	POSITION TO WHICH ASSIGNED 9/30/2002	EXECUTIVE	2002 APPROVED BONUSES
VISN 1	Network Director, VISN 1, VISN Office - Bedford, MA	CHIRICO-POST, Jeanette MD	15,000
VISN 2	Acting Network Director, VISN 2, VISN Office - Albany, NY	FLESH, Lawrence H. MD	15,000
VISN 3	Network Director, VISN 3, VISN Office - Bronx, NY	FARSETTA, James J	26,000
VISN 4	Network Director, VISN 4, VISN Office - Pittsburgh, PA	BIRO, Lawrence A	15,000
VISN 5	Network Director, VISN 5, VISN Office - Linthicum, MD	NOCKS, James J MD	20,000
VISN 6	Network Director, VISN 6, VISN Office - Durham, NC	HOFFMANN, Daniel F	26,000
VISN 7	Network Director, VISN 7, VISN Office - Atlanta, GA	DEAL, Larry R	20,000
VISN 8	Network Director, VISN 8, VISN Office - Bay Pines, FL	HEADLEY, Elwood J MD	20,000
VISN 9	Network Director, VISN 9, VISN Office - Nashville, TN	DANDRIDGE, John J. Jr,	20,000
VISN 10	Network Director, VISN 10, VISN Office - Cincinnati, OH	PARKIS, Clyde L.	26,000
VISN 11	Network Director, VISN 11, VISN Office - Ann Arbor, MI	BELTON, Linda W	20,000
VISN 12	Network Director, VISN 1 2, VISN Office - Hines, IL	CUMMINGS, Joan E MD	12,000
VISN 15	Acting Network Director, VISN 1 5, VISN Office - Kansas, City, MO	NORBY, Ronald B RN	26,000
VISN 16	Network Director, VISN 1 6, VISN Office - Jackson, MS	LYNCH, Robert E MD	26,000
VISN 17	Network Director, VISN 1 7, VISN Office - Dallas, TX	STRANOVA, Thomas J	15,000
VISN 18	Network Director, VISN 1 8, VISN Office - Mesa, AZ	JENKINS, Smith, Jr	15,000
VISN 20	Network Director, VISN 20, VISN Office - Portland, OR	BURGER, Leslie MD	15,000
VISN 21	Network Director, VISN 21, VISN Office, Vallejo, CA	WIEBE, Robert L MD	26,000
VISN 22	Network Director, VISN 22, VISN Office - Long Beach, CA	CLARK, Kenneth J	20,000
VISN 23	Network Director, VISN 23, VISN Office - Minneapolis, MN	PETZEL, Robert A MD	12,000

CONGRESSMAN EVANS TO DEPARTMENT OF VETERANS AFFAIRS

Questions from the Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
For the Fiscal Year 2004 VA Budget

VA Response to Health Questions

1. **The Office of Management and Budget has a stated goal of outsourcing 50% of federal employees. Its guidance to VA is to outsource 15% of its workforce within the next 5 years. VA plans to study about 52,000 workers (or 24% of its total workforce)-mostly in blue-collar positions such as laundry, housekeeping, food service, and maintenance occupations.**

   Question A. What are the estimated costs for selecting positions for evaluation for possible outsourcing, analyzing the dynamics and mission impact of each competitively sourced position, developing standards and performance requirements for each position or group of positions, managing the contracting process for initial award of contracts, training and integrating contract employees into "One-VA", and providing adequate oversight of the performance of each contract employee? Considering OIG concerns regarding the current performance of VA on contracting issues, how large will VA need to grow its contracting and oversight team to keep pace with this monumental task? What will be the total cost?

Response:

The Department of Veterans Affairs (VA) has very limited experience in conducting formal competitive sourcing studies. VA recently completed its first formal A-76 study of VBA's property management function involving approximately 240 FTE. The study took more than 3 years to complete at a cost of approximately $1.7 million (roughly $7,100 per FTE). These findings appear to be consistent with criticism of the A-76 process heard by the Commercial Activities Panel that competitions often take years to conduct and frequently have a high cost-per-position studied.

VA worked with OMB to come up with competitive sourcing approaches that make sense for VA, in the context of our unique mission. We worked with OMB to obtain approval to use a modified A-76 market-based, competitive sourcing process for all functions including health care. This process requires the development of a Performance Work Statement to define the scope of work and the development of a government Most Efficient Organization proposal that often involve business process reengineering. However, the process does not include a formal solicitation rather, the Department conducts a detailed market analysis of

available sources to assess cost and capabilities of potential contractors. This approach should save VA (and the taxpayer) considerable time and money, while leading to an objective competitive sourcing decision.

Based on a review of DoD's experience over a number of years, VA projects that formal A-76 studies would, on average, take anywhere from 24 to 36 months to complete and would cost well over $1 million per function studied. Using VA's modified process, we estimate it will take from 3 to 12 months and range in cost from $100,000 to $800,000 per study, depending on complexity.

VA has established a new Competitive Sourcing office with a dedicated Service Director and an initial staff of five to oversee and manage the Department' competitive sourcing program. In addition, VA has contracted with IBM consulting to provide technical support as we proceed with the initial implementation. IBM is supporting VA with the development of a Competitive Sourcing Handbook for managers and practitioners, an information Web Portal that will include policies, procedures, best practice summaries, and other reference information to support the conduct of studies. IBM is also supporting the development and rollout of a comprehensive training program for VA managers and practitioners who will be involved with competitive sourcing.

VA does not anticipate an increase to the number of FTE required for contract management and oversight. Should VA decide to contract out for certain functions, it is anticipated that some number of current VA program managers and staff associated with the function will perform the contract oversight function. In addition, the Office of Acquisition and Materiel Management will continue to support the Competitive Sourcing and Management Analysis Service and VA's program offices by providing guidance on acquisition policy and the procurement process.

###

Question B. VA is on record advising the Office of Management and Budget that outsourcing the 19 functional areas it has identified "for study" will have a disproportionate effect on minorities and women who comprise the workforce. What will be done to ameliorate this effect?

Response:

VA has initiated several policies and programs to assist displaced employees, if a function is outsourced. Employees may be re-assigned within a facility to a job for which they are qualified, provided training for a new job, re-assigned to another facility with full relocation expenses and/or provided job search assistance. When a function is identified for competitive sourcing, a policy is issued to recruit only temporary or term

employees to fill vacant positions until a competitive sourcing decision is made. This action minimizes the number of permanent employees that would potentially be affected by an outsourcing decision. In addition, national and local labor unions are kept abreast of all competitive sourcing plans, actions and decisions, as appropriate and a single VA Intranet website is being created to serve as a repository for all competitive sourcing information in the Department. This website will be available to union representatives, as well as all employees.

###

Question C. Given that 58% of V A's blue-collar workforce are disabled veterans or other employees who have veterans' preference, how will VA's competitive outsourcing plan impact veterans preference and VA's track record of employing veterans?

Response:

The same approach VA plans to use for minorities and women addressed in answer B above will be used for those employees that are veterans.

###

Question D. At one time, the Administration made a clear distinction between "clinical" and "non-clinical" services and did not intend to subject clinical positions to outsourcing competition. This concept was captured in statute. Between 1982-1996, 38 USC §8110© generally prohibited contracting out of direct patient care activities or those incident to direct patient care. Some of the functional areas now being studied-pharmacy, pathology, and radiology- however, are clearly clinical. Why the change in policy?

Response:

During the 1980s, the concept of direct and non-direct care was utilized to distinguish between the types of staff providing services in VA health care. This concept subsequently evolved into direct patient care and ancillary support services. Direct patient care primarily involved physicians and nurses. Ancillary support services involved functions or services such as pharmacy, laboratory, dietetics, etc. At that time, the primary focus of A-76 was on administrative functions such as laundry, transcription, grounds maintenance, etc.

Historically, clinical areas were not involved in A-76 studies because of the immediate need for care providers, the lengthy process time associated with studies, and potential impact on patient care. Some ancillary support

services, as well as some direct patient care services, are already being contracted. This is a direct result of recruitment, retention, and salary structure issues. For example, VA's Centralized Mail-Out Pharmacy (CMOP) currently utilizes substantial contract staff to adjust to ever-changing workload.

Through VA's Enhanced Sharing Authority, VA has been able to contract for necessary clinical services in a reasonable timeframe and without the unnecessary costs and time associated with detailed studies. For example, if a facility's sole Urologist resigns, the facility could initiate a sharing agreement with their academic affiliate to provide necessary services in a matter of days. This allows the facility to provide continuity of patient care services until a new Urologist can be recruited. After review, it may turn out to be more cost effective to retain the services through a sharing agreement instead of recruitment of a replacement physician. Ancillary services have also utilized VA's Enhanced Sharing authority in the manner described above.

In addition to the sharing arrangement described above, significant efforts have been made to increase inter- and intra- facility consolidations, technology advances, etc. For example, several networks have already consolidated food production within their region, implemented the core reference laboratory concept and introduced a variety of tele-health initiatives such as tele-radiology. These initiatives have minimized staffing need in both direct and ancillary support staff.

###

Question E. Will employers who furnish outsourced services provide their employees the same employee benefits as are currently received by VA employees? Could outsourcing result in fewer employees with health insurance, for example?

Response:

Service employees, defined as any person engaged in the performance of a service contract other than those in a bona fide executive, administrative, or professional capacity, are protected under the Service Contract Act (SCA) of 1965, as implemented in Part 22 of the Federal Acquisition Regulation (FAR), for all non-exempt contracts over $2,500. This protection consists of ensuring, among other things, that such contract employees are paid minimum wages and fringe benefits as specified by the Secretary of Labor in a wage determination applicable to the particular classification(s) of labor involved. Although such determinations are not necessarily identical with those of Federal hires, the FAR further requires that a Statement of Equivalent Rates for Federal

Hires be included in all contracts subject to the Act as a disclosure of comparison.

Regarding health insurance for employees, as mentioned above, the Act covers only service employees and service contracts under specific definitions, and provides for certain exclusions/exemptions. In those cases where the Act does not apply, market forces and prevailing labor practices, as brought to bear on individual employment contract negotiations, may provide the only impetus for a particular fringe benefit, such as health insurance, to be provided. Further study/research would be required to determine if outsourcing would in fact result in fewer employees with health insurance.

###

Question F. What are the long-term implications on human resources investment in VA should VA outsource 50% of its workforce? How will this impact team building? Will the quality of the replacements be equal to the quality of current employees if employee pay is reduced for the same work in a competitive market and contractors siphon funds to pay owners, managers, and advertisers? How will VA replace lost capacity, i.e. if laundry is outsourced and VA laundry facilities are closed, what happens if contracting out costs escalate in a limited market; what options remain? Has VA studied past performance in these regards?

Response:

VA does not anticipate that competitive sourcing will result in the outsourcing of 50% of our workforce. VA does plan to conduct competitive sourcing studies of approximately 55,000 FTE out of the more than 223,000 individuals employed by the Department. Competitive sourcing is a management tool intended to help optimize available resources to ensure high quality services are provided to veterans. This approach will allow VA to focus its workforce planning and development on our core functions. We believe that proactive communications regarding the intent and processes to be used by the Department in this area will minimize the impact on team building.

Regarding the capabilities of any contractors who might win competitive sourcing competitions, VA will use a best value determination, as opposed to lowest price, in the competitive sourcing process. This will ensure the service and products received meet the needs of a health care environment. For example, laundry production requires not only clean linen, but also requires compliance with strict OHSA, FDA and JCAHO requirements for infection control and sterilization of linen products. Strict quality control requirements are an integral part of the PWS for laundry

production. If a contracted function fails to meet these standards, standard contracting mechanisms exist to correct deficiencies. In addition, VA plans to use performance based contract management approaches to establish clear performance standards for our contractors. Should the contractor fail to meet established standards, they will be required to develop improvement plans. Should performance remain deficient, VA may terminate the contract and procure services from other qualified vendors. This will ensure continued high quality services for our veterans.

Regarding contract costs, consistent with standard VA contracting procedures, long-term contracts are generally awarded for five years (base-year plus four option years). Full costs for five years are considered in the competitive sourcing process rather than just base-year costs. VA anticipates re-validating contract costs in concert with contracting cycles (every five years). When this occurs, in-house costs would again be considered as one option to continued contracting. However, for a variety of functions (e.g., laundry, food production, etc.), the in-house cost would be forced to include major capital investments to physical plant and equipment that might have been re-allocated, excessed, etc., at the time a function was outsourced.

###

2. **One of the tenets of the Capital Assets Realignment for Enhanced Services (CARES) process is to better ensure delivery of health care in the most appropriate and cost effective location. Oftentimes, to VA, this means closing inpatient beds and opening community based outpatient clinics (CBOCs). CBOCs have demonstrated a great potential for drawing more veterans into the health care system - when a VA CBOC opens, about 60% of the users are new. How does this strategy fit with current efforts to curtail veterans' demand for services?**

Response:

Our actions, including the enrollment decision announced in January, will allow the VA to refocus the mission of the healthcare system by reducing waiting times and rebuilding our capacity to provide for the tertiary care and special needs of the service-connected, low income, and special needs veterans. These actions have been necessary for the system to maintain the high quality of health care we provide to all patients.

While it is true that any new site of care (such as a CBOC) will likely attract new users, CARES planning guidance and current criteria for

CBOC planning will assure appropriate focus on addressing current workload needs and higher priority veterans.

CARES planning is based on actuarial projections of future demand for both outpatient and inpatient services. These projections take into account veteran demographics and VA eligibility rules, regional reliance rate, regional degree of community management, and regional trends. CARES planning guidance requires plans for new CBOCs to meet the criteria of VA's current CBOC Directive, which address waiting times, among other factors, in the planning and prioritization of new CBOCs. Additionally, the recently revised CBOC business planning process requires an analysis of the impact of primary care and specialty care waiting times at the parent or closest VA facility, as well as minimum population expectations for our core service population (Priority Groups 1-6). Decisions to establish new CBOCs through the CARES process, therefore, would be based on a need to improve access to meet travel-time guidelines and the volume of workload projected for the area.

###

3. Please describe the purpose and activities of the CPEP office located in Nashville. I understand that it is VHA-funded, but reports to VBA and supports the VBA initiatives to improve the VA's C&P exam process. For the record, please provide a detailed an thorough response that includes, but is not limited to, answers to the following questions:

- What is CPEP's mission, when was it established, is it a permanent operation?
- Has the mission changed? If so, how and why?
- How many staff work for the organization?
- What do they do?
- Who pays for this organization and staff that support it?
- To whom (organization and individual) does CPEP report?
- What has the CPEP organization done to date? Describe the results of CPEP activities.

Response:

Congressional representatives and veterans service organizations have all raised concerns about the quality of claims processing in the Department of Veterans Affairs. The concerns have focused on the backlog of claims, delays in reaching disability decisions, adequacy of compensation and pension examinations, and accuracy of disability decisions, all of which affect the quality of service provided to our veterans. Claims processing in

the disability compensation and pension programs is the responsibility of the Veterans Benefits Administration (VBA). Providing medical information needed to determine eligibility is a responsibility of the Veterans Health Administration (VHA), which performs about 90% of the compensation and pension (C&P) examinations, and a private contractor, QTC Medical Group Inc., which performs the remaining 10% of C&P examinations.

The Secretary of Veterans Affairs has identified improving C&P claims processing as one of the agency's highest priorities. Secretary Principi has stated that compensation and pension claims processing is not a VBA or VHA problem, it is a VA problem that must be resolved cooperatively by both Administrations. To meet this challenge, numerous goals have been defined.

A critical goal shared by the Under Secretaries for Health and Benefits is to improve the compensation and pension examination process. To achieve that goal, a Memorandum of Agreement was executed on February 20, 2001, establishing the Compensation and Pension Examination Project (CPEP). VHA and VBA agreed to jointly fund and unite in this collaborative initiative to improve the compensation and pension examination process; identify and/or develop best practices; and disseminate those best practices to medical centers and regional offices.

What is CPEP's mission?

CPEP MISSION

The mission as defined in the Memorandum of Agreement is to establish a joint initiative between VHA and VBA for the sole purpose of improving the compensation and pension examination process.

To define activities and expectations for CPEP to fulfill its mission, the Under Secretaries agreed on a CPEP Charter. The Charter identified the following responsibilities and gave CPEP full authority to carry them out:

- Perform a review and analysis of all critical elements and components associated with the C&P exam process.
- Development of performance standards to measure quality and timeliness of the compensation and pension examination process (what should the gross or macro performance levels be, what tools are available to measure performance, etc.).

- Development of a baseline, goals and expectations. Aggressive targets and rigorous standards will be developed, analyzed and updated periodically by the management team of the Project Office.
- Development of an incentive awards system.
- Development of training and communication systems to convey the performance standards, measures and goals to all levels involved with the compensation and pension examination process, e.g., medical examiners, veterans service representatives, VBA and VHA support staff, etc.
- Design of a system to provide feedback regarding quality and timeliness to all levels involved with the compensation and pension examination process; e.g., medical examiners, veterans service representatives, VBA and VHA support staff, etc.
- Design of a customer satisfaction survey for veterans who have undergone the compensation and pension examination process.
- Development of a system for data collection and reporting.
- Development of information technology (IT) initiatives that standardize and accelerate the C&P process.

When was the CPEP Office established?

The Compensation and Pension Examination Project (CPEP) Office was created by a Memorandum of Agreement signed by the Under Secretaries for Health and Benefits on February 20, 2001. The office, which is physically located at the VA Medical Center in Nashville, TN, began operations on June 18, 2001.

Is it a permanent operation?

The CPEP charter, signed by the Under Secretaries on April 20, 2001, states that CPEP is established as a permanent element of the organization until such time as it is disbanded by the Under Secretaries for Health and Benefits.

Has the mission changed?

CPEP's core mission has not changed. It remains focused on improving the quality and timeliness of C&P examinations. Strategy and tactics for achieving this improvement have evolved since the establishment of CPEP, in part as a

result of recommendations contained in the VA Claims Processing Task Force Report dated October 3, 2001, which identified the quality of medical examinations as a critical component of decision accuracy. This report recommended that CPEP's responsibilities include:

- Review, monitor, and provide training to Regional Office staff to improve the quality of C&P examination requests and ensure that the flow of C&P examination requests proceeds in an orderly and cost-effective manner.
- Keep the Clinician's Guide (formerly the Physicians Guide) and Examination Worksheets up-to-date and disseminate changes to the field in an expeditious manner.

How many staff work for the organization?

VHA has 7.5 FTEE and VBA has 6.6 FTEE funded in FY 2003.

CURRENT VHA CPEP Staffing - FY 2003

Position	FTE
Director, CPEP, MD	1
Medical Director, MD (Recruiting/Hiring)	1
Program Officer GS-340-15	1
Health Systems Specialist GS-671-14	1
Director, Quality Improvement GS-671-14	.5
Health Systems Specialist GS-671-14	1
Secretary GS-318-9	1
Program Assistant GS-344-8	1
TOTAL	7.5

CURRENT VBA CPEP Staffing - FY 2003

Position	FTE
Deputy Director GS-996-15	.5
VBA Staff Lead GS-996-14	1

Veterans Claims Examiner GS-996-13 (Star Team Members)	2
Veterans Claims Examiner GS-996-13 25 FTEE (16 positions filled) assigned to work 5 hours a week on CPEP reviews	3.1
TOTAL	6.6

What do they do?

The CPEP Office realizes that an innovative, systematic approach is required to meet the Departmental goal of improving compensation and pension examination quality. This approach involves:

♦ A new, valid system to measure exam quality that is being used by CPEP reviewers to conduct approximately 3,000 reviews of completed compensation and pension examinations per month.

♦ Elevating the priority of C&P exam processes by incorporating the quality measurement into performance measures.

♦ Frontline field implementation strategies for VBA and VHA to bring about improvement using system-wide quality improvement breakthrough collaboratives, facility-level performance improvement plans, education and training, and information technology tools.

Specific tasks performed by CPEP staff to implement these improvement strategies include the following:

Develop and Implement Quality Measurement Strategies and Tools

♦ Identify and analyze C&P exam processing issues in order to develop quality improvement processes and quality measures.

- Develop new measures of C&P exam quality that are reliable and valid and can be used as a benchmark to indicate the performance of the C&P exam process. These measures are developed in a consensus-building collaboration between CPEP staff and a Clinical Advisory Board (CAB), which is composed of expert VBA and VHA physicians.

- Develop and maintain active working relationships with experts within and beyond VA, including outreach for clinical expertise,

legal expertise, rating and regulation expertise, quality improvement expertise, information management expertise, and performance measurement expertise.

♦ Design statistically valid quality studies of random samples of the full population of exam reports from a given period of time.

♦ Design, implement and maintain an end-to-end computer-based C&P exam quality review process, including the gathering and storage of electronic C&P exam report data from around the country; assignment and review of randomly selected exams; recording of review scores; continuous tracking and management of reviewers and review processes; and generation of reports necessary for analysis and all other information needs.

♦ Analyze statutory and regulatory changes and update C&P exam review protocols to reflect changes.

♦ Manage the ongoing C&P exam quality review process and perform the reviews.

♦ Perform statistical and qualitative analysis of the collected data.

♦ Publish and distribute reports to all VA medical facilities and regional offices, the Secretary's office, Under Secretaries' offices, veterans service organizations, and Congressional staff.

♦ Train exam quality reviewers (STAR staff and out based senior Rating Veterans Service Representatives) in applying the quality indicators to exam reports.

♦ Develop and apply a quality evaluation process for exam requests.

Develop and Implement Quality Improvement Processes

Plan, organize, and staff Collaborative Breakthrough Series on Improving C&P Exam Report Quality:

♦ Develop curricula for conferences.

♦ Educational sessions.

- Hands-on training for Breakthrough Series participants in using quality indicators to review and improve quality at the local level.

- Hands-on training in quality improvement techniques and clinical approaches to compensation and pension.

♦ Assist participants in developing C&P Quality Improvement Plans for their facility.

♦ Ongoing support for participants is provided through:

- Communications, by sponsoring, monitoring, and participating in a "bulletin board" email group that connects Breakthrough Series participants and faculty.

- Serve as coaches and subject matter experts to the 137 medical centers and numerous regional office staff participating in the Breakthrough Series.

- Arrange conference facilities, accommodations, speakers, etc.

Implement and Support Facility-level C&P Exam Performance Improvement Planning

♦ Design and implement strategies to institutionalize ongoing performance improvement at each facility.

♦ Develop, distribute, and provide technical support templates and data management tools for use at each individual facility.

♦ Oversee medical center compliance with performance improvement planning.

Produce Training, Reference, and Educational Materials

♦ Work with system-wide subject matter experts to develop curricula that address longstanding and newly identified training needs. Develop training programs that focus on areas identified by CPEP quality review process as opportunities for improvement.

♦ Produce and distribute educational training videos to improve the clinical knowledge base of C&P practitioners.

- Select training subject matter (i.e., specific exam or body system to be addressed).

- Collaborate with subject mater experts to develop program content that addresses basic training needs and needs documented by the C&P exam quality review processes.

- Coordinate tapings, editing and other logistics with expert practitioners, hosts, and video technicians.
- Develop continuing medical education exams based on educational programs.
- Distribute copies to all medical centers and regional offices.

♦ Develop and maintain CPEP intranet website (vaww.cpep.med.va.gov) and computer-based training tools that provide accessible and up-to-date information to field-based clinicians who conduct C&P exams.

♦ Disseminate training and educational information and products to field-based C&P exam programs to enhance their ability to improve exam report quality.

♦ Develop training curriculum for CPEP reviewers.

- Orientation to CPEP quality review.
- In-depth training on exam-specific and core quality indicators.
- Group discussion of practice exams in hands-on training sessions.
- Proficiency testing of individual reviewers.
- Staff training of new reviewers.

Who pays for this organization and staff that support it?

The Compensation and Pension Examination Project (CPEP) Office staff and operational costs are jointly funded by the Under Secretaries for Benefits (VBA) and Health (VHA).

To whom does CPEP report?

Both the Compensation and Pension Examination Project (CPEP) Office Director, Dr. Steven H. Brown, and the Deputy Director, William Bauer, are organizationally aligned under and report to the Under Secretaries for Benefits (VBA) and Health (VHA) in this joint initiative. They also provide reports to the Secretary on the activities of the CPEP Office.

All staff members selected for positions in the CPEP Office remain organizationally in the Administration from which they were selected, i.e., VHA staff is paid by VHA and VBA staff is paid by VBA.

What has the CPEP organization done to date? Describe the results of CPEP activities.

CPEP is engaged in a systematic, concerted effort that leads VA along a continuum from defining C&P exam quality to implementing quality improvement at each facility. This effort involves a logical progression of components, starting with the creation of new exam report quality scores that provide a valid yardstick of compensation and pension exam quality. The next step involves national-level education and quality improvement. CPEP has already demonstrated that significant exam report quality improvement is attainable. For example, data from the second Collaborative Breakthrough Series showed that Joint Exam scores had improved from 67% to 93%. CPEP is elevating the priority of C&P exam quality at the individual medical center level by institutionalizing C&P performance improvement plans at all local facilities. A proposed VISN-level performance measure for C&P exam quality will assure regional accountability for quality improvement results. Finally, CPEP has identified critical training needs of C&P examiners and distributed an initial set of training tools to impart to VA's C&P clinics the knowledge and skills needed to meet performance improvement goals. CPEP has received unwavering support from both Administrations for its efforts.

The following are highlights of CPEP's accomplishments through its first year and a half of existence:

Developed and Implemented Quality Measurement Strategies and Tools

- Conducted and analyzed a nationwide survey of VHA examining facilities and VBA regional office personnel about the C&P claims process.

- Completed pilot study of key quality indicators October 2001.

- Finalized 94 key quality indicators for the ten (10) most frequently requested C&P examinations.

- Developed an electronic database of over 100,000 C&P examination reports completed nationwide in the 4th Quarter of FY 2001.

- Designed, implemented and continue to maintain an end-to-end computer-based review process. This system is in daily use by CPEP reviewers in Nashville and around the country. The system's capacity includes the gathering and storage of electronic C&P exam report data from around the country; assignment and review of randomly selected

exams; recording of review scores; continuous tracking and management of reviewers and review processes; and generation of reports necessary for analysis and all other information needs.

♦ Completed national-level review of C&P exam report quality using CPEP Quality Indicators for the Ten (10) Most Frequently Requested C&P Exams. Briefed the Secretary and Under Secretaries for Benefits and Health on findings documented in the CPEP draft report "Quality Measurement of Compensation and Pension Examinations." Final report (dated July 10, 2002) was released electronically in August 2002. Bound copies were distributed in mid-September 2002 throughout VHA and VBA.

♦ Completing VISN-level review of C&P exam report quality using CPEP Quality Indicators for the Ten (10) Most Frequently Requested C&P Exams. Reviewed C&P exam reports for tracking quality to the VISN level. [NOTE: Data collection complete. Analysis phase began February 28, 2003.]

♦ Developed criteria for evaluating quality of exam requests by regional offices.

♦ Developed quality indicators for the next ten (10) C&P exams (by frequency requested).

Developed and Implemented Quality Improvement Processes

♦ Planned, organized and staffed Collaborative Breakthrough Series' on Improving C&P Exam Report Quality (two Breakthrough Series' completed and one in progress to date).

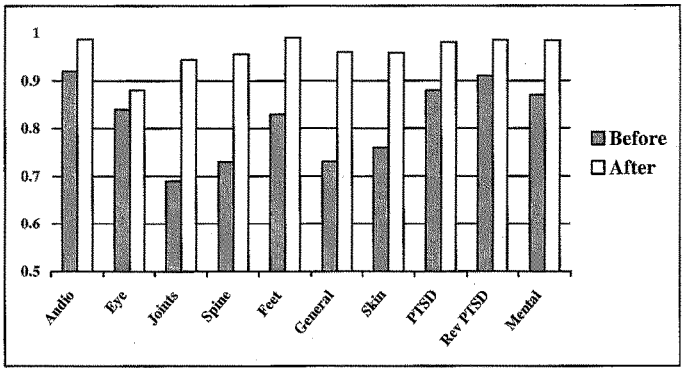
♦ Collaborative Breakthrough Series 1 "Improving the C&P Exam Process" Results:

- 27 teams composed of medical center and regional office staff participated.
- Approximately 10% improvement in processing time despite an increase in volume.
- Facility level improvements in exam sufficiency rates, timeliness and veteran satisfaction (see vaww.cpep.med.va.gov for facility details).

♦ Collaborative Breakthrough Series 2 "Focus on Improving C&P Exam Quality" Results:

- 43 teams participated from March – September 2002.
- 14% improvement in overall processing time despite an increase in volume.
- Dramatic improvements in C&P Exam Quality as measured by CPEP quality indicators for the top ten requested C&P exams in the graph below:

BTS Improvement from Baseline
CPEP Quality Score: Top Ten Exams



◆ Conducting Collaborative Breakthrough Series 3 "Focus on Improving C&P Exam Quality" for 93 additional teams. First session was held January 28-30, 2003. Second session will be held in July 2003.

◆ **Implemented and Continued Support of Facility-Level C&P Exam Performance Improvement Planning.**

- Process developed, endorsed by Under Secretaries, and distributed to medical centers and regional offices.
- C&P Quality Performance Improvement Planning Template developed and distributed.
- Data management tools developed and distributed.
- Review of Quality Improvement Plans from facilities that participated in Collaborative Breakthrough Series 2 underway.

Completed Training, Reference, and Educational Materials

♦ Produced and distributed examiner training video series on conducting Compensation and Pension General Medical, Foot, and Musculoskeletal Exams. Computer-based training being completed for the same topics.

♦ Developed and distributed national registry for VHA and VBA Compensation and Pension Contact List to all medical centers, regional offices, and all national and state veterans service organizations.

♦ Developed and distributed posters to all medical centers and regional offices summarizing the findings of CPEP's national baseline performance study of the ten most frequently requested C&P exam types.

♦ Compiled and distributed C&P Improvement Kits to all medical centers. Kits were designed to provide the tools to improve quality of the musculoskeletal exam.

♦ Ongoing development of a C&P Clinician's Guide website and content management system to provide up-to-date information for clinicians that conduct C&P exams.

♦ Developed C&P exam quality review training package for VBA out-based reviewers and conducted four one-week training sessions.

###

4. Please provide, for the record, a simple, but complete, description of the program called CAPER. The response should include information responding to, but not limited to, the following:

- **What are the goals and objectives for the program?**
- **Who is responsible for implementation and oversight of the program?**
- **How is the program funded?**
- **How much has been spent to date and what are the expected total costs and the expected objectives, along with the time line?**
- **What is the current status of CAPER as compared to its original projected timeline?**
- **Was approval for the project obtained through the Office of the Chief Information Officer? If not, why not?**
- **How does this project relate to RBA 2000 and CPEP?**

Response:

- **What are the goals and objectives for the program?**

  CAPER is an initiative to enhance the disability examination request and return process, as well as the disability evaluation process, across the Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), Board of Veterans' Appeals (BVA), and private contractor examiner organizations.

  CAPER will integrate various Commercial Off The Shelf (COTS) and Government Off The Shelf (GOTS) applications, including Compensation and Pension Records Interchange (CAPRI), and build a knowledge-based application that supports both a standardized disability examination process and a rules-based disability evaluation process. These processes are essential to determine and award VA C&P benefits in a timely manner. Using web-enabled, rules-based technology, it will construct a revised model for evaluating medical disabilities. CAPER will implement a more efficient and modernized disability evaluation system by reducing claims development rework actions and enhancing the quality of VA rating determinations. CAPER will accomplish this by ensuring that C&P disability examinations are effectively requested when the available medical evidence is insufficient to decide a claim. Utilizing C&P Examination Project (CPEP) criteria, CAPER will ensure that C&P examination results address the necessary examination protocol elements contained in VA disability examination worksheets, thereby enabling a disability evaluation for adjudication purposes.

- **Who is responsible for implementation and oversight of the program?**

  CAPER is a One VA initiative comprised of multidisciplinary VA employees from VBA, VHA, and BVA. VBA, C&P Service, Business Management staff is the lead sponsor for CAPER and exercises oversight via its VBA Program Manager and Project Manager.

- **How is the program funded?**

  CAPER is funded in two distinct phases: 1 & 2. Phase 1 comprised a review of the electronic disability examination request and return process as well as existing VA software applications, an evaluation of COTS products, and the development of a recommendation for alternative process solutions. The Integrator Contractor in collaboration with VA staff and the Independent Verification & Validation Contractor developed a prototype system to serve as a "proof of concept," which was completed January 31, 2003. CAPER Phase 1 was funded by a firm-fixed contract price.

It is anticipated CAPER will proceed to Phase 2 (production version) if approved by VA leadership. A CAPER Capital Asset Plan and OMB 300 was submitted in September 2002.

- **How much has been spent to date and what are the expected total costs and the expected objectives, along with the time line?**

  CAPER Phase 1 began in September 2001 and ended in January 2003, with approximately $2.7 million having been spent to date. If approved by VA leadership, it is forecasted that CAPER Phase 2, the production version, could be incrementally deployed from FY 03 to FY 08. It is estimated that the life cycle cost for CAPER Phase 2, covering FY 03 to FY 08, is approximately $17 million.

- **What is the current status of CAPER as compared to its original projected timeline?**

  CAPER Phase 1 was scheduled for completion in September 2002, but was not completed until January 2003. The project was delayed for various factors, including but not limited to: requirement for extensive COTS market surveys and product demonstrations; IT integration challenges; and exhaustive review of alternative analyses required before final decision to build the prototype around a centralized solution using COTS products. Assessment of the CAPER prototype continues. The project team is investigating alternatives for Phase 2 before presenting final recommendations to VA leadership, currently scheduled for 4th quarter FY 03.

- **Was approval for the project obtained through the Office of the Chief Information Officer? If not, why not?**

  The CAPER concept was initially presented to the VBA Information Technology Investment Board (ITIB) in August and October 2001. Milestones 0 and 0.5 covering project initiation and approval were submitted in June 2002. In October 2002, a CAPER Milestone 1.0 briefing for development and approval of the CAPER Phase 1 prototype was presented to the ITIB. In January 2003, the VA CIO was briefed on CAPER and other projects concerned with improving the quality of the C&P examination request and return process. As a result, the VA CIO determined in January 2003 that the next step for CAPER was to present Milestone 2.0 for system development and approval. Formal VA leadership approval of CAPER Phase 2 (production version) is a prerequisite for Milestone 2.0 submission.

- **How does this project relate to RBA-2000 and Compensation & Pension Examination Project (CPEP)?**

  CAPER will alert the Rating Veterans Service Representative (RVSR) if the medical evidence of record is sufficient to decide a veteran's claim without the need to request a C&P exam. CAPER will ensure that the proper C&P exam is requested when required. Utilizing CPEP quality assurance factors, CAPER will assure that C&P exam findings are adequate for rating purposes, thereby promoting consistency and reducing the number of inadequate C&P exams nationwide. CAPER will facilitate preparation of a rating decision by providing an RVSR useful information which can be incorporated into a final RBA-2000 rating decision.

###

5. **VA estimates $154.9 million in cost avoidance subsequent to its implementation of the recommendations of the May 2002 Report of the VA Procurement Reform Task Force. Specifically, how does VA verify these savings through cost avoidance in medical/surgical item, pharmaceutical, and high-tech equipment procurements?**

Response:

Response - When standardizing an item, the procurement history is used to establish baseline usage. An assumption is then made that the same amount will be used after standardization. Cost avoidance is calculated using the new negotiated prices under the standardization program versus previous prices paid (i.e., Federal Supply Schedule, open market).

CONGRESSMAN EVANS TO DEPARTMENT OF VETERANS AFFAIRS

Questions from the Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
For the Fiscal Year 2004 VA Budget

VA Response to Benefits Questions

1. **Current reports indicate that 14,000 claims remanded before October 1, 2001 are still awaiting action by VA regional offices. This is approximately the same number of remanded claims that were pending for 15 months or longer at this time last year. Please describe the anticipated time frames for completing remands, the actions taken to expedite remanded claims at the regional office and the results of those actions. Please indicate the reasons why such a large number of remands would take more than 15 months to expedite.**

Response:

There are currently 11,398 claims remanded before October 1, 2001, which are still at VA Regional Offices. At this time last year, there were 12,994 remands pending which had been issued prior to October 1, 2000. Nationwide targets have been placed in the Director's Performance Standards to reduce the number of pending remands to 1,000 by the end of September 2003. Regional Offices are being monitored by the Office of Field Operations and Compensation and Pension Service to ensure that remands are correctly considered prior to being returned to BVA. Ultimately, VBA's goal is to process remands in less than 200 days.

There are several reasons remand development often takes a great deal of time to complete. Remands often require extensive development for additional evidence to support the appeal. Often, additional evidence is received after the appeal reaches BVA, necessitating additional development such as Military Unit Records from the Center for Unit Record Research (CURR) to establish stressors in connection with PTSD claims, specialized medical exams/opinions, and veterans' requests for personal hearings with the Traveling Section of BVA. There are currently about 500 cases waiting for Travel Board hearings. At the present time, these cases average 540 days before a hearing is conducted. In many cases, development must be performed in a sequential manner, with the completion of one step required before the next can begin. The veteran may also file new or amended claims that must be finally adjudicated before the remanded appeal can be returned to BVA.

###

2. Please provide a copy of the job description for VBA regional Office homeless coordinators.

Response:

POSITION DESCRIPTION
LEGAL ADMINISTRATIVE SPECIALIST (CONTACT REPRESENTATION)
HOMELESS VETERANS' OUTREACH COORDINATOR (HVOC)
PUBLIC CONTACT TEAM
GS-901-10

INTRODUCTION: Incumbent serves as a member of the Public Contact Team, located in the Veterans Service Center and is the focal point at the station level of VBA's efforts to assist homeless veterans.

VA offers a wide array of special programs and initiatives specifically designed to help homeless veterans live as self-sufficiently and independently as possible. VA's major homeless-specific programs constitute the largest integrated network of homeless treatment and assistance services in the country. The programs strive to offer a continuum of services that include aggressive outreach to those veterans living on streets and in shelters who otherwise would not seek assistance, clinical assessment and referral to needed medical treatment for physical and psychiatric disorders, including substance abuse.

DUTIES AND RESPONSIBILITIES:

Represents the VBA Regional Office as liaison with local VA and non-profit community homeless specific organizations, homeless advocacy groups and other support activities. As such, coordinates VA benefit programs to best serve homeless veterans and their families.

Establishes VBA presence and support at local homeless shelters (day and night), soup kitchens, homeless community centers and other homeless specific agencies. Maintains membership in various community-based organizations which provide service and programs to the homeless.

Provides training materials (pamphlets, handouts etc.) to shelters, homeless service providers and homeless veterans. This includes, but is not limited to, benefit orientations, counseling and assistance with claims. When necessary, must be able to interpret and accurately reflect VA policies, procedures and eligibility requirements for VA homeless programs.

May perform outreach functions as part of a Homeless Chronically Mentally Ill Program (HCMI) team to provide improved access to Department of Veterans Affairs (VA) benefits and services for homeless. The HCMI team will spend time

in the community at homeless shelters, soup kitchens and all other areas where homeless veterans can be found. As a member of the HCMI team, the HVOC will focus on the identification of homeless veterans, relationship building, and assuring that homeless veterans receive comprehensive services through the team and through linkage to non-VA programs. The HVOC will provide referral, application assistance, advocacy and follow-up, when necessary, to appropriate service programs. Such service includes but is not limited to:

- housing programs administered by the Secretary for Veterans Affairs and the housing program for veterans supported by the Department of Housing and Urban Development;
- compensation, pension, vocational rehabilitation, and education benefits programs administered by the Secretary under 38 USC or any other provision of the law;
- the homeless veterans' reintegration program of the Department of Labor under section 2021 of 38 USC (Homeless veterans reintegration programs);
- the programs under section 2033 of 38 USC (Additional services at certain locations);
- the assessments required by section 2034 of 38 USC (Coordination with other agencies and organizations);
- establishing linkages with Social Security, Income Maintenance, Federal Housing Administration, State Department of Veterans Affairs, community housing programs, and State job services and assisting homeless veterans in applying for these programs;
- referral for legal counseling and assistance;
- referral through the team medical clinicians for needed medical and counseling services.

Conducts comprehensive VA benefits and services briefings to groups of homeless veterans, who as a result of their economic medical or social problems have found it difficult, if not impossible, to request VA benefits and services.

Uses a wide range of briefing techniques and communications skills to include psychological and motivational counseling during encounters with individual homeless veterans to encourage use of available VA benefits and services.

When possible, will obtain the necessary information and complete a claim while the veteran and/or family member is present. In certain circumstances may monitor the claim to eliminate unnecessary delays in receiving needed evidence and to assure the claim is fully developed.

Speaks to individuals or groups or otherwise represents the agency on media programs involving matters of interest to veterans and their dependents. Conducts seminars, conferences, and other information dissemination activities.

Serves as the CHALENG Point of Contact (POC) for CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans' Program in coordination with VA Medical Centers. Project CHALENG enhances coordinated services by bringing the VA together with community agencies and other federal, state, and local governments who provide services to the homeless to raise awareness of homeless veterans' needs and to plan to meet those needs. As CHALENG POC, participates in the annual Project CHALENG survey that asks for current perceptions of homeless veterans' needs, the degree of VA/community cooperation and collaboration in serving homeless veterans, and progress on local homeless veterans program initiatives of both local VA staff and community participants (local government, service providers, formerly and currently homeless veterans).

Coordinates the Regional Office participation in Stand Down. Stand Downs are one part of the Department of Veterans Affairs' efforts to provide services to homeless veterans. Stand Downs are typically one to three day events providing services to homeless veterans such as food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and substance abuse treatment. Stand Downs are collaborative events, coordinated between local VAs, other government agencies, and community agencies who serve the homeless.

Maintains an extensive and comprehensive information system as a centralized source of data relating to homeless veterans in order to identify opportunities for improvement.

Acts as advocate for veterans and their beneficiaries in their dealings with other VA elements and organizations that affect their claims. Provides away from office counseling and as necessary provides in-home counseling to those who are geographically isolated or physically unable to go to a VA facility due to physical or mental incapacity.

Explains decisions made by the VA and communicates the reasons to the claimant for these decisions, orally or in writing. Advises on the right of appeals and assists claimants in making appeals. Presents benefits or claims appeals at personal hearings.

Prepares technical correspondence to veterans and their dependents providing benefit information, representation rights, and response to miscellaneous inquiries. Signs such correspondence for the Veterans Service Center Manager.

Receives and responds to congressional and White House inquiries concerning VA benefits for homeless veterans and other claimants. Analyzes inquiries, researches issues involved, consults with other federal, state and local agencies as necessary and prepares written replies or furnishes replies by telephone or other medium to congressional or White House staff members.

Prepares correspondence to members of Congress and special interest groups on case assignments.

Maintains extensive and comprehensive information systems relating to homeless and specialized veteran groups to identify opportunities for improvement. Insures that each opportunity for improvement is followed through to resolution and that findings, conclusions, recommendations and actions taken are documented. Analyzes trends and patterns and works with management and staff to continually improve service provided to veterans.

Prepares periodic and special written statistical and narrative reports to management and others to determine use of service, benefits and resources by the homeless and aging veteran population.

Performs other related duties as assigned.

FACTOR 1 - KNOWLEDGE REQUIRED BY THE POSITION

Knowledge of the Veterans Benefits Administration's philosophy, objectives, identified outcomes and the provisions of all laws administered by the Department of Veterans Affairs and their relationship to other related programs.

A comprehensive knowledge of an extensive body of federal laws, regulations and implementation procedures pertaining to compensation, pension and other VA benefits, in order to accurately advise veterans and/or their dependents of entitlements and eligibility to a full range of veterans' programs. Knowledge must be sufficient to not only provide accurate information to the claimant but thorough enough to positively impact the timeliness and quality of claims processing.

Knowledge of federal, state and local laws, assistance services and programs, sufficient to help or direct veterans to the appropriate resource to resolve problems that are beyond the scope of the VA's programs. This includes state laws involving dependency status, social service programs, Medicaid, special income-based programs, Social Security Administration benefit programs, and domestic relations.

General knowledge of legal opinions, the Office of General Counsel, the Court of Appeals for Veteran's Claims (CAVC), the Board of Veterans' Appeals (BVA), and state and federal courts having a relationship to VA programs.

Skill in establishing and maintaining effective working relationships with community-based organizations which provide service and programs to the homeless.

Skill in presenting information orally in a logical and clear manner to explain programs, projects or activities to both internal and external groups.

Ability to interpret and apply laws, guidelines, regulations and precedent opinions in order to provide accurate entitlement determinations and benefit payment information.

Ability to effectively listen and communicate verbally with people in person or on the telephone. This includes skill in conducting interviews that yield the necessary data essential to make a proper decision on a claim, explaining benefit information to claimants, presenting claims appeals at personal hearing, and fostering a positive relationship between the public and the VA.

Skill in written communication to inform claimants of VA and related benefits, evidence requirements, the reason and basis for decisions and appellate rights.

Knowledge of the process and skills needed to manage data, such as gathering, analyzing, trending and evaluating data to be used for developing reports and identifying opportunities for improvement.

Knowledge of electronic data processing systems including benefits delivery network (BDN), CAPS, COVERS, CAPRI/AMIE, etc. to monitor and update the status of claims processing, resolve benefit delivery problems, and for correspondence preparation.

Knowledge of state laws involving dependency status, social services programs, Medicaid, special income-based local, state, and federal programs.

Knowledge of the Privacy Act and Freedom of Information Act requirements for release of information to requesters.

Ability to organize and prioritize so that deadlines are met and work is produced systematically.

Ability to create and interpret databases, develop effective tracking and filing systems to assure that action items are completed.

Ability to lead a program which often works with difficult and confidential team-

related problem solving. Ability to maintain a respect and confidentiality for the persons involved is essential.

Ability to work in both an independent and team environment.

FACTOR 2 - SUPERVISORY CONTROLS

Duties and work assignments are performed under the general supervision of the Public Contact Team Supervisor. Outreach assignments and some training will be coordinated through the HCMI team leader. Speaking engagements and visits to agencies and other organizations will be coordinated by the supervisor. The supervisor and employee discuss Veterans Service Center objectives in planning and scheduling work to be accomplished in the area of outreach, public relations, and visits to homeless shelters, etc.

The incumbent frequently works independently away from the office without the need for direct supervision. Sets priorities and deadlines for his/her own work. Is responsible for accuracy, soundness of judgment and compliance with regulations and directives.

When performing outreach or community awareness duties, the incumbent performs work independently without the need for direct supervision. Work is reviewed in terms of effectiveness in meeting goals; although occasionally monitoring may be accomplished to evaluate the quality of service provided.

FACTOR 3 - GUIDELINES

Guidelines include laws (Public Law 107-95) and supporting regulations; 38 USC 7722 (Outreach services), 38 CFR 1.710 (Homeless claimants: Delivery of benefit payments and correspondence); agency policies, procedural requirements of the various veterans' benefits M21-1, Part VII, 6.06 (Homeless Veteran Outreach), VBA Circular 20-91-9 (Procedures for Processing Claims for Homeless Veterans), VBA Circular 27-91-4 (Outreach to Homeless Veterans). Guidelines are voluminous and include laws and supporting regulations, agency policies, procedural requirements of the various veterans' benefits, evidentiary requirements and restrictions. These guides are numerous, extensive, and complex and may change, sometimes frequently, due to new legislation and court decisions. The incumbent must exercise a high degree of independent judgment, skill and initiative in adapting guidelines and procedures to individual case circumstances.

FACTOR 4 - COMPLEXITY

Outreach to homeless veterans will require innovative approaches for establishing contact with this destitute population. Generally, homeless veterans do not willingly visit or seek assistance from VA or any other structured

organization. As a result of their inability or unwillingness to cooperate or help themselves, the HVOC will be required to visit places where homeless individuals live in abject poverty or hide to include: under bridges, wooded areas, inner city homeless communes, day and night shelters, soup kitchens and other areas where they might congregate.

The employee routinely deals with innovative, controversial, and often sensitive programs and information. The work includes assessment of conflicting information received from the claimant and/or found in the electronic case file. The incumbent must identify and sort out the issues, including those that may be obscure, in order to advise the claimant of their benefit entitlements and process to acquire/complete documents and evidence required to process their claim. Exceptional judgment, tact, and understanding along with the ability to maintain confidentiality are required.

The incumbent must continually keep up-to-date on legislative changes and court decisions to properly advise claimants about VA benefits and to revise orientation presentations or informational material.

FACTOR 5 - SCOPE AND EFFECT

The purpose of the work is to assist homeless veterans, their dependents and their beneficiaries in filing claims for all types of VA benefits; to furnish outreach services; explain decisions made by the VA; serve as veterans' advocate and raise awareness of veterans programs to the public. Duties need to be carried out in a timely, accurate and efficient manner.

The incumbent conducts assessments of the programs relating to the needs of the homeless veteran populations, evaluating the manner and extent to which we are fulfilling those needs in the delivery of benefits and care. In the course of accomplishing these assessments, the incumbent may participate in various committees and community organizations that work with this population.

Additionally, the incumbent reviews court case decisions, legislative changes and contact representational data in order to analyze and explain new laws and recommend improvements in service delivery.

It is essential that a professional, knowledgeable and sensitive approach be used with a wide variety of VA staff. The incumbent must be well-versed in VA programs and organizational makeup. The work is vital to the processes through which the agency informs and serves the public. It directly affects the quality and timeliness of claims processing to veterans, and other recipients, as well as public opinion and confidence in VA programs.

FACTOR 6 - PERSONAL CONTACTS

The success of VBA's homeless veterans outreach and claims processing largely depends on close collaboration between RO HVOCs and VHA homeless veterans' coordinators. All RO HVOCs will establish and maintain an effective network, open communications, and a referral system with all VHA homeless veterans' coordinators in their RO's area of jurisdiction.

Areas of program coverage are general and all segments of the general public may be encountered as potential veteran applicants, beneficiaries and designated representatives. Contacts may also include representatives of public or private advocacy groups, service organization representatives, state and local government officials, staff of congressional committees, other agencies and institutions providing related payments and services. These contacts require considerable knowledge and require sound judgment, courtesy and cooperation. Contacts may occur inside or outside of the employee's office.

FACTOR 7 - PURPOSE OF CONTACTS

The primary purpose of this position is to establish a highly visible presence in order to raise the consciousness and awareness of VA's Homeless Veteran Programs within the jurisdiction of the RO.

Contacts with veterans or advocates/representatives are made to explain the programs and to elicit information upon which entitlement, post-entitlement, and reconsideration decisions are made. Contacts with other agencies and institutions may involve negotiating to obtain information or to represent a claimant's needs or rights to payment or services. Much of the eligibility information is acquired through interviews conducted which may involve probing of very personal and/or sensitive situations. The incumbent must also be able to satisfactorily explain complex rules and requirements to individuals who may be hostile, uncooperative, antagonistic, fearful, concealing information, mentally ill, and possibly dangerous. The incumbent must control the interview and keep it on track to orchestrate the desired objective.

FACTOR 8 -PHYSICAL DEMANDS

The work normally involves mental rather than physical exertion. There is walking, standing, and carrying of light items such as papers, books, claims folders, and files from one desk to another or for returning to storage. Occasionally incumbent supports or assists veterans and carries their belongings when moving them from one facility to another.

FACTOR 9 - WORK ENVIRONMENT

Work is performed in a typical office setting which is adequately lit, heated, and ventilated. However, incumbent daily visits area shelters, soup kitchens, hospitals, and other areas, including streets that are in poor and dangerous

sections of various cities. Some assignments, such as outreach activities, require travel. It may be necessary to modify the employee's normal workday to adjust for a more liberal day/night work schedule to accommodate the shelter schedules and to permit the realignment of the time schedules to meet the individual needs of homeless veterans.

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3. Please describe the initial and on-going training program for VBA Regional Office homeless coordinators.

Response:

- *Initial Training.* Homeless Veterans Outreach Coordinator (HVOC) training needs are initially assessed locally and local available resources are used for training. Familiarization with the programs outlined in Public Law 107-95 (Homeless Veterans Comprehensive Assistance Act of 2001) is the first step in the process. Regional offices work with VHA homeless coordinators and treatment staff to gain further knowledge about homeless programs available through the local medical facilities and with other agencies, such as the Department of Labor, to learn more about local programs through that source.

- *Ongoing Communications.* The Compensation and Pension Service (C&P) Homeless Veterans Outreach Program Manager communicates regularly with RO HVOCs via e-mail and through individual telephone contacts. As program information becomes available through the working groups on which VBA is a representative, information messages are sent to the HVOCs. For example, e-mails have been to all HVOCs about the Online Newsletter published by the National Alliance to End Homelessness and the Department of Justice web site on the Serious and Violent Offenders Reentry Initiative.

- *Quarterly Conference Calls.* The Homeless Veterans Outreach Program Manager has scheduled quarterly conference calls with RO HVOCs beginning in March 2003. Each call will include a training segment. VHA representatives have been asked to join us on the March call to outline methods for building strong working relationships between the VBA and VHA HVOCs.

- *HVOC Intranet Web Page.* A web page has been created for HVOCs on the C&P Intranet site. The page is being upgraded to be a training tool for HVOCs and will contain information on various homeless

programs, resource directories, and best practices. It also contains a listing of the RO HVOCs to promote networking and stronger communications among coordinators in geographic areas, nationwide, or one- on-one.

- *National Coalition for Homeless Veterans Conference.* The 20 full-time HVOCs as well as other RO HVOCs will attend the National Coalition for Homeless Veterans (NCHV) Conference (Shaping America's Agenda for Homeless Veterans), scheduled May 5-7, 2003, in Washington, DC. This is a training opportunity for RO HVOCs, especially the 20 full-time HVOCs assigned under Public Law 107-95. They will be able to network with various members of VA and non-VA organizations who work with homeless veterans. The conference will have workshops on topics relevant to the HVOCs such as: Department of Labor Veterans Reintegration Program; Incarcerated Veterans Reintegration; VA Properties and Transitional Housing Loan Programs; Stand Downs; Strategic Corporate Partnerships, etc. A VBA workshop has also been scheduled during the conference.

- *Department of Justice Training Program.* Department of Justice has scheduled four workshops in May and June for various state officials, under the Serious and Violent Offenders Reentry Initiative. Approximately 17 states will be represented at each workshop. VBA HVOCs will provide training to the attendees and will also participate in the other segments of the workshops. Following the "Barriers and Bridges for Medical, SSI, VA, and Medicaid Benefits" workshops, information learned will be shared with RO HVOCs nationwide.

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4. Please provide the number with job titles and employing station of all VBA employees who are currently on leave from their positions for six months or more in order to perform military service. What actions will be taken to provide for performance of duties by others which had been performed by these servicemembers?

Response:

A total of 67 employees have been activated to date. Of this number, 24 have been activated for six months or more. Their employing stations and job titles/grades are as follows:

Eastern Area:

Regional Office	Position Title	Grade
Philadelphia	Rating Veterans Service Representative	GS-9
Philadelphia	Legal Admin. Specialist	GS-10
Philadelphia	Claims Assistant	GS-4

Southern Area:

Regional Office	Position Title	Grade
Atlanta	Veterans Claims Examiner (Education)	GS-7
Atlanta	Veterans Claims Examiner (Education)	GS-9
Atlanta	Veterans Service Representative	GS-10
Roanoke	Mail Clerk	GS-4
St. Petersburg	Veterans Service Representative	GS-7
St. Petersburg	Supervisory Veterans Service Representative	GS-13
St. Petersburg	Rating Veterans Service Representative	GS-9
St. Petersburg	Veterans Service Representative	GS-7

Central Area:

Regional Office	Position Title	Grade
St. Paul	Loan Specialist (Realty)	GS-11
Muskogee	Veterans Claims Examiner (Education)	GS-9
Muskogee	Veterans Claims Examiner (Education)	GS-9
Muskogee	Veterans Claims Examiner (Education)	GS-9
Muskogee	Veterans Claims Examiner (Education)	GS-9
Muskogee	Veterans Claims Examiner (Education)	GS-9
Houston	Veterans Service Representative	GS-9
Houston	Veterans Service Representative	GS-7
Houston	Program Support Clerk	GS-2
Houston	Vocational Rehabilitation Counselor	GS-12

Western Area:

Regional Office	Position Title	Grade
Denver	Veterans Service Representative	GS-10
Phoenix	Information Technology Specialist	GS-7
Phoenix	Appraiser-outbased	GS-12

To accommodate the loss in staff, station directors have had to shift the work within their regional offices. Nationally, however, the impact has been minimal.

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5. A large number of long-time employees at the Hines Benefits Delivery Center appear to be close to retirement age. Describe all measures being taken to assure continuity of operations in the event that the projected completion date for the VETSNET replacement system is extended?

Response:

As of March 1, 2003, the Hines Information Technology Center (ITC) has 228 fulltime permanent employees. The average age is almost 51 years, with 38 current employees (16%) eligible for regular retirement. With this background in mind, the following actions were taken to ensure continuity of Benefits Delivery Network (BDN) operations:

- The Hines ITC was reorganized to ensure manageability and accountability of resources.
- Ten new employees were hired to support the BDN.
- Fifteen of the 38 current retirement eligible staff who are considered critical are receiving retention bonuses.
- VBA has purchased a new Bull DPS9000/TA42 system with fully supported hardware and software, and is seeking approval for a Bull service contract to implement the system. Contract support is no longer available for the old hardware and software, and the few remaining employees with necessary skills to maintain them are retirement eligible. New hardware and software will be contract supportable and will be appropriate to the skill sets of younger employees and new hires.

- VBA is conducting an analysis of the operation of the BDN to maximize accuracy and efficiency. Over the last several years, the Hines ITC has lost valuable operating expertise on the BDN. This evaluation will help VBA adjust to the changed environment by highlighting the specific skills and knowledge that will be required of new hires.

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6. Please provide the number of compensation, DIC and pension claims which a fully trained veterans rating specialist is expected to produce per year.

Response:

A Performance Plan for Rating Veterans Service Representatives (RVSR) was implemented nationwide last summer (2002). Based on the production element of the plan and average available hours for work per year, a minimum acceptable level of claim production would be 600 ratings per RVSR per year. Current data show that nationwide, 74% of RVSRs are meeting the production element of the performance plan.

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7. Provide the total number and functional responsibilities of all additional staff needed to implement the recommendations of the General Accounting Office concerning the tracking of attrition rates and the reasons for attrition of newly hired employees.

Response:

To effectively implement the recommendations of the General Accounting Office (contained in its draft report, "Better Staff Attrition Data and Analysis Needed" (GAO-03-491)) concerning the tracking of attrition rates and the reasons for the attrition of newly hired employees the Veterans Benefits Administration (VBA) will be required to:

- Develop a standard protocol for conducting exit interviews at local facilities.
- Develop a standard method for collecting exit interview results (e.g. reasons for losses).

- Train VBA's Human Resource Assistants responsible for entering "reasons for resignation", into the VA Personnel Data System, on the appropriate codes and uses.
- Collect data on where separating employees find employment.
- Consistently compare VBA's attrition rates with attrition rates of other comparable agencies.
- Estimate the cost of recruiting and training new employees and determine the cost of attrition.
- Evaluate labor market conditions in locations where attrition rates exceed "reasonable" levels and develop strategies to minimize the impact of such conditions.
- Assess impact of attrition on VBA's veteran and minority employee representation.
- Develop methods for projecting attrition and incorporate results of the analysis of attrition rates into VBA's workforce planning efforts.

While the majority of these functions will be accomplished at VBA's corporate level, local facilities will be required to consistently perform exit interviews, collect and analyze resulting data to assess local impact, and report appropriate data to VBA's headquarters for national analysis and evaluation. Resources required to perform such functions at the regional office level will vary, depending largely on the resources currently dedicated to performing other human resource management functions. Regional offices with employment exceeding 100 FTE will require at least one FTE dedicated to functions associated with local recruitment and hiring, employee orientation and retention, exit interviews, attrition tracking and analysis, workforce planning, and similar human resource management responsibilities.

At VBA headquarters, the functional responsibilities needed to implement GAO's recommendations must be implemented in two phases. The first phase will require design and development of the necessary policies, guidance, and tools (e.g. exit interview guide and process, data collection instruments) required to communicate expectations and implement the necessary efforts VBA-wide. The second phase will require the ongoing collection of data from local facilities and comparable federal agencies, including the Department of Labor for local labor market conditions. Analysis of collected data will be required, as will the development of national and local strategies and recommendations to address and improve the attrition rate. Such efforts will initially require a total of two

FTE dedicated to the functions for phase one of this effort. Accomplishing the ongoing functions associated with phase two will require one dedicated FTE.

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8. Please provide the number of decisions referred for development by the Board of Veterans' Appeals and the manner in which Board employees are given credit for work on claims which involve both a grant or denial and development.

Response:

Through the end of April 2003, 11,834 cases were referred to the Board's Evidence Development Unit. Attorney and Board Members are given credit for preparation of the Development Memorandum which explains in detail what actions they wish the Development Unit to take.

If some issues in an appeal could be granted and others required development, a decision was prepared and dispatched on the granted issues and a Development Memorandum was prepared for the issues requiring development. Credit was given for both.

However, if some issues were to be denied and others developed, a Development Memorandum was prepared for the issues requiring development. Credit was given for the Development Memorandum. When the development was completed, all issues were covered in one decision. Credit was then given for the decision.

In a decision issued May 1, 2003, the United States Court of Appeals for the Federal Circuit invalidated the VA regulation authorizing the Board to develop evidence. Disabled American Veterans et al. v. Secretary of Veterans Affairs, Nos. 02-7304 –7305, -7316 (Fed. Cir. May 1, 2003). The Department is currently evaluating the impact of this decision.

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9. Please provide the status of the CAPS program. Which types of claims are entered into CAPS? Which types of claims are not entered into CAPS? Please describe any problems encountered in integrating CAPS with other VA IT systems and results of all remedial actions taken.

Response:

The Claims Automated Processing System (CAPS) application was fully deployed nationwide 2001. At that time, Regional Offices were instructed to use CAPS to control: 1) all cases requiring development that would generally take more than 30 days to resolve, and 2) special cases such as terminally ill claimants, former POW's, etc. Following implementation of the Claims Processing Initiative all existing claims requiring development must be placed in CAPS within seven days. CAPS is not integrated with other VA IT systems.

The CAPS application will be retired once our new Modern Award Processing – Development (MAP-D) application is fully deployed this year. MAP-D is the replacement application for CAPS and is part of VETSNET. We are presently in the process of training and deployment of this new application. CAPS records are converted into our corporate database for MAP-D use as stations transition from CAPS to MAP-D. This step ensures CAPS claim history is preserved.

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10. Please describe each problem encountered in implementing the SHARE program and all remedial actions which have been required. Describe the cost and results of each remedial action taken.

Response:

The SHARE program was deployed nationally in 2000 to facilitate inquiry to the Social Security Administration for information concerning SSA monthly benefits and Medicare deductions. This information is important in determining eligibility or continued entitlement to VA income related benefits. Since then, an additional function has been added to SHARE. That allows VBA to simultaneously update the Benefits Delivery Network (BDN) and the corporate database. Nationwide training for the additional function of SHARE was accomplished in October 2002.

VBA experienced one problem recently with the SHARE program. Our research identified a defect in the program that resulted in incorrect names being printed on checks for some beneficiaries in receipt of death benefits. The error occurred only when a specific sequence of user actions took place. The program has since been corrected. Our analysis of beneficiaries impacted by the error revealed that 12 beneficiaries received a check with the incorrect name. The regional offices having jurisdiction over those payments were notified and special procedures were put in

place to issue and deliver replacement checks. The cost for this for this correction was minimal.

We have identified a couple of remaining problems that do not affect payments to beneficiaries. They do, however, require correction.

- The Share Diary processing is not working correctly. Since Diary processing exists in the BDN, this input will be done in BDN until Share is fixed.

- There is an automatic default that is used so the system can set up a record for later processing. The default in not working properly and requires a manual entry until the application is corrected.

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