THE U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2009

HEARING

BEFORE THE

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

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

FEBRUARY 7, 2008

Serial No. 110–67

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CONTENTS

February 7, 2008

Page

MATERIAL SUBMITTED FOR THE RECORD

THE U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2009

THURSDAY, FEBRUARY 7, 2008

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

The Committee met, pursuant to notice, at 1:00 p.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Brown of Florida, Snyder, Michaud, Herseth Sandlin, Hall, Hare, Berkley, Donnelly, McNerney, Space, Walz, Buyer, Moran, Brown of South Carolina, Miller, Brown-Waite, Lamborn, Bilirakis, Buchanan.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good afternoon. And welcome to this meeting of the House Committee on Veterans' Affairs.

Secretary Peake, we welcome you to your first meeting with us in an official capacity and I know you have met with many of us unofficially. We thank you for starting our relationship off with good, positive notes and we look forward to your year in office and your testimony today. Of course, if you do your job right, we might be able to extend that.

So we certainly welcome you all. This is obviously one of the most important hearings that we could have as we hear the budget presentation from Secretary Peake.

We have other witnesses also who have a direct stake in the U.S. Department of Veterans Affairs (VA) budget and we thank all of you who have worked hard and have been diligent to ensure the VA budget is sufficient to meet the needs of our veterans.

Obviously the benefits, the services, the healthcare that we provide for our Nation's heroes are our prime responsibility and we must make sure that we provide the resources needed by our servicemembers returning from Iraq and Afghanistan and also, of course, we cannot forget the veterans from the previous conflicts.

This will not be cheap, but the service that has been rendered has been real and our VA budget must provide real funding levels to meet the needs of all our veterans.

Part of the cost of war is the cost of treating our veterans. I wish that you would talk to the President, Mr. Secretary, that when you have a supplemental funding request for the war, we need a supplemental for the warrior, too. The President is leaving it to the regular budget process to try to take care of those costs rather than provide for them in a supplemental.

The budget you are presenting today, Mr. Secretary, increases VA medical care by $2 billion, which is a 5½-percent increase; and would just barely cover the increase in inflation for healthcare in our Nation.

We are glad you increased that budget, but you are going to have to get used to me waving this around. This is *The Independent Budget*. I hope you have looked at it. I hope you will look at it. *The Independent Budget (IB)*, which we will hear more about today, also asks for an additional $1.6 billion over what you have asked for healthcare.

And although you have put in an increase for medical care in the budget, seven out of the ten major accounts in the VA budget you have decreased, including major construction projects, minor construction projects, grants for State cemeteries, grants for State homes, et cetera.

So although you have increased the healthcare budget, it is at the expense of the rest of these accounts. We are particularly concerned that in your 5-year budget estimates, there is a $19 billion decrease over 5 years below the current services budget. We have concerns about not only this year, but how you are projecting for the future.

We are disappointed again that the VA has submitted a budget, which assumes the continuation of the enrollment ban on so-called Priority 8 veterans. Although you were not here, Mr. Secretary, we were promised a detailed report by January of this year listing the resources needed by the VA to lift this ban and we still have not received that report and that information.

The ability of the Secretary to deny enrollment to a group of veterans was provided to the VA in order to address unexpected and unforeseen circumstances in the short term. It was never meant by Congress to provide the VA with the ability to ban groups of veterans year after year after year.

Again, in this budget—as has been the case over all the budgets from the Bush Administration—legislative proposals are included to increase fees and co-payments for certain veterans. Enrollment fees and increases in pharmacy co-payments have been rejected year after year after year by this Congress and, yet, they are back again.

So I would like to know, and I think this Committee wants to know, why you have offered these proposals again and the policy reasons for deeming the proposed receipts from these proposals mandatory dollars.

We will seriously look at your budget proposal. We have concerns, as I have mentioned, and we have incredible needs as you well know.

We have hundreds of thousands of young men and women coming back from Iraq and Afghanistan with post traumatic stress disorder (PTSD) and traumatic brain injury (TBI). They are not adequately diagnosed. They are not adequately treated. They are like ticking timebombs in our society, and as you know, suicide rates have reached Vietnam levels.

There was an incredible report in the *New York Times* about PTSD veterans who have committed homicides. A third of those diagnosed with PTSD seem to have felonies. This is a national trag-

edy and it is up to us to deal with it. In fact, if we have sufficient resources, we can deal with most of the problems we see happening.

We hope the budget will take care of these needs. We see already, as we see with Vietnam veterans, homeless Iraqi War veterans. We cannot allow this to happen and we will be looking at the budget to try to make sure that it does not.

I will recognize the Ranking Member, Mr. Buyer, for his opening statement.

[The prepared statement of Chairman Filner appears on p. 64.]

OPENING STATEMENT OF HON. STEVE BUYER
RANKING REPUBLICAN MEMBER

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

I would like to welcome you, Secretary Peake, to your very first testimony, this being the second session of the 110th Congress. It is my pleasure to welcome you as our first witness.

Secretary Peake is a retired Lieutenant General of the United States Army Medical Corps. He is a combat-wounded Vietnam veteran, a Silver Star recipient, and former Surgeon General of the Army.

I know from my tenure on the Armed Services Committee that Secretary Peake is a man of principle, who adheres to Army values, and I am encouraged that our perspectives over the years are similarly aligned with regard to serving America's soldiers, sailors, airmen, Marine, Coast Guardsmen, and our veterans and their dependents.

I also recognize as you move into this position, Mr. Secretary, that you step into it with a pretty good team when I look at Admiral Cooper and General Kussman and Mr. Tuerk, and you have a champion to your right over there in Gordon Mansfield.

Gordon has been around a long time. He knows a lot about the systems and knows a lot about the personalities, the players, knows a lot about the Veterans Service Organizations (VSOs), knows who is substantive and who makes noise. I mean, he knows. And so he can be very valuable to you in his candor. He is a good man.

Mr. Secretary, when I read your written statement, I was struck by some things. Number one, your top legislative priority is to implement the recommendations of the Dole-Shalala Commission. With the influx of thousands of returning combat veterans from Iraq and Afghanistan, we must act promptly to make the fundamental changes in the way VA and the U.S. Department of Defense (DoD) compensate and assist veterans and their survivors for disabilities and deaths attributed to military service.

It is urgent that Congress, the VA, and DoD work together in a decisive manner to implement such reform while the will to do so exists. Otherwise, we will be merely passing the targeted problems off to others.

Successful reform would make great strides toward our mutually held goal of ensuring that veterans returning from military service are able to make a smooth and easy transition back to a productive life.

Mr. Secretary, I am heartened by some other provisions in your budget proposal. I commend the legislative proposal to expand the specialized residential care and rehabilitation in VA and approve medical foster homes for TBI patients. However, I do have some concerns with one of the other provisions.

Now, I differ with the Chairman when it comes to enrollment fees and co-pays because these are very good management tools. I personally agree with cost-sharing fees for higher income, non-service-connected veterans.

Now, in your proposal for the first time I have seen that any funds collected would go to the Treasury. I think they should stay within the VA. My gut tells me this Committee once again will not accept an increase in co-pays or enrollment fees. It is one of the massive errors that we made as a Committee when we opened it up. We should have given these tools to you and we did not. And you keep asking for them and this Committee will not do it. And I will not belabor it.

Another issue, the claims backlog continues to be a looming problem, but according to the budget proposal, you anticipate with additional employees the backlog can be reduced by 24 percent. We are very optimistic and we will get into how you can justify that.

I am also encouraged that the VA is perhaps finding a foothold. However, I question how these remarkable efficiencies can be achieved. You know, 24 is a big number, so I am pretty eager.

We learned, not long ago, from Admiral Cooper with regard to staff training as a challenge and the exams that you gave and how many did not pass those exams. So we are interested to hear how the training is going.

I also want to get into how you are making a better use of the information technology (IT) to reduce the backlog problem. I also understand you have an initiative underway and we want to hear about that.

Also, any updates, Mr. Howard, you can give us with regard to how the IT transition is going and what needs that you may have. I see we have a bump up in our IT budget, so if you can tell us what that is going toward, software, hardware, as you implement your centralization model that is of great interest to us.

And, Mr. Secretary, you mentioned in your written statement that one of your highest legislative priorities is the establishment of a new position to serve as the VA's Chief Acquisition Officer. I have long been interested in procurement reform at the VA and I look forward to discussing this and other procurement reform initiatives. And I am not the only one. The Chairman and others are very concerned about procurement issues.

Also, in your budget, you are asking for $64 million for seismic corrections to the main hospital building in San Juan, Puerto Rico. Two years ago, we passed the law and we asked for you, the VA, to explore options for construction of a new VA medical facility in San Juan, so I am interested in the results of that study.

With that, Mr. Secretary, we welcome you and we look forward to your testimony.

And I yield back to the Chairman.

The CHAIRMAN. Thank you, Mr. Buyer.

Mr. Secretary, the floor is yours and we look forward to hearing from you. We will have questions from Members after your testimony.

Secretary PEAKE. With your permission, Mr. Chairman, I have a written statement that I would like to submit for the record.

The CHAIRMAN. Without objection, so ordered. Thank you.

Secretary PEAKE. Thank you.

STATEMENT OF HON. JAMES B. PEAKE, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY HON. MICHAEL J. KUSSMAN, M.D., MS, MACP, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION; HON. DANIEL L. COOPER, VADM (RET.), UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION; HON. WILLIAM F. TUERK, UNDER SECRETARY FOR MEMORIAL AFFAIRS, NATIONAL CEMETERY ADMINISTRATION; HON. ROBERT T. HOWARD, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY AND CHIEF INFORMATION OFFICER, OFFICE OF INFORMATION AND TECHNOLOGY; HON. ROBERT J. HENKE, ASSISTANT SECRETARY FOR MANAGEMENT; AND HON. PAUL J. HUTTER, GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary PEAKE. Mr. Chairman, Congressman Buyer, ladies and gentlemen of the Committee, I am honored to be here as the sixth Secretary of Veterans Affairs now responsible for the care of veterans. I appreciate the opportunity that the President has given to me to make a difference.

With me today, Congressman Buyer has already introduced my leadership team, and he is right about the quality, from my far left, our General Counsel, Paul Hutter; Mr. Bill Tuerk, our Under Secretary for Memorial Affairs; Mr. Bob Henke, our Assistant Secretary for Management. From my far right is Bob Howard, our Assistant Secretary for Information Technology; Admiral Dan Cooper, our Under Secretary for Benefits; Dr. General Mike Kussman, our Under Secretary for Health.

In my almost 2 months at the VA, I have seen both the compassion and the professionalism of our employees. It is frankly just exactly what I expected. The culture is one of deep respect for the men and women that we serve. The group at this table, and the VA at large, understands that America is at war and it is not business as usual.

I appreciate the importance of and I look forward to working with this Committee to build on VA's past successes, but more importantly, to look to the future to ensure veterans continue to receive timely, accessible delivery of high-quality benefits and services earned through their sacrifices and services and that we meet the needs of each segment of our veterans' population.

The President's request totals nearly $93.7 billion, $46.4 billion for entitlement programs and $47.2 billion for discretionary programs. The total request is $3.4 billion above the funding level for 2008 and the funding level that I am talking about is the funding level that includes the $3.7 billion plus-up from the emergency funding.

This budget will allow VA to address the areas critical to our mission, that is providing timely, accessible, high-quality healthcare to our highest-priority patients. We will advance our collaborative efforts with the Department of Defense, including progress toward secure, interoperable electronic medical records system.

We will improve the timeliness and accuracy of claims processing and ensure burial needs of veterans and their eligible family members are met and maintain the veterans cemeteries as national shrines.

Young men and women in uniform who are returning from Iraq and Afghanistan and their families represent a new generation of veterans. Their transition and reintegration into our civilian society when they take that uniform off is a prime focus. Those seriously injured must be able to transition between the DoD and VA system as they move on their journey to recovery.

This budget funds our polytrauma centers and sustains the network of polytrauma care that Dr. Kussman and his team have put in place. It funds the Federal recovery coordinators envisioned by the report of the Dole-Shalala Commission and it sustains the ongoing case management of all levels of our system.

We know that prosthetic support must keep pace with the newest generation of prostheses as our wounded warriors transition into the VA system. In this budget, you will see a 10 percent increase in our budget for this.

In 2009, we expect to treat about 333,000 Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. That's a 14 percent increase. We are seeing already a little bit of increase in the cost per capita of caring for these and we have increased our budget projection 21 percent to cover this. That is nearly $1.3 billion to meet the needs of OIF and OEF veterans that we expect will come to the VA for medical care.

This budget will sustain our outreach activities that range from 799,000 letters that we have sent out to more than 205,000 engagements with our Vet Centers reaching out to National Guard and Reserve units as part of the PDHRA, post deployment health reassessment process. It does not mention the 8,154 military briefings to about 300,000 veterans, service men and women that the Veterans Benefits Administration (VBA) has conducted.

This is also part of seamless transition. With the authority to provide care for 5 years for service-related issues, we can, without bureaucracy, offer the counseling and the support and care that might be needed to avert or mitigate future problems. And we want these young men and women to get those services.

Mental health from PTSD to depression to substance abuse are issues that I know are of great concern to you and they are of great concern to us. This budget proposes $3.9 billion for mental health across the board. That is a 9 percent increase from 2008. It will allow us to sustain an access standard that says if you show up for mental health, you will be screened in 24 hours and within 14 days have a full mental health evaluation if needed.

It will keep expanding the mental health access according to a uniform mental health package, trained mental health professionals and our community-based outpatient clinics, and there are

51 new community-based outpatient clinics (CBOCs) planned for 2009. And that is in addition to the 64 that are coming in 2008.

Our Vet Centers will bring on yet an additional 100 OIF and OEF counselors. And Dr. Kussman is prepared, as the need is identified, to add additional Vet Centers.

We appreciate the issues of rural access in this arena and our Vet Centers are budgeted for 50 new vans to support remote access as well as expanding telemedicine into 25 locations.

But this budget and our mission is more than just about these most recently returning men and women. We should remember that 20 percent of VA patients who in general are older and with more comorbid conditions than the general population have a mental health diagnosis. In fiscal year (FY) 2007, we saw 400,000 veterans of all eras with PTSD.

This budget will sustain VA's internationally recognized network of more than 200 specialized programs for the treatment of post traumatic stress disorder to our medical centers and clinics that serve all of our veterans.

We have a unique responsibility to those that have served before and, you know, we still have one World War I veteran. One died earlier this week actually. The World War II and Korea veterans are recipients of our geriatric care and our efforts at improving long-term, noninstitutional care where in this budget we have increased funding 28 percent will make a huge difference in their quality of life.

We currently have 32,000 people served by home telehealth programs. This budget continues our work in this area and in the expansion of home-based primary care.

Overall, the President's 2009 budget request has $41.2 billion for VA medical care, an increase of $2.3 billion over the 2008 level, but that is more than twice the funding level available at the beginning of the Bush Administration. With it, we will provide quality care, improve access, expand special services to the 5,771,000 patients we expect to treat in 2009, 1.6 percent above our current 2008 estimate.

In April of 2006, there were over 250,000 unique patients waiting more than 30 days for their desired appointment date. And you are right. That is not acceptable. As of January 1st, we had reduced the waiting list to just over 69,000. With this budget request, we believe we have the resources to virtually eliminate the waiting list by the end of next year.

Information technology cross-cuts the entire Department and this budget provides more than $2.4 billion for this vital function, 19 percent above our 2008, and reflects the realignment of all IT operations and functions under the management control of our Chief Information Officer, Robert Howard.

A majority, $261 million of that increase in IT funds will support VA's medical care program, particularly VA's electronic records system. I emphasize this here because it is so central to what we do and to the care we provide and the care that is touted in such publications as the book, *Best Care Anywhere*, as the key to our quality that is lauded worldwide.

This IT budget also includes all the infrastructure support such as hardware and software and communication systems for those 51

CBOCs that I mentioned as an example. And there is $93 million for cyber security continuing us on that road to being the gold standard.

IT will also be key as we move our claims model down the road to paperless processes. It is an investment that we must make. This budget sustains the work of VETSNET that is giving us management data already to really get after our claims processing and virtual VA, our electronic data repository.

In addition to IT, this budget does sustain a 2-year effort to hire and train 3,100 new staff to achieve our 145-day goal for processing compensation and pension claims in 2009. This is a 38-day improvement, 21 percent in processing time than it was from 2007 and that 24-day or 14-percent reduction from this year.

This is important because the volume of claims received is projected to reach 872,000 in 2009. That is a 51-percent increase since 2000.

Can we show that slide, that graph up here? The active Reserve and National Guard returning from OEF and OIF have contributed to an increase in new claims and bring with them really an increasing number of issues with each claim which you can see the difference between the claims growth on the bottom curve and the issues curve growth on the top curve. It is out of proportion.

[The graph referred to is attached to Secretary Peake's testimony, which appears on p. 75.]

And what you see also is that Dan Cooper has been able to keep that time to complete, that average days to complete relatively flat even with that growth. Each one of those issues has to be separately adjudicated and judged and can really be separately rated, if you will.

The President's budget includes seven legislative proposals as has been mentioned totaling $42 million. One of those proposals expands the authority to cover payment for specialized residential care and rehab in VA approved medical foster homes for OIF and OEF suffering from TBI.

We again do bring you a request for enrollment fees for those who can afford to pay and for a raise in the co-pays. Again, this does not affect our VA budget and I believe that is the same as it was last year. The money would return to the Treasury. That is $5.2 billion over a period of 10 years, not in the short term, but it does reflect the matter of equity for those veterans who have spent a full career in the military and under TRICARE who do pay an annual enrollment fee for that care.

The $442 million to support VA's medical and prosthetic research program, though less than what we have had from the augmented 2008 budget, is actually about 7.3 percent more than what we received in 2007 or what we asked for in 2007 and 2008.

It does contain, however, $252 million devoted to research projects focused specifically on veterans returning from service in Afghanistan and Iraq, projects in TBI and polytrauma and spinal cord injury and prosthetics and burn injury. In fact, we anticipate with this Federal grants and other grants, we will have a full research portfolio of about $1.85 billion.

This budget request includes just over $1 billion in capital funding for the VA, with resources to continue to five medical facility

projects already underway in Denver, Orlando, Lee County, Florida, San Juan, and St. Louis and to begin three new medical facility projects at Bay Pines, Tampa, Florida, and Palo Alto, two of which relate to our polytrauma rehab centers and continue our priority in this specialized area of excellence.

Finally, we will perform 111,000 interments in 2009. That is 11 percent more than 2007. The $181 million in this budget for the National Cemetery Administration (NCA) is 71 percent above the resources available to the Department's burial program when the President took office.

These resources will operationalize the six new national cemeteries that will open this year, providing a VA burial option to nearly a million previously unserved veteran families, and will maintain our cemeteries as national shrines that will again earn the highest marks in government and private sector for customer satisfaction.

This budget of $93.7 billion, nearly double from 7 years ago, and with a healthcare component more than twice what it was 7 years ago, will allow us to make great progress in the care of all of our veterans and will keep us on this quality journey in health and the management of an extraordinary benefit and ensuring the excellence of our final tribute to those who shall have borne the battle.

It is an honor to be with you, and I look forward to your questions.

[The prepared statement of Secretary Peake appears on p. 65.]

The CHAIRMAN. Thank you, Mr. Secretary.

We will begin the questions with the Chairman of our Health Subcommittee, Mr. Michaud.

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

And I want to thank you, Mr. Secretary, and your staff for coming here today to present the President's budget.

The 2009 budget submission for medical services is based primarily on actuarial analysis founded on current and projected veterans' population statistics, enrollment projections of demand, and case mix associated with current veteran patients.

Did that analysis include an increase in manpower deployment to support the surge and the subsequent redeployment back to the United States?

Secretary PEAKE. It did, sir. I understand that in a previous year, we may have been a little bit low on that projection and we, I think, made the appropriate adjustments with that, working with DoD, understanding the Congressional Budget Office (CBO) model and so forth. So that has been taken into account with this projection of 333,000.

Mr. MICHAUD. Good. And did that analysis also include the recent downturn in the economy and increased unemployment?

A lot of times, if you have a veteran who might be working, they might be provided healthcare benefits at their job of employment. But if they lose that job, then they are left in a lot of cases without any healthcare provided, so they look toward the VA. Did that include the downturn in the economy?

Secretary PEAKE. We did, I think, project the fact that we have open access for the first 5 years now to be able to bring them into our system and it does not matter whether they are employed or

not employed. If they have something that can be related possibly to their involvement overseas, we can take care of them.

Mr. MICHAUD. So did your projection include that consideration of the downturn though? I know you can take care of them. But if you have an influx because of the downturn and you are not accounting for them, then that is going to be a——

Secretary PEAKE. Right. I cannot tell you specifically, sir, if we looked at a rise in unemployment. I do not know if that was in our model.

Mr. MICHAUD. If you can check and get back with the Committee.

Secretary PEAKE. I will, yes.

Mr. MICHAUD. My next question deals with the enrollment fee. With the enrollment fee that you are proposing, I believe in 2007, it was estimated that that would result in approximately 200,000 veterans leaving the system if they had to pay an enrollment fee.

Under this, is there an estimate of how many veterans might leave if the enrollment fee is introduced?

Secretary PEAKE. Again, it is an estimate. This does affect just the Priority 8s really because so few of the Priority 7s would fit into that. It would be on the order of folks that use us of perhaps 140,000, which is really a relatively small number, and that we also know that many of those also have insurance and do not necessarily use VA as much anyway.

It gets to some of the management issues that Congressman Buyer was talking about. You think about it. You put a little skin in the game with an enrollment fee, they are perhaps more likely to come to us and get the full benefit of what we can offer them and we would be happy to do that.

Mr. MICHAUD. And could you provide the Committee, I asked this the last time, the Department had proposed an enrollment fee, and I never received the information if you submitted it, but could you provide a breakdown on that enrollment fee, so, say if someone makes $100,000, how many people are affected, how much revenue that would produce? I would like to have a further breakdown on that, how you came up with your numbers on that enrollment fee, if you could provide that for the Committee.

Secretary PEAKE. I will provide that for the record.

[The information was provided in the response to Question 5(a) in the Post-Hearing Questions posed by Mr. Filner and Responses from VA for the Record, which appear on p. 155.]

Mr. MICHAUD. Okay. Thank you.

My last question deals with not only VA but also the Army. There was a report in the news on January 29th, and I received confirmation from VSOs from my area, where the Army actually blocked VA staff from assisting transitioning soldiers because the soldiers had been receiving higher rating in their medical evaluation board.

What is the VA doing in regards to that?

And another area actually just brought to my attention earlier this morning from the Ranking Member also deals with the Army dealing with dental work. The Army more or less is shifting that cost on to the VA and not taking care of the soldiers.

Could you respond to both those?

Secretary PEAKE. Sure. Let me address those. First, we are still trying to sort out who said what to whom on the issue of the counseling at Fort Drum. I can tell you the first report to me is that some of our people were actually helping write the requirements that were within the military system.

Our folks are not really necessarily trained to do that, but we clearly have a role of being there, advising servicemembers on what their VA benefits might be and what their ratings might be from the VA.

This actually talks to the issue of why we need to get ahead and streamline this disability system so it is not so confusing and it is not, oh, well, they are the VA and there is the DoD. So, again, the Dole-Shalala recommendations give us a road ahead on that and we need to sort out the details so we get it right.

On the issue of dental care, that has been an issue for the military and particularly for the Reservists for a long time. I had to come up here and testify why we took out so many teeth when we mobilized people in my previous life. So perhaps it would be nice if the military were able to have that all taken care of for the Reservists. But when they come rolling back in and come back to their home station, at least when they come to the VA, and I will give great credit to Dr. Kussman, we have gone and we have purchased the care because we are authorized to provide that dental care within what, 60 days or——

Dr. KUSSMAN. Ninety days and we're going to 180.

Secretary PEAKE [continuing]. Ninety days and we are going to 180 if the legislation is passed. And it will help the soldier and it, I think, will improve medical readiness because some of these people are still in the Reserves.

Mr. MICHAUD. Thank you very much.

And thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Lamborn, you are recognized for 5 minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

And, Mr. Secretary, feel free to answer this question or pass it on to one of your Under Secretaries.

But first I would like to say thank you, Chairman Filner and Ranking Member Buyer, for your leadership and dedication to the calls of our Nation's veterans.

I would also like to thank Chairman Hall for working with me in a bipartisan manner on the Disability Assistance and Memorial Affairs Subcommittee of which I am now the Ranking Member.

Secretary Peake, I am pleased to see that the fiscal year 2009 VA budget request addresses the concerns of our veterans. Ensuring that our national cemeteries are maintained as shrines is emblematic of the VA's core beliefs. And I look forward to working with you and Under Secretary Tuerk on this important issue.

While I remain concerned about the disability compensation claims backlog, I am encouraged that VBA plans to utilize proven information technologies to decrease processing times.

As you know, I introduced two bills last year that would authorize a pilot program to test the capabilities of an automated claims processing system that helps VA employees process claims faster and more accurately.

And, Mr. Peake, also, I would like to ask you that, this is possibly something under the purview of Under Secretary Tuerk, the budget mentions a request for $5 million for a new land acquisition line item. I understand that this money is to be allocated for those regions with the highest projected need in the future for new cemetery space for existing cemeteries.

Based on the criteria used to assess this need, is it true that Fort Logan National Cemetery in Denver, Colorado, will be the next cemetery to reach capacity?

Secretary PEAKE. Perhaps Bill can offer the specifics. The money is designed to allow us to get moving on acquisition when the opportunity arises and so that we can ensure we do not have to close cemeteries.

Mr. TUERK. To answer your question specifically, Congressman, as I look across the universe of our larger cemeteries that are going to meet capacity, there is one cemetery, Jefferson Barracks National Cemetery in St. Louis, which would reach capacity before Fort Logan. But we already have a plan in place to acquire land contiguous to the cemetery from the medical center next door.

Based on the numbers that I have seen as recently as this morning, it would appear that Fort Logan is the next large cemetery that will reach capacity on the acreage that it currently owns.

Mr. LAMBORN. Thank you.

And as a followup, is it true that this land acquisition needs to be completed prior to Fort Logan or another such example reaching capacity because the process for acquiring land to build a cemetery is time-consuming and sometimes unpredictable?

Mr. TUERK. Shall I?

Secretary PEAKE. Please.

Mr. TUERK. Certainly the market, the catchment area if you will, of Denver and Colorado Springs is currently served by Fort Logan. We would not want to see that that area, which has a significant number of veterans, certainly well beyond our 170,000 criterion—possibly twice as many veterans than that criterion live within the catchment area of those two cities—cease to be served. We would certainly want to begin planning for a successor cemetery to Fort Logan before that cemetery closes so there will not be a lapse in service for the veterans on the eastern slope of the Rockies in Colorado. So in response to your question, the answer is yes, we most definitely plan to, intend to, and are beginning now to plan for, a successor cemetery lest there be an interruption of service.

Mr. LAMBORN. Okay. Thank you very much.

And I have a separate topic I would like to address briefly if my 5 minutes are still going. Mr. Secretary, over the past year, Members from both sides of the aisle have continued our push to require VBA to move toward a paperless claims processing system that uses rules-based technology.

This was something that was added to the Republican fiscal year 2008 views and estimates and was included in my legislation, H.R. 1884 and H.R. 3047.

I am happy to read about VBA's new paperless claims processing initiative. What is the funding level for this project and how much funding will be required over the next several years to complete this project?

Secretary PEAKE. A request for information (RFI) was put out for rules-based engines. That information is coming back. And then we are planning on getting a systems integrator to come in and look at all of the process that is put together. And so we will have to find what that future cost is based on the estimates that come out of these processes.

But I will assure you it is a high priority for me to get us moving in that direction. All you have to do is walk through the VBA mail room to make you believe that this is time to change.

Mr. LAMBORN. Thank you.

And I yield back.

The CHAIRMAN. Thank you, Mr. Lamborn.

The Chair of our Economic Opportunity Subcommittee, Ms. Herseth Sandlin, is recognized for 5 minutes.

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

Again, Mr. Secretary, welcome to the Committee. We look forward to working with you on a whole host of issues. And certainly Mr. Boozman and I look forward to working with you on the range of issues in the jurisdiction of our Subcommittee. And I do have a few questions for you about some of those issues, but I also want to talk with you a little bit about rural health and long-term care.

There was a handout that you had provided for the Veterans' Affairs Committee staff on February 4th. And in that handout, there was a chart as it relates to mandatory spending. And for housing, it shows an appropriation fiscal year 2007 of $50 million, fiscal year 2008 of $815 million, and fiscal year 2009, $2 million for a percentage change of 100 percent based on the fact that we are going, you know, less $813 million.

And I was just wondering if someone could explain that to me a little bit further as to why there would be such a drastic percentage change in the mandatory funding for the housing programs administered by VA.

Secretary PEAKE. If I may, I will ask Mr. Henke to answer.

Mr. HENKE. Yes, ma'am. There is a good reason for that. It is no change from our previous practice. It relates to the practice of credit reform legislation that we have had in place since 1992, now for 15 years.

There is no change in the number of loans, 180,000 loans that we are going to guarantee with the 2009 budget. It simply reflects the way we account for the risk for those loans and it is no different than we have done in the past.

Ms. HERSETH SANDLIN. So can you explain why then there was the jump from $50 to $815 million from last year?

Mr. HENKE. Because it is a projection for what is expected in that year for loan costs related to all of the cohorts that go back to 1992. What we projected in 2009 is the cohort from 2009.

Ms. HERSETH SANDLIN. Okay. Well, I think I will explore this a little bit further with you in a different setting because I want to get to some of the others.

On vocational rehabilitation loans, in the budget submission, the VA claims that fewer vocational rehabilitation loans will be provided in fiscal year 2009 than in fiscal year 2008. It is a difference of about $210 million or so.

And so I am just wondering what leads you to believe that there will be fewer loans established given the increasing numbers we are seeing, especially of OIF and OEF veterans returning home. I anticipate that there might actually be a greater need for these vocational rehabilitation loans.

Secretary PEAKE. Admiral Cooper.

Admiral COOPER. Those loans are used primarily to help people while their claims are being processed. In other words, if a person comes in and we can immediately qualify him or her for vocational rehabilitation, we go ahead and do that. And, if they need money immediately, we provide them loans. We felt as we looked at the estimate that we were higher than we needed to be right now. So we feel that the current estimate is a correct estimate.

Ms. HERSETH SANDLIN. Is that based on actual numbers then for fiscal year 2008?

Admiral COOPER. It is based on trends that we have seen over the last few years and the number we expect to come in. We feel that we do have a sufficient amount there.

Ms. HERSETH SANDLIN. Okay. Well, I will look forward to working with you——

Admiral COOPER. Yes, ma'am.

Ms. HERSETH SANDLIN [continuing]. Admiral Cooper, because we know there have been problems with the methodology in the past. I know we have tried to make some improvements to that, but we will look forward to pursuing that in a little bit more detail as well.

Secretary PEAKE. If I may just add——

Ms. HERSETH SANDLIN. Yes.

Secretary PEAKE [continuing]. We are increasing the number of vocational rehabilitation people in the field. We think this is a great program. We think it is underused. We think that we would like to see more people actually graduate from it. And so that is one of the first briefings I asked to get because I think it is a program that we really want to get behind.

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

I do think that especially with, and this will relate to my next question on rural health and rural veterans, when we have so many folks coming home and because of the National Guard and Reserve, many of them coming from rural areas, I think these loans not just for veterans in rural areas but anywhere, but in particular rural areas and the costs associated with maintaining the training programs if they are living a further distance and how much they are paying for other expenses just to continue participating in the program. And, like you said, increasing those rates of completion of the program is very important.

The VA Office of Rural Health, I notice that the budget submission is $1 million for one full-time employee. Given that studies indicate that over 40 percent of the veterans returning home from OEF and OIF come from rural communities, I am a little concerned about whether or not this is enough given the scope of the office in terms of conducting studies, developing policies. I know that we have made tremendous progress with the community-based outreach clinics. We have a number of them in South Dakota.

But as it relates to again the rural veteran population and the challenges that they face in getting care and the additional chal-

lenges with a new generation of veterans, many of whom are in rural areas, I am a little concerned about the budget request.

Secretary PEAKE. Actually, we have two people and you say, boy, is that enough? I am not sure it is if you just say, well, that is the only two people interested in rural health in the VA. I have asked the same question.

In fact, we have contract support that is the several million dollars level. I do not recall that number off the top of my head. And we have really an integrated effort.

When I sat down with this Office of Rural Health, the one person, the second person, just joined, she was surrounded by a lot of people from Dr. Kussman's team that are working collaboratively. And so it is an area that I think is really important.

You start looking at our numbers, about 38 percent of veterans live in rural areas. About 1.7 percent live in highly rural areas. When you look at where our CBOCs are, about 41 percent of our CBOCs are in rural areas. About 5 percent of our CBOCs are in highly rural areas.

That is why I was excited to see the 50 vans focused with our Vet Centers, so they can do that outreach and be the first face of the VA there, and why I am excited about this issue of telehealth and telemedicine and being able to reach out into their homes even out there.

As a matter of fact, one of my first trips is going to be to Montana because Senator Tester and I have had discussions about rural health. And so I appreciate your concern about it and I will assure you that we are paying some attention to it.

Ms. HERSETH SANDLIN. I appreciate that.

And, Mr. Chairman, I know I am over my time, but I know we just mandated the creation of that office fairly recently, within the last year or so. But I do hope that through the course of the year——

Secretary PEAKE. A year is a year. I appreciate that.

Ms. HERSETH SANDLIN [continuing]. We can lay the groundwork so that depending on the changes that are made to the budget as we undertake that work and what that leads to for the request for the next year, we hope we have more information going forward.

And then, finally, Mr. Chairman, one of the things I want to, because I have pursued this with previous Secretaries, is the issue of long-term care. And I know that there is a statutory requirement relating to the average daily census and that the budget submission does not meet that.

And I am not going to beat anybody up about that. I would rather engage in a longer conversation at some point about the rebalancing that is needed across States, across regions, across health systems to better address how long-term care has evolved because that statutory obligation was put in in 1999. And we have seen a lot of changes in long-term care since then.

So I just wanted to make mention of that, Mr. Chairman, for a topic that I know others of us have been interested, and we look forward to working with the Secretary on.

The CHAIRMAN. Thank you very much.

Mr. Brown, you are recognized for 5 minutes.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here today and thank you for your commitment to our veterans. And I enjoyed our conversation the other day and I was going to ask some continuing questions along those same lines.

Number one, there is a cemetery, a veterans' cemetery that has been proposed for Columbia, South Carolina. I know there has been some negotiation, I guess, with the Fort Jackson system there.

But could you tell me where we are in that process? Has there been some land exchanged between, you know, the Fort Jackson and the cemetery?

Secretary PEAKE. Can I ask Under Secretary Tuerk to answer that, please.

Mr. TUERK. Yes, sir, Mr. Brown. We have reached an agreement with the Department of the Army to transfer land from Fort Jackson to us. That transfer has not yet been effected. It is authorized by statute. We have reached an agreement with the Army on the transfer, but lawyers are working out the details, the title transfer, et cetera. And we expect actual title to pass probably in September of this year. But, we are not waiting for title to pass before we start designing the cemetery. Indeed, we have already let contracts for the design of that cemetery. I have already seen a master plan of that cemetery in sketch form. And right now we are scheduled to break ground in July even in advance of taking title with the goal of opening that cemetery for burials before the end of this year.

Mr. BROWN OF SOUTH CAROLINA. The next question is about the VA Medical University Association in Charleston. I know in 2006 in the authorization bill, we actually put $38.6 million there to start the design phase. The Medical University is already in a construction mode now.

They have already built their first tower. And we were hoping that by use of this $38.6 million or some portion thereof to start some design for replacing the old VA hospital with a new bed tower adjacent to the Medical University.

Could you give me an update on that, please.

Secretary PEAKE. Sir, as we discussed the other day, our engineer and facilities folks suggest to me that there is a longer life expectancy for that building than perhaps has been considered, the current VA hospital there down on the grounds.

We are also looking at what the requirements might be to support the veterans in that area and what kind of collaboration we might be able to build with the university.

We have this week had an engineering team down with the Navy looking at the old Charleston Naval Hospital to understand whether that might well become a better site for us to invest in to be able to provide really what we are looking at, almost a new model of care where we have a really robust ambulatory center that is capable of doing day surgery and those kinds of things, ambulatory surgery, so that people do not have to travel all the way down the peninsula.

And so I look forward to working with you, sir. And, actually, just talking to the Ranking Member about going down perhaps to visit and see you there and look on the ground. But we are looking at how to best serve the needs.

I know we have the work up at Goose Creek going on as well. So I think if we look really at the whole population area and trying to make the decision as we move forward is what we would like to be able to do.

Mr. BROWN OF SOUTH CAROLINA. Okay. I really do appreciate the opportunity to show you physically on the ground the close proximity of the VA and the Medical University and hoping that, you know, maybe by giving you an oversight of where, you know, the facilities are located, it might give you a little bit closer view.

I know we have been working on, you know, consolidating some services between the VA and some other hospital, not just for the Charleston region but across the whole system. I think it would be a whole lot of savings incurred there. And I know we appreciate Dr. Kussman for his, you know, continuing dialogue along those lines too.

So look forward to having you down in Charleston, and thank you for coming today.

Secretary PEAKE. Thank you, sir.

The CHAIRMAN. Thank you, Mr. Brown.

The Chairman of our Disability Assistance and Memorial Affairs Subcommittee, Mr. Hall, is recognized for 5 minutes.

Mr. HALL. Thank you, Mr. Chairman and the Ranking Member.

And, Secretary, thank you so much for you and your associates for being here today and thank you for your service to our country both in uniform and with the Veterans Administration.

I wanted to start by asking in light of questions before your tenure, the VA's budget submission in fiscal year 2007 estimated that we would see 109,000 OEF/OIF veterans and current records now show that the VA instead saw 206,000.

In fiscal year 2008, the estimate was that VA would see 263,000, but now that number has risen to 293,000. So, in other words, it is an 87,000 person increase over fiscal year 2007. This year, you estimate that you will see 333,000 OEF/OIF veterans in 2009, an increase of 40,000.

In light of the previous underestimating of that number, what should this Committee honestly expect? Do you think that 40,000 is a realistic number when the previous numbers were off by as much as 87,000?

Secretary PEAKE. Sir, I believe it is a legitimate number. I will tell you we do not want to underestimate that number. My understanding is that we have cranked in the right considerations and the Kentucky windage to try to make sure that we are coming in with a very legitimate number.

Mr. HALL. That is good. I am praying for that to be accurate.

And I wanted to know what the impact on the budget would be or if you know, if anybody in your team knows what the impact would be if we had universal screening of all veterans who are leaving active duty and separating from the service and becoming veterans and coming under the VA's jurisdiction.

The reason I ask is because we have had testimony before the Subcommittee on Disability Assistance and Memorial Affairs and before the full Committee about veteran suicides presumptively due to PTSD among other factors. And we know we are facing a

record number of suicides, not just among veterans but among soldiers, active-duty men and women.

And it was suggested by one of the parents of a person who took his life that it is too hard to self-identify, that the veterans who are coming out, they are taught to be tough and they do not want to have something on their record that might hinder their advancement in the Guard or Reserve or hinder their advancement in private business. So they stand in line and do not go to door number five to see the psychiatrist or whatever, you know, when they are told the opportunity is there.

And this father said he would like us to look at screening everybody. And the percentage coming back from Iraq and Afghanistan with PTSD seems to be high enough that it might be warranted anyway.

What are your thoughts about that and what do you think of those budget-wise?

The CHAIRMAN. Mr. Secretary, before you answer, if you would yield for a corollary question.

Most of you, when you testify, you use this little phrase. You say, "if you show up" at the VA, you will get a full screening. The problem is that, not everybody shows up. We have to have far more universal screening because the percentages are so high and you keep saying "if you show up." We need to go out and do it in cooperation with the Department of Defense.

Secretary PEAKE. Thank you, Mr. Chairman.

Mr. Chairman, I agree with your premise of "if they show up" and that is why this outreach is so important. That is why I tried to emphasize it in my opening remarks because I agree with you. What we want, as I was trying to point out, is to bring these people in.

Let me address your point, sir, a couple ways. One, in the military, there is an attempt to do this. It is called the post deployment health assessment. It is followed up at a later date because we know if you hit them right away, they just want to go home. And I mean, I have seen it. I do not even want to fill out that form, just let me go home. Okay. I will fill it out, boom, boom, boom.

And a paper that was published in November by the military, Dr. Millican, said that what they found on the post deployment health assessment, which again is sort of self-referral and self-selection, you have to fill out the form and then you get a face to face, is that there was a higher number of folks that actually identified themselves as needing some help.

Our Vet Centers are putting people at those sites with the Reserve components where they do that post deployment health reassessment. So we are trying to do exactly what you say.

I will say also that anybody that comes to us, even if they are not coming for mental health, come in for a sprained ankle or, feeling bad or whatever, in Mike Kussman's whole arena, you get screening for mental health, you get screened.

There are actually specific questions asked for PTSD, for TBI, for suicide risk, because we do want to be sensitive to those kinds of things, identify those people who are not necessarily coming in for that even.

And that is one of the other reasons why we want mental health people in our community-based outpatient clinics, because we know that people show up for physical illnesses because they have mental illnesses sometimes, mental issues.

And so it is not a very simple issue, but it is one that I think we are dealing with on multiple fronts and we want to continue to do that outreach.

Mr. HALL. Thank you, Mr. Chairman. I will submit more questions for the record.

[Questions for the Record to VA from Mr. Hall appear on p. 163.]

The CHAIRMAN. Thank you.

Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you.

Mr. Secretary, pleasure to initially make this acquaintance and look forward to having conversations with you in the future.

I especially wanted to thank your colleague, Under Secretary Tuerk, for his personal attention that he provided in helping us resolve a cemetery issue, a lack of space at Fort Riley. And everything I know is that that has been a good outcome and I appreciate the personal attention, but also the let us get it done attitude that he and his staff exhibited.

I offered an amendment. In fact, I have done it for 5 years now since I have been in Congress and ultimately it became law. We increased the amount of money available for medical mileage.

Mr. Secretary, I represent a district that has no VA hospitals. It is 60,000 square miles and many World War II veterans who live hours from a VA facility. I appreciate the cooperation I have had with our VA system, our Veterans Integrated Service Network (VISN) in CBOC opportunities.

But one of the things that has been a cause for me since I came to Congress is trying to recognize that 30 years is a long time to raise the medical mileage stuck at 11 cents.

As I understand it, the VA has reached the conclusion that this 28½ cents mile—first of all, let me thank you for implementing it what I would say is rather quickly and took a long time to get there, but it seemed to me that the Department responded in an appropriate timely fashion after the appropriation bill was signed.

That money or that rate, 28½ cents a mile, I would like for you to confirm. It is my understanding that the VA expects that rate to continue into future years, that this is not a 1-year 28½ cents mile and it drops back to 11 cents in the future.

Secretary PEAKE. Sir, that is my intent. I would tell you that we need to keep watching the price of gas.

Mr. MORAN. As do our veterans.

Secretary PEAKE. Right.

Mr. MORAN. And the $125 million was set aside for this purpose and the VA concluded you were bound by law, that with the increase in the mileage rate, you had to increase the co-payments which, if that is the case, it seemed to me that the estimate, the CBO estimate was a cost of $113 million.

So the language in our amendment talked about 28½ cents a mile. You concluded that you had to raise the co-payments. CBO says that increasing the mileage rate is $113 million. There is a gap. It seems to me we picked the worst options for our veterans

as the co-payment has to be paid and we will not increase the rate above the 28½ cents a mile that is in the language, yet we had another $12 million to spend.

Secretary PEAKE. Sir, what went out with that guidance was pointing out that that co-payment could be waived. So we are expecting that to be the norm actually.

Mr. MORAN. You are telling me something I do not know. Be waived in certain circumstances?

Secretary PEAKE. My understanding is that we have not been collecting the co-pays or, I am sorry, the deduction is what it is actually.

Mr. MORAN. The deduction, you do not intend to collect an increased amount from the veterans even though the mileage rate went up?

Secretary PEAKE. That is correct.

Mr. MORAN. I am glad I asked this question because I was expecting a different answer, but I am pleased with the answer.

Secretary PEAKE. The guidance was clear in the letter I sent. As a matter of fact, it had to go out again.

Mr. MORAN. So the deductibles will remain the same while the mileage rate increases?

Secretary PEAKE. They are not paying the deductibles now. I mean, they are——

Mr. MORAN. That will be news to my veterans who complain to me constantly about their mileage check being reduced by a deductible. We will explore this, I guess, further.

Secretary PEAKE. Let me get with you separately on it and I will address the issue.

Mr. MORAN. Very good. I also would raise just two more points in the 49 seconds that I have left. My impression of, in fact I say that perhaps the greatest accomplishment of the 2007 year in Congress was the significant increase in healthcare funding for our veterans.

But one of the things I have discovered is that despite the increased funding, the VA has a significant challenge, as does the private sector, in recruiting healthcare professionals.

And I would be interested in hearing at some point in time about the efforts at the VA to increase the pool or the opportunity that you have to recruit nurses, doctors, mental health professionals, psychiatrists, psychologists. The message I am getting from my VA employees back home is, it is great to have more money, we appreciate that, but the end result is that we may not be able to recruit to fill those positions.

Secretary PEAKE. Sir, it is geographically dependent in the United States. It is a problem across the country. I think we have been aided recently in the opportunity to pay more competitive fees for healthcare providers. And that has made a difference. As I have looked at some of the graphs already, you can see some upturns in the number of providers that we have, nurses and physicians specifically.

Mr. MORAN. That is good to hear.

Secretary PEAKE. But there are areas where we do have challenges with it.

Mr. MORAN. And, finally, I just would remind you that I think a priority for the Department of Veterans Affairs and should be in the budget is the elimination of Priority or Category 8. I wish that was a higher priority within the Department and your budget process.

To me, our Priority 8 veterans deserve to be included, not excluded. And my guess is that we disagree, me as a Member of Congress, you as the Secretary of the Department of Veterans Affairs.

As you prioritize your budget, I just would encourage you that you have the authority to waive that and I wish it was included in the request from the Administration on the budget.

Secretary PEAKE. Thank you, sir.

Mr. MORAN. Thank you, Mr. Secretary.

The CHAIRMAN. Mr. Secretary, I would just like to remind you when the question is asked from an individual, he is really asking as a Member of the Committee and any information should be provided to the whole Committee.

Secretary PEAKE. Absolutely.

The CHAIRMAN. Thank you.

Ms. Berkley, you are recognized for 5 minutes.

Ms. BERKLEY. Thank you very much, Mr. Chairman.

First, I also would like to welcome you. I think this position is so very important in the cabinet. I view the Secretary's role as being the primary advocate for the veterans and not an apologist for the Administration. And I like a Secretary that will fight the good fight for the vets and let the chips fall where they may.

For me, the cost of veterans' care is the cost of doing more and should be part and parcel. You cannot send young men and women overseas to fight this Nation's wars without the expectation that they are coming home and they are going to need healthcare and other benefits, and we need to provide not only as they leave, but when they come back as well.

I also want to compliment you on how well prepared you are. I appreciate that and I think it shows a great sign of respect for the Committee and also for your job. And so I thank you very much for being so well prepared and being so new at the same time. I do not think that has been lost on any of us.

I have a number of areas that I wanted to touch bases with you. And, of course, all politics is local, so I am going to localize my comments to you and my questions.

First of all, as you know, we have been very pleased that we are in the process of building a VA medical complex in north Las Vegas that will take care of the 200,000 plus veterans that call southern Nevada home. This has been a long time coming, but it is coming out of the ground.

And I was just there as recently as last month, had an opportunity to walk the 147 acres with the two contractors that have been selected. And I would love to have you come and see for yourself.

A couple of questions that I have is, one, is I do not know whether you realize Montana is very close to Nevada. So as long as you are going to Montana, you might want to make a little side trip down to Nevada and see what we are doing.

I would like to work with you and your Department to keep this project on track. Right now we are up to 2011 and we cannot wait too much longer. As you know, we have some serious needs. So that is going to be an issue that, you know, as I have said, if I have to go out with nail and hammer myself, I am going to do this. But I think it would be much better if the contractors did this and with your help, that will happen.

Also know that it is going to cost, I understand, about $100 million to get this up and running after it is completed with the technology and the furnishings and the equipment and the hiring of the new personnel.

And I would appreciate some guidance on when we start requesting those funds as well because it is not going to do us very much good if we have state-of-the-art buildings and no equipment or no personnel to actually provide the healthcare services to my veterans.

There was something that I think we cleared up earlier, but if you would not mind going on record. Let me find this. There was something that was—let me find this. We asked the question there was something in the budget regarding lowering the cost of—diverting 50 percent of primary and mental healthcare from the complex to ancillary sites. And you gave me a satisfactory answer. I believe that someone from your office did.

But could you go on record and explain the diversion because it is not actually a diversion, but I would like that for the record.

Secretary PEAKE. The idea was rather than all of that care being done at that complex that it would be providing for community-based environments for primary care to support that larger community. It would probably be more convenient, would be less expensive for that project, but also more convenient for the veterans, and it would be tied together electronically and so forth. So it will be part of an integrated system.

Ms. BERKLEY. Okay. So it is not a diminution of funding? Okay. I am glad we got that taken care of.

I am very concerned about something and I had a story, but we do not have the time to. I go to Walter Reed and I visit our wounded and one that was particularly touching to me, although he did not live in my congressional district, he lived in Arizona, was a young 24-year-old Lieutenant who had lost his arm and his leg. Quite a remarkable young man that I have gotten to know since my visit to Walter Reed even better, and he came for a second honeymoon with his wife to Las Vegas when he got out of Walter Reed. And we have kept in touch.

But why this is so significant is that was on a Thursday a couple of years ago. And on Tuesday, when we came back and were presented with the VA budget for the following year, there was a cut of $12 million from prosthetic research. And now, Republican and Democrat alike, we fought that and got the money back in.

I notice in this budget, unless I am misreading it, there is a $28 million cut in medical and prosthetic research. Is that really where we want to be trying to balance our budget on the arms and legs of these young men and women?

Secretary PEAKE. Well, first of all, for prostheses itself and buying prosthetics and the things that go with that, it is a 10 percent

increase. From the research perspective, it is not just prostheses. It is across the board. It is a medical research piece. And we——

Ms. BERKLEY. Why are we cutting that?

Secretary PEAKE. We appreciate the plus-up from last year. This really is consistent with what we have asked in the past. We believe we can leverage that.

We also put, if you think about the operational moneys that Dr. Kussman has in terms of the salaries of our investigators and so forth, that is another $440 million contributing to it.

We also get Federal funds, Federal grants to the tune of about $750 million, another $200 and some million from other than Federal grants. So we will have a research portfolio of about $1.85 billion.

And I think that we can meet the needs. Really our critical needs are focusing on our veterans with that amount of money.

Ms. BERKLEY. I suspect that this Committee is going to fight to restore those cuts and I think that would be an appropriate role for the Committee.

May I take one more minute?

The CHAIRMAN. Yes.

Ms. BERKLEY. Thank you. Thank you.

There is another issue that I am kind of confused about and let me set this up. The hardest call I had to make, and I call everybody in the State of Nevada, everybody's family when we lose someone, the hardest call I had to make was to a grandmother who had raised her grandson who had killed himself because he was so depressed. He was very depressed and suffering from PTSD.

Another tragedy in my community was a man named Justin Bailey who had a substance abuse problem when he returned and his family, parents insisted that he go to a VA hospital and get treated. The treatment exacerbated his situation because they gave him more drugs and he eventually overdosed while in the care of the VA hospital.

I have legislation pending, but I am a little concerned when I read this budget. And it also has a proposed cut of $4 million to substance abuse research under designated research areas. I would think that is one area that we would like to plus-up rather than cut.

And I know I have a bill pending, "The Mental Health Improvement Act." There are other Members of this Committee who have bills that deal primarily with PTSD and substance abuse. I would like to see this plussed-up and not cut.

Secretary PEAKE. Thank you, ma'am.

Ms. BERKLEY. And with that, I have other questions, but I know there are other Members of the Committee that wish to talk to you.

Thank you for your courtesy, Mr. Chairman.

And thank you very much. And we all wish you great success.

The CHAIRMAN. Thank you, Ms. Berkley.

Mr. Buyer, you are recognized for 5 minutes.

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

And, Mr. Secretary, I have a 2:30 meeting with the Ambassador of Panama, so I am going to run out to that and come back. Ms. Brown-Waite is going to take the chair here.

General Howard, under the cyber security funding line, that line item has been zeroed out, so I would like for you to explain to me, when a breach of personal identifiable information occurs requiring notification and a provision of credit monitoring services goes to a veteran, where does that funding come from?

Hold on to that. I am going to get the questions, so get ready to answer that one. And tell me about that plus-up. Okay?

The other is with regard to San Juan. It is a candidate site for a new VA medical center, so why would you want to spend this large amount of money you are proposing on an existing facility when proposing a replacement? So I would like you to answer that one.

With regard to Charleston, we are going to have a side bar conversation. I hope you and I can go to Charleston at a time when I can be there with Mr. Brown. But if I cannot, please, please go. There is a lot of push and pull on Charleston. You have some who work for you saying, "Oh, do not do that." We have a different kind of an idea. We have created the Charleston model. We tried to leverage it. We are trying to catch the wave of the future here.

And so one of us has to be an agent of change and take on a culture. And that is a side bar conversation that we will have.

The other I would like for you to know is about our previous conversation regarding dental. I did not prompt that question to the Chairman of the Health Subcommittee. I saw you smile at me. He has had an equal concern because he is a bill payor for Army Dental.

And if we, as a Congress, are going to embrace what General Casey as the Chief and General Cody as the Vice are doing to operationalize the force to include the Guard and Reserve, yes, we pay on the front end on sending them, but then when they come home, what are we doing? They are sending them to the VA to pay for dental.

And you coming from your medical profession say, well, you know what. At least somebody is taking care of them. But you know what, General. The Army has to be doing that.

And so we tried to get them to do a study and they took a look. They took care of the Sergeant Major's unit there, the first of the 34th. When they came back, they did all those dental exams and x-rays. You know why? Because I had them do that survey. Now we are finding out that in my calculations, they cooked the books.

I would like your reaction because I am not very happy. And this is an issue that we have as a Committee, and I am going to have some more conversations with the Chairman, we are going down and we are going to flip the beds over here on the Army Dental Corps because they told me 2 days ago that the demobilization is not their mission. Can you believe that? The Chief of the Army Dental Corps looks me in the eye and says not our mission. Taking care of soldiers not your mission? I do not get it.

So this is something that we, as a Committee, are going to take on. We will coordinate with Ike Skelton and we want to work with you. We opened up the access for the VA to take care of soldiers, not to be a bill payor for DoD.

Now, if you want us to send the Army Dental Corps a bill, I am sure Mr. Michaud would be more than happy to do that, would you

not? We will just send them a bill, because the more we pay on them, see, they will cost shift more to us, right? Well, wait a minute. Take care of your own. There are some intangibles there about the Army taking care of the Army.

And I know you spent 40 years in the Army. And I know you have to believe if we are going to move to operationalize the force, that we have to take care of them when they come home, especially with the Army Force Generation model. Would you not concur?

Secretary PEAKE. Sir, we know that the dental care deteriorates in the theater just because of the hygiene, the Coca-Cola and everything else. But I agree that we need to get them taken care of. And when we have the authority to do it, we will keep doing it until it is done in a different way.

Mr. BUYER. Well, you are correct. I know that. We are going to try to change that. We want the Army to embrace and take care of their soldiers.

Secretary PEAKE. We will be happy to work with you and the Army, sir.

Mr. BUYER. Thank you.

General Howard.

Mr. HOWARD. Sir, I believe I have two questions to answer. The first one refers to the supplemental funding credit protection being zeroed out. You see, there in the 2007 timeframe the $15 million. You know that was provided to us through the supplemental.

To give you an estimate of how much it has cost us in 2007 for credit protection, the number is $6.5 million. So, in other words, although we had set aside a large amount of money, we have not used it all. As you know, the veterans opt in, to the credit protection service, and that amount is $6.5 million.

Mr. BUYER. Okay.

Mr. HOWARD. The mailings associated with all that is about $1.3 million. So during 2007, that whole activity cost us about $8 million.

Why is it zero? Sir, we hope it is going to be zero in fiscal year 2009, that it is not going to cost us anything. We do not know how much to put in there and I hope it is nothing. There is just no way to estimate what that number is going to be.

But the fact of the matter is, whatever it is, is paid for right now out of the cyber security. We have to absorb it within that line item.

Mr. BUYER. What have you spent on notification? About $30 million?

Mr. HOWARD. The mailings cost about $1.3 million in 2007.

Mr. BUYER. I think we are probably going to have a problem. We gave you breathing room because we know that as you move to this new model that the chances of breaches are going to occur because the Under Secretary knows full well that he asked for a waiver. So we have a lot of docs out there with a lot of laptops and not everybody "as compliant." And so the chances that one of those laptops can either be stolen or lost are pretty real.

So if you have to do it, where do you go? What pot are you going to go and say I zeroed it out because I believe we will have no breaches this year, but if you have one, where are you going to get the money?

Mr. HOWARD. Sir, first of all, the personal equipment can be used. You are exactly right. The rules are very, very clear about the use of that. You know, we have recently published our handbook 6500, which augments the directive. The rules associated with the use of personal equipment are very clear: approval by the supervisor, the protection of the device, the rules that if you are a physician using your own laptop, it has——

Mr. BUYER. General Howard, I know that. If, in fact, a violation occurs, where are you going to get the money? You have zeroed out the account.

Mr. HOWARD. Right now out of cyber security, we have to absorb it, whatever it happens to be.

Mr. BUYER. All right. You can answer the other questions for the record.

Thank you, Mr. Chairman.

[The Post-Hearing Questions and Responses for the Record from Mr. Buyer appear on p. 174.]

The CHAIRMAN. Ms. Brown, you are recognized for 5 minutes.

Ms. BROWN OF FLORIDA. Thank you. It has been so long since I have had the microphone.

Mr. Secretary, welcome. You will find that our Committee is very bipartisan and we work really well together in trying to do what we can for the veterans.

I have a general question and then I have a specific question about my district. But the general question is, I know that we have raised the issue about suicides and, of course, many stories on television about the homeless. Mental health is the nuts of the problem.

Are we working with community-based organizations? Are we subcontracting and any way working with those organizations to work with us with our veterans?

Secretary PEAKE. Yes, ma'am, we are. We do in our homeless program, with our transitional housing. And I visited one of our transitional housing units actually down in Richmond within the first couple of weeks I was there. And we are increasing that. I think there are 3,000 new beds that will come on with that Grant Per Diem Program that we have.

In terms of the homeless folks, it is better than $1.6 billion worth of healthcare that we give to homeless people. I have been to one of our homeless stand-downs. Actually, the one out here at the Washington, D.C., VA Medical Center.

Ms. BROWN OF FLORIDA. I participated in the one in Jacksonville. But I am wondering, part of it has to be the mental health though.

Secretary PEAKE. Yes, ma'am.

Ms. BROWN OF FLORIDA. That has to be a part of it because they are homeless. They are having problems.

Secretary PEAKE. You are exactly right. It is mental health. It is substance abuse. I think those are the things that really are big drivers to it.

And if you look at our domiciliary programs, they have treatment programs built into those. And we are also going to see a rise in the domiciliary beds. I think there were 11 new domiciliaries that were approved in the last 3 years that will be coming onboard and coming online. So I think that is a positive story.

Ms. BROWN OF FLORIDA. The Orlando Hospital has been in the making for over 25 years. And I think we recently just signed the contract for the land.

I mean, can we look at, and I spoke with you about this when you first——

Secretary PEAKE. Yes, ma'am.

Ms. BROWN OF FLORIDA [continuing]. Took the job, design build. It should not take another 5 years. We have great people in the area. I visited the Gainesville facility. I told you that they are building a cancer hospital right next door to it. It is a design build. It is going to be up in 16 months and we are talking about years.

And the facility, they are trying to do a wrap-around in Gainesville, the facility, but you have men five and six in a room and the facility for showers is down the hall. Now, that was great when I was in college, but that is not what our men need in these facilities.

Secretary PEAKE. I went back and checked after your conversation, ma'am. We are at 100 percent design, so the design piece is not the holdup. And so we are moving.

I did also check about the hospital across the street and there was really work back there in April of 2006. So I mean, even though they may not be so visible, it has been on the books a little bit longer than that 18 months. But these are complex facilities, but there is no question, because I also went back and looked to understand the need that you have in Gainesville.

Ms. BROWN OF FLORIDA. Yes.

Secretary PEAKE. So I have talked to our people about let us see what we can do with the contractor to work to speed that baby up. But the design build will not help us in this case because we are at 100 percent design and you are fully funded for it.

Ms. BROWN OF FLORIDA. But it would help us in the Orlando facility.

Secretary PEAKE. I will go back and look at that to see if there is a way that would make a difference for it. I know we are on the Orlando facility, the first thing going back to your other point is the domiciliary is one of the first projects that is going into that campus.

Ms. BROWN OF FLORIDA. Now, on Tuesday, I am going to spend the day in New Orleans with your people there on that hospital there because I want to know what is the status, how can we speed it up, how we can work with the community people.

And I am finding that people are great in the field, but I want us to do our part. We are always talking about how we do things, how we can speed up putting these facilities online when we actually fund it here.

Secretary PEAKE. Yes, ma'am. For the New Orleans facility I looked at the testimony last year, I think we are a little further along. We are really working hard on the site that is across from Louisiana State University. So I think we have the downtown site and we are still crossing the Ts and dotting the Is with the city and——

Ms. BROWN OF FLORIDA. I will be meeting with the city and with your people Tuesday.

Secretary PEAKE. I think we are getting ready to go there.

Ms. BROWN OF FLORIDA. Good. Thank you, and welcome.

Secretary PEAKE. Thank you.

The CHAIRMAN. Thank you, Ms. Brown.

Ms. Brown-Waite.

Ms. BROWN–WAITE. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. I am the Ranking Member on the Oversight and Investigations Subcommittee. We recently held several hearings and the Office of Inspector General (OIG) gave us reports that were very relevant to the subject matter at hand. One actually happened to be credentialing and privileging.

And at this Subcommittee hearing, we were concerned that the Inspector General whose budget was plussed-up could indeed have his budget reduced. I think especially because the need is there for additional oversight and investigation that the Inspector General's Office performs a very valuable task. And I see you shaking your head. Obviously you agree——

Secretary PEAKE. I do.

Ms. BROWN–WAITE [continuing]. Mr. Secretary. I know that it was not your budget that actually cut back the funding for the Inspector General's Office to reduce the 48 plus-up positions that the appropriations for 2008 actually provided; is that correct?

Secretary PEAKE. Well, this is my budget. I can tell you that when I looked at that, I asked a question. And if you look at it, we are about 8 percent more this year than what it was the year before, before the plus-up.

I will tell you I do believe that the OIG is a very important organ for us and for us collectively, we in the VA and you in the Congress. And so I have not had specific discussions with Mr. Opfer yet on if he feels like he has any significant shortfalls here. But I do believe in the value of the OIG.

Ms. BROWN–WAITE. Well, would this not in effect take the 48 positions that were added and eliminate them?

Secretary PEAKE. I know he does some of his work by contract and I cannot tell you——

Ms. BROWN–WAITE. I believe it is 48 full-time equivalents (FTE) that would be eliminated as a result of the budget request. And I know that Members on both sides of the aisle and on this Committee are committed to making sure that the Inspector General's Office is adequately funded.

And I do not think adequately funded would translate into a reduction of the number of people in the Inspector General's Office. And so we had actually discussed this in the Oversight and Investigations Subcommittee about how important it is that the Members of this Committee support the increase from last year and perhaps even plus it up more.

We want to make sure that that funding is there and that staffing levels are appropriate for the needs of the VA. And while the Office of Management and Budget (OMB) may have been the entity that made that cut, I do believe that Members on both sides of the aisle will support going back and restoring that funding.

Let me ask you another question and that is on compensation and pension. I see where you are talking about adding 700 new FTE positions and if it takes I am told 3 years to train new compensation and pension employees, how is this going to work out to

address the immediate need and the immediate backlog that exists right now mainly because of the increasing number of benefits being sought?

Secretary PEAKE. Well, it is a challenge and training is a challenge. I know that Admiral Cooper and I have talked about some of the things that he is doing to try to shorten that time between bringing you on and making you effective to include things like training them on some of the simpler things where they can go back and unburden some of the more experienced people in their work sites, allowing them to focus on the harder claims, and then learning more on the job using more electronics in terms of the computers to be able to train people.

But I think the real answer is that we need to get after change in the process and making a simpler process using these rules-based engines—but that is going to take more time to deal with the issue.

Ms. BROWN–WAITE. But you are looking at having them do the more simpler tasks to free up the more experienced claims rating——

Secretary PEAKE. And I would be happy to have Admiral Cooper go in more detail if you would like.

Admiral COOPER. Yes, ma'am. Part of our plan is to more effectively utilize new people earlier in their training by having them process the simpler claims first. So we have started doing that. In the month of January, we produced more end products, the third most in the last 6 years. So we are making progress.

But another important point is that we will have hired the total number of people we expect for Compensation and Pension (C&P) Service, 10,750, and we will have them onboard at the beginning of the year. The buildup will be done by the beginning of 2009, so we should be able to take greater advantage of those assets that we have.

Ms. BROWN–WAITE. Thank you.

I yield back.

The CHAIRMAN. Thank you. And thank you for the concern over the OIG budget.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. Nice to meet you for the first time.

Secretary PEAKE. Nice to meet you, sir.

Mr. HARE. Just a couple of things I would like to say before a question or two for you. I want to commend Under Secretary Tuerk. He came out to my district. We have the Rock Island Army Arsenal Cemetery. And we spent a lot of time on a very cold day. And you could just tell and so could the veterans, Under Secretary Tuerk, how much and how honored you were to be there and what a great job you did. So I just want to give a complement to your boss here.

The other thing, too, and I want to thank the VA. I know they are taking a look at, Mr. Secretary, the possibility of getting a CBOC in Sterling, Illinois, which is in my congressional district. And I understand that that information that you are gathering might be completed by late summer and we are hoping and praying in Sterling, Illinois, that that can happen. It is certainly needed.

One of the top legislative priorities of most of the VSOs, Mr. Secretary, is legislation that will require mandatory funding for the VA. Thirteen out of the last fourteen VA appropriations bills have been late in providing critical funding for the Veterans Health Administration (VHA).

I have a bill that you are probably aware of. It is the Assured Funding Bill that I have introduced and have about 130 co-sponsors to the bill.

You know, we heard a lot the other day on Super Tuesday about who won and who lost. The veterans in my State actually won. We had a referendum on most of the counties, with 102 in Illinois. Ninety-seven percent of the people, Republicans, Democrats, and everybody that voted, voted yes, so it was a nonbinding, but it was a sense of where people wanted to go.

And the Lieutenant Governor mentioned this very issue of assured funding and 97 percent of the people on both sides that came out on a very cold and nasty day voted in support of this.

I was pleased to see that during your confirmation hearings, you expressed an interest in looking more closely on the issue of mandatory funding and would be interested to maybe get some thoughts from you on that.

You know, I hear so much from so many people that it is very difficult to figure out what you are going to spend when you do not know and if you are not even going to get the money in a timely fashion.

So I would like to maybe just ask you about your position on that and would certainly love to, down the road obviously, sit down and maybe have a conversation with you outside the hearing on the matter, too, but kind of wanted to see where you were at there.

Secretary PEAKE. Yes, sir. I will tell you that there is concern and I share it about getting into some magic formula when we have potentially changing needs that might come with conflict or whatever. I think we have gotten much better with our population models and our actuarial projections.

In fact, with Admiral Dunne and really a shop dedicated to that, I think as I have looked at our numbers, we are getting closer and closer to really being able to have good actuarial projections that should be able to help us.

I apologize. I am not familiar with your bill. I have not had a chance to study it, but will.

Mr. HARE. Thank you, sir.

Secretary PEAKE. I am certainly willing to look at it and understand it about what ways we can have to get more consistent funding. It is a problem when we do not get money early on in the year or when it delays and those kinds of things.

But I am not sure just a mandatory funding with a stock formula tells us all we need to know about the changes in medicine, the changes in technology, and those kinds of things. But I am willing to explore it with you, sir.

Mr. HARE. Thank you, Mr. Secretary.

The other quickly, I know we talked about the disability backlog. And my friend, Mr. Donnelly, from Indiana is sitting here. We were having coffee one morning saying how, from just a commonsense

perspective, how can we possibly fix this. And, you know, hiring other people is an idea and training them up and everything.

But Joe said why don't we treat our veterans like we treat people that pay their taxes. They put the form in and if they have a refund coming, they get their refund. If they do not, they do not. If there is something there they want to question, they can audit it.

But to clear up the time and maybe erring on the side of veterans. I have done a number of town meetings and I come from a very rural district. And hopefully we can bump up, and I want to throw this in quickly, the rural funding in the budget.

But, you know, veterans said, well, why does it take 177 days on an average to be able to get this. And I think it puts them in a very—you know, they get angry. They are frustrated with the system. And is there a way that we can err on the side of the veteran, the presumption that the veteran's disability claim is legitimate?

The vast majority, 99.99, I believe in my heart of hearts that submit these are not going to try to pull one over on anybody, to be able to really effectively get that backlog caught up in some fashion other than just hiring people that is going to take some time to get them trained up to do it. So I just wanted to maybe throw that out as something to think about, you know, down the road.

Secretary PEAKE. I have asked about that and some of the numbers, about 49 percent of folks have issues that do not get adjudicated, that are found not to be service connected. Now, that is not a whole claim necessarily, but it is all those many issues that we are starting to see within each claim. So I think that there are some things that we should be able to look at.

I am not sure just forgiving it off the top, you know, blanketly is the right answer. Every time that we do give somebody—I mean, we do have situations now, prestabilization as an example, where we will adjudicate somebody at 50 percent or 100 percent and then go back and check them later. And every time we do and it goes down, it is a big problem because it looks like we are being unfair to the veteran when really it may be the fair thing.

So somehow we would have to figure out how to deal with those kinds of issues because, otherwise, it will just go up and up and up and growing when it is not necessarily legitimate.

Mr. HARE. I know I am over on my time. Thank you, Mr. Chairman.

And, Mr. Secretary, I wish you all the best.

Secretary PEAKE. Thank you.

Mr. HARE. And if there is anything that this freshman veteran from Illinois can do to help or any ideas that you are looking for, I would be more than willing to. I mean, you know, veterans come first and foremost to me. So I thank you very much.

Thank you, Mr. Chairman.

Secretary PEAKE. Yes, sir.

The CHAIRMAN. Thank you, Mr. Hare.

And just two things before you get too long into your Secretaryship. I do not want you to have misconceptions about mandatory funding. It does not mean a stock formula, as you put it, because formulas can change. It is just a question of where the funding comes from under the budget rules.

As you know, the history of the Department's formulas has not been exemplary as shown by the fact that you forgot to plug in the war a few years ago. So mandatory funding does not mean that it is completely inflexible. Please keep that in mind.

And, on Mr. Hare's point about presumption of disability claims, we are exploring the idea that if the disability claim was prepared with the help of a VA certified service officer, that we grant the claim. And we can take into account some of the problems you brought up with the professional help, which has been built up in the VSOs and the County Veteran Service Organizations and certainly, in VAs all over the country.

Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

And, Secretary Peake, I thank you and congratulations. I cannot tell you how much I appreciate you taking this job.

I would also like to thank your team here. I have had the pleasure to get to know and work with them and find that the passion for our veterans and the expertise they bring to the job is very encouraging. And these are all gentlemen that could find work in the private sector and they have chosen to serve our veterans.

And I see Mr. Mansfield here. I thank him also for the work that he has done.

We also have a room full of people I would like to thank. We have representatives from a lot of Veteran Service Organizations that I have worked with over the years. I see a lot of familiar faces.

I think I saw Rose Lee for a while from Gold Star Wives there in the back. I have often thought that there probably should be some chairs up front for the Gold Star Wives. We might want to work on that one.

But the point being, this is the one place passions are high and their passions are high for the right reason, for our veterans. And it is the one place where I think you can hear there is cooperation about one goal and whether they are sitting here or sitting at the table or sitting out there, trying to get better care for our veterans is the goal.

So I thank you for taking this. I think many of us are very, very hopeful that your experience in DoD and then coming over to VA to help bridge that gap will really help us.

I think a lot of us felt last year we made great strides. We think that we did things for veterans that needed to be done. We showed that it was a priority and we showed the American public we could follow through with that. And I am very, very proud of that.

And we are here today to discuss the budget a little bit and to talk specifically on that. And the one thing I think it is important to keep in my mind is constitutionally the President's budget is a suggestion to us and I very much take it as a suggestion.

And I see some of the things in here, whether it is fees or copays. I have a 15-month-old son at home. My wife keeps telling me stubbornness is a virtue. And so the President is bringing them to us and we are going to be just as stubborn on saying that there is a better way to do this.

But I appreciate the difficult situation you are in, but it is one that you have taken on the challenge and we are very, very hopeful for that.

I did want to just mention and go back to Ms. Brown-Waite. I was in the same Subcommittee hearing on this issue of the OIG and something came up in there that was quite troubling for me for the reason that I think you and I, Secretary, share a belief.

And I know one of your quotes was OIG operations provide a return on investment of eleven to one. That is the type of thinking that really makes me encouraged, that we are seeing ways and that I think all of us know. When we are talking budgeting and we are talking funding, it is not the panacea for everything, but there are ways to target our funding to be smarter about this.

And the OIG, and I have seen it time and time again, many of us see the OIG as a critical component in ensuring care and how we are taking care of our veterans.

But something came up last week that quite honestly I have lost sleep over this comment because it is very disturbing. We were having an Oversight and Investigations Subcommittee hearing on the investigation of some deaths at the Marion, Illinois, facility. And in there, we heard from a widow who talked about her husband dying from what was substandard care. And I will have to say, just like I told your predecessor, you will not find a more staunch supporter and someone who is more proud of the VA than me. But I will also be its harshest critic. So we have problems. I want to know what the situation was, as does everyone else here.

And I asked the representative from the Office of Inspector General if they thought there was a correlation between resources and their ability to perform their duty and stop these problems from happening. And the OIG representative said with more resources, we could have done more.

And I pressed on and I said, this was an exact quote, are we falling into a conundrum where you are not getting the resources you need to help stop patients' deaths and we are turning into substandard care. And there was a silence, and then a yes.

Now, there is a widow sitting there and an Inspector General saying, had I had more resources in their professional opinion, and I applaud this under oath and taking a stand like that, because I think all of us know that case is far from over and it is going to end up in a court of law where it rightfully should be adjudicated, but the issue of this being that I believe in the VA. I believe in the Inspector General. And I had an Inspector General telling me that they felt the resource issue led to substandard care and then I get the budget and I see we are going down.

Now, I know you addressed it with Ms. Brown-Waite. It is 6 percent less than we had this year and 9 percent less than *The Independent Budget*.

My question I guess to you, General, is how do I answer that to that widow? She heard that and I do not believe it was an OIG representative speaking out of turn.

Secretary PEAKE. I did not get that feedback from them, but I will look at that. In the Marion instance, we asked the OIG to go in afterward and take a look. The whole incident was detected because of the processes that were in place to look at quality and we would need to tighten those so that we maybe get the flag a bit earlier. But I think Dr. Kussman and his team immediately took aggressive action. It was not triggered by the OIG. It was not trig-

gered by an OIG inspection. And that is not to argue at all about the importance of the OIG or whether or not they need more resources.

But in Marion, just for the record to be clear, that was picked up by our internal quality assurance policies and procedures that I think are really remarkable and then led to swift action by the leadership.

The other issue I absolutely will address for the OIG to understand what their shortfalls are. And as I mentioned with Ms. Brown-Waite, I have not had that discussion with them yet.

Mr. WALZ. Okay. And I do appreciate that. And the issue that did come up, and this is what is so difficult and I have said it time and time again, this is a zero sum game. And the investigation was started. But when that investigation was ongoing, it was after the time that the investigation had been initiated that Mrs. Shank lost her husband.

So it is one of those issues that we are going to have to continue to get better. I know this team is committed to that. Our question is, are we providing the resources? Are we getting into a situation where we are focusing those resources to fix it?

But, again, I thank you. You have given up an incredible amount of your valuable time to come here and I hope you know this Committee is here to do whatever we can to work with you for our veterans.

I yield back and thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Walz.

Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

I feel like I should call you Secretary General because I have never called anyone Secretary General before and you are the first person that would qualify. But, General Peake, it is good to see you——

Secretary PEAKE. It is good to see you again.

Mr. SNYDER [continuing]. In your new role as Secretary. I appreciate all the work you did.

I had to go and meet with our National Guard folks from back home and then came back. I understand that Ms. Berkley, as she often does, beats me to the punch on things. But I wanted to pursue this issue of the research again, which I think I have talked about every year for the last 10 years and probably your staff told you about it.

But this is your document here and on page 2A2 in which you discuss medical and prosthetic research, the VA's 2008 budget estimate was that you could mobilize $769 million in Federal resources from the National Institutes of Health (NIH) and other Federal resources, correct?

The reality is that it is now looking, by your estimate from your document, it is going to be $708 million which is $61 million less than the President's budget last year at this time told us you would mobilize and other Federal resources, leverage other Federal resources.

And, yet, now you are coming back with a budget this year saying, hey, you know what, we think we can leverage $751 million. Well, you are a smart guy. You learn from the past. We learn from

the past. You did not do it last time. We told you you would not do it last time. NIH budget is flat in the President's budget this time again. He is not going to do it.

Why put this number out? I am curious, Secretary Peake. Do you all know what the number was that you requested for research for your Department? I suspect OMB has cut you off. I am curious. What number did you request? I cannot imagine that you all would have gotten together and said let us fail to learn from our experience. Do you know what number you all requested?

Secretary PEAKE. I do not know the number offhand, but as I look at the kind of researchers that we have in the VA and the academic affiliations that we have, I would hope that we would be able to compete effectively for those dollars.

Mr. SNYDER. Yeah, but you will not. You will not. That is not the way this is going to work. I do not know why we are going to expect other Federal agencies to pick up VA's responsibility on research.

And this is not some, you know, pie in the sky kind of thing. You are talking about, I suspect, I do not know, maybe you can share with us sometime or inquire since you are new on the job, I suspect you have an abundance of top-notch researchers——

Secretary PEAKE. We do.

Mr. SNYDER [continuing]. With research projects that would speak right to the heart of some of the problems facing our veterans today, whether it is prosthetics or prevention stuff or vaccines or PTSD or whatever, all kinds of things, that would benefit from additional funding.

And at this time in our history, I just do not understand why we are not looking on this as an opportunity to say let us do better than keep up with inflation. Let us recognize this, that we are in for the long haul here with a new generation of veterans.

Why not really pump some money into this at this point and, by the way, let us make a commitment to recognize that good research depends on not an annual budget cycle? Good research and attracting good researchers, they need to know we are with you for 3 to 5 years. I mean, you know that.

This is not new information for you and I suspect you are part of the choir here. But when we see this, when we heard from your predecessor we will be able to leverage dollars and your own document right here says we failed to leverage dollars by $61 million, but we are going to try it again, that is not going to happen.

And it does a disservice to this Committee and to the American people, but even greater, it does a disservice to veterans that depend, you know, that they are hoping, they do not know anything about these numbers, but they are hoping that something better will happen in their medical conditions.

I wanted to ask a question involving claims. Who is our claims guy? I toured our regional office last week. They have a great team up there of personnel. In fact, they are doing some of this training for their people there from Oklahoma and other places, this training for new claims evaluators.

And then I toured their facility and they have a real problem with storage, infrastructure, but they think they are on the way to solving it. That is not what I wanted to ask about.

This is the question I want to ask about. This Committee has a lot of interest in going to computerized medical records and computerized forms. And we think that is the direction everything is going in the universe right now.

In fact, it appeared to me when it comes to applications for disability claims, it is going in the wrong direction, that veterans are going to the Internet and finding documentation themselves or their advisors or whatever that say, hey, this stuff is great, let us add this to the file. And then, in fact, the claims, the paper trail on the claims, are getting longer and longer and longer.

And so I went back in the file room and they were a bit like canyons with three-volume files that were not like the medical record, but attached documentation in nonelectronic form and the canyons are getting higher. There is no room for it in the drawers and the trend is for thicker, thicker files, that veterans are being encouraged, and I would do the same, attach all this documentation that you can find.

Now, why are we not moving in the direction of an electronic filing? Why is that? Where am I off-base here, because clearly the trend is we are running out of space, whereas 10 years or 20 years ago for the same number of claims, we would have been able to get everything in the file drawers and we cannot now at a time when we think we can move to computerized stuff?

Admiral COOPER. You are correct. We are overburdened with paper. We are moving to become more paperless as the Secretary mentioned before. We are doing everything we can, working with IT to get to the point of using the Virtual VA system in place of paper records.

Mr. SNYDER. But do you agree with me that, in fact, per file, per claim that the trend is actually going in the wrong direction, that the files are actually getting bigger in paper?

Admiral COOPER. They are getting bigger because of all the material that people are sending in, and also because of the things we require today.

We started in the year 2000 with VCAA, "Veterans Claims Assistance Act," which was established, properly in my mind, to ensure that we helped the veteran. But in doing that, we also said there are certain things you have to provide and we have to assist you in obtaining.

Since then, the courts have made several decisions which have increased what we should try to get to ensure we absolutely look at the claim and ensure that we do everything we possibly can to adjudicate the claim right. But what that has meant is more and more paper coming in. You are absolutely correct. We are being overrun by that and trying to control that, but we hope to process more claims in a paperless environment within a couple years, and start doing away with some of the paper. But the fact is, right now we have requirements that we have to fulfill and, by sending letters back and forth, we get a lot more information to support each claim.

Mr. SNYDER. I am sorry. My time is up.

Well, I do not have a problem with, you know, if there is a lack in the file and you send a letter that says we are lacking this. My issue is, why does that have to be done by paper? Why can this not

be done—just because I ask for more information now than we did 5 years ago does not mean it has to be in hard mail. I mean, in fact, if it came electronically, it would come like that rather than have to go through the mail. I see Secretary Peake is trying to get a word in here too.

Secretary PEAKE. Just that I am in agreement with you, sir. Maybe one of these days we can travel to Winston-Salem or Salt Lake City, Utah, where we have two pilot programs using paperless rating of the BDD claims. We are also moving toward a paperless environment in our new pension claims. So, we have some pilots in there, but it is like walking back into the 1950s. I have been there.

Mr. SNYDER. Yeah. And I am over my time, Mr. Chairman. But I do not know if I am just the slowest kid on the block here, but we have talked about this going to paperless stuff for some time. I actually thought that we were kind of moving in the right direction, although slower than we would want. In fact, it is going the other way. And there may be a way we want to follow that in terms of what is the actual number of paper claims versus electronic claims and what is the number of pages that are being submitted because we are not talking about the difference between 30 and 60 pages. We are talking about the difference between 50 pages and 3 or 4, 5 or 600 pages. And they are sitting back there in volumes about to fall on our staff.

Thank you.

The CHAIRMAN. Thank you. Could you get me a memo on that? Thank you.

Mr. Secretary, thank you for being with us. Let me just ask you a couple of questions before you leave.

One of the top priorities of this Committee this year is going to be a GI Bill for the 21st century, and we are working on that. I think I mentioned it when we met. In our view, the bill will include an update in education benefits to take into account the true cost of college and provide flexibility for those payments. As you know, if you have a shorter course you cannot apply that money to the whole tuition if it is a 3-month course, and making the Guard and Reserve units who have seen active duty eligible for that GI Bill. It will also include an improvement to the housing program to meet the real needs out there, such as inflation, and maybe include homelessness and mental health.

But if we move in that direction, will you work with us and try to find the funding?

Secretary PEAKE. I will.

The CHAIRMAN. As you know, nothing is mentioned in the budget, obviously.

Secretary PEAKE. I will work with you on that. I think education is important. I already commented on the emphasis I would like to place on our vocational rehabilitation education programs that already have a very good benefit for those that have 20-percent disability from their service.

So I look forward to working with you. I know that the Montgomery GI Bill was a peacetime bill and right now, as I say, everybody here appreciates that we are in a war.

The CHAIRMAN. Well, we are going to take that very seriously.

By the way, I had a forum with your people in the Home Loan Program and its relationship to the current crisis that we are in. And it just seemed to me, and from townhall meetings, that the VA Home Program is sort of irrelevant to the crisis in that the loan value is too low to help in California and a lot of other places.

The refinancing cap is just meaningless given the crisis that people have. The fees for refinancing are incredibly high and make it basically useless for someone in this current crisis. You have rules about condominiums that seem to be out of date.

I have legislation to try to change all that. But it seems to me that the VA can contribute right now to helping veterans or active duty personnel actually deal with this crisis that millions of people are facing.

I also believe that we should have a policy that says no foreclosure for anybody on active duty because it is a crime if somebody comes home and finds that they have to lose their home.

Again, I hope you will work with us on that. We have to do this right away, as part of the stimulus package we are doing. The maximum mortgage amount is raised temporarily for Fannie Mae and Freddie Mac and the FHA but not the VA. So I think we have to do that and work with you on that——

Secretary PEAKE. Yes, sir.

The CHAIRMAN [continuing]. Because I think we can contribute a little bit to solving that crisis.

I do not know if you were aware, when I mentioned in my opening statement, that the Priority 8 study that we asked for when we went through this with your predecessor, he said, well, it is a lot more complicated than just giving you a figure for how much it is going to cost. And I asked him to give us a study. And we are still waiting to receive that. So I hope you will——

Secretary PEAKE. Sir, I understand the study should be up here in February.

The CHAIRMAN. Okay. Thank you.

In previous budget submissions, I believe that although we may have had to drag it out of you instead of getting it from the VA, there were some estimates around of how many veterans would leave the VA healthcare system due to the increased enrollment fees and pharmaceutical co-payments.

Did you do anything about that, your estimate of how many people could not afford that and may leave the system?

Secretary PEAKE. Sir, what I understand the estimates are is that about 440,000 enrollees of which about 144,000 that actually use the VA would not pay the enrollment fee.

The other point that I understand is the majority of those have other health insurance already that they would—and that the 144,000 users are those who do not use us very much anyway already. Those are the numbers as I understand.

The CHAIRMAN. How about the co-pays, the pharmacy co-pays? Did you do any estimates on that?

Secretary PEAKE. I think that is included in that same number.

The CHAIRMAN. Well, I hate to have you leave the VA with a legacy of saying, oh, whatever it is, 140,000, 440,000, I did not understand quite what you were saying there.

Secretary PEAKE. We have——

The CHAIRMAN. You know, they left the VA because they could not afford it. You do not want that as your legacy, I do not think. So we will take steps to make sure you do not have that legacy. This is not a time to say that veterans should not be served.

One last thing. I do not know if I will call it a sermon or not. I think you and your staff will do better with this Committee with honesty and a nondefensiveness about issues that everybody knows are there, but never come up in your reports.

I did not see how many backlogged claims there were. Did you put a number in there? Whether it is 600,000, 400,000 or 700,000, if you do not tell us and say, look, we are working on this or here is what we need to do it, you look like you are not confronting it and you are hiding it.

I went through this, I do not know if your staff told you, with the head of your Mental Health Division with the suicides. We had media estimates of 6,000 veterans a year or so dying from suicide. And your guys were telling us how great a job they were doing and now, there were 300 people who called in—300 people we talked to. And I kept saying what about the 6,000.

We have to have honesty about these issues. We are not holding you personally responsible. We just have to have an understanding, a joint understanding between Congress, the Executive Branch, and the public about what these issues are because then we can work together to solve them.

But if we do not know about them, or you do not recognize them, or you do not want to talk about them officially, it creates the impression that you are hiding this, that you do not really care and are not doing the job.

And we know how dedicated everybody is. But when those official statements come to us and you did not tell us in your paper that there is going to be a $19 billion decrease over the next 5 years, I mean, why is that and what can we do with you to avoid that from happening?

We are not trying, just to say "got you"—we want to look at the problems honestly and try to deal with them together. That is the spirit in which I hope we can work together.

You have the floor for any final comments you would like to make.

Secretary PEAKE. Sir, first of all, let me thank you all for the hearing today. And I thank you for particularly that last comment because I hope that you will find me and this great team to be open. It is not about hiding anything. And perhaps we sometimes err on the side of trying to tell the good news story.

I think my predecessor said something about the VA being the greatest story never told or something, so maybe we err on that side. It is not to hide issues. There are issues that we need to deal with.

In terms of that out-year projection, I understand that that is just a placeholder for all agencies and they reflect no policy decisions or VA demand. So, I mean, it is almost, as I understand it, it is irrelevant to our future and what we——

The CHAIRMAN. I will tell the President that.

Secretary PEAKE. I have a year, I guess. But, you know, I have been tremendously impressed with the quality of the people here

just as you say, sir. And I think that we all are dedicated to the same thing. We have a common sense about the importance of our veterans and there is probably not a time in our recent past that it has been more important.

So I welcome the opportunity to work with this Committee and with the other parts of Congress to make some progress here.

The CHAIRMAN. Thank you, sir. Again, it is a pleasure to have you here. It is a pleasure to be working with you.

We will let this panel go so you can go back to work on behalf of our veterans. Thank you so much.

The second panel that we will hear from today is from the four organizations that provide *The Independent Budget*; the Paralyzed Veterans of America (PVA), the Disabled American Veterans (DAV), the Veterans of Foreign Wars (VFW) of the United States, and American Veterans (AMVETS). And in addition, the American Legion and the Vietnam Veterans of America (VVA) will be testifying on this panel.

We thank you for all the work that goes in *The Independent Budget*. We look forward to working with you to make it a reality. Each of you have 5 minutes. We have some new technology you see that is in front of you. It tells you how much time you have. And, of course, your complete statements will be made an official part of our record.

Mr. Blake is with PVA and we welcome you here.

STATEMENTS OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; KERRY BAKER, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; RAYMOND C. KELLEY, NATIONAL LEGISLATIVE DIRECTOR, AMERICAN VETERANS (AMVETS); STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AMERICAN LEGION; AND RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you, Mr. Chairman and Ranking Member Buyer. On behalf of the four co-authors of *The Independent Budget*, I would like to thank you for the opportunity to testify today on the funding requirements for the Department of Veterans Affairs' healthcare system for fiscal year 2009.

For fiscal year 2009, the Administration requests approximately $41.2 billion for veterans' healthcare. This includes approximately $2.5 billion from medical care collections.

Although this represents another positive step forward in achieving adequate funding for the VA, it still falls short of the recommendations of *The Independent Budget*.

For fiscal year 2009, *The Independent Budget* recommends approximately $42.8 billion for total medical care budget authority, an increase of $3.7 billion over the fiscal year 2008 appropriated level and approximately $1.6 billion above the Administration's request.

In order to properly reflect the Administration's change to the medical services account and our recommendation, the separate accounts for medical services and medical administration must be added together.

With this in mind for fiscal year 2009, *The Independent Budget* recommends approximately $38.2 billion for medical services.

Our increase in patient workload is based on a projected increase of approximately 120,000 new unique veterans, including category 1A veterans and covered nonveterans. We also estimate the cost of these new unique patients to be approximately $792 million.

The increase in patient workload also includes a projected increase of 85,000 new Operation Iraqi Freedom and Operation Enduring Freedom veterans at a cost of approximately $253 million.

Our policy initiatives include $325 million for improved mental health services and traumatic brain injury care on top of what is already being provided, $250 million for long-term care, $325 million for funding of the fourth mission which encompasses homeland security and emergency preparedness, and $100 million to support centralized prosthetics funding.

For medical facilities, *The Independent Budget* recommends approximately $4.6 billion. This amount also includes an additional $250 million for nonrecurring maintenance for the VA to begin addressing the massive backlog of infrastructure needs.

Although not proposed to have a direct impact on veterans' healthcare, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription drug copayments from $8 to $15 and an index enrollment fee based on veterans' incomes.

Although the VA does not overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans would leave the system and more than 1 million veterans will choose to enroll, notwithstanding the discussion from the previous panel.

It is astounding that this Administration will continue to recommend policies that would push veterans away from the best healthcare system in America. Congress has soundly rejected these proposals in the past and we call on you to do so once again.

Finally, Mr. Chairman, as you know, the whole community of National Veteran Service Organizations strongly supports mandatory funding or an improved funding mechanism for VA healthcare. However, if the Congress cannot support mandatory funding, there are alternatives which could meet our goals of timely, sufficient, and predictable funding.

We are currently working on a proposal that could change VA's medical care appropriation to an advanced appropriation which would provide approval 1 year in advance, thereby guaranteeing its timeliness.

Furthermore, by adding transparency to VA's healthcare enrollee projection model, we can focus the debate of the most actuarially sound projection of veterans' healthcare costs to ensure efficiency and sufficiency.

Under this proposal, Congress would retain its discretion to approve appropriations, retain all of its oversight authority, and, most importantly, there would be no PAYGO implications.

We ask this Committee in your views and estimates for fiscal year 2009 to consider and possibly recommend to the Budget Committee either mandatory funding or this new advanced appropriations approach to take the uncertainties out of healthcare for all of our Nation's wounded, sick, and disabled veterans.

This is a proposal that we began meeting with staff for already and we would offer the opportunity to speak both with your staff and Mr. Buyer's staff further on this issue.

Lastly, Mr. Chairman and Mr. Buyer, I would like to offer my thanks for your staff allowing us the opportunity to get together with them prior to the release of the President's budget to discuss our recommendations and to kind of lay ourselves bare.

The previous panel mentioned about not having anything to hide and in the last couple of years, we have taken to briefing the Committee staff in advance because in my honest opinion, we have nothing to hide. And, in fact, it gives us an opportunity to begin the debate with the key policymakers long before the President's budget is actually submitted.

So with that, Mr. Chairman, I would like to thank you again for the opportunity to testify. This concludes my testimony, and I would be happy to answer any questions you might have.

[The prepared statement of Mr. Blake appears on p. 75.]

The CHAIRMAN. Thank you, Mr. Blake.

Representing the Disabled American Veterans is the Associate National Legislative Director, Kerry Baker.

STATEMENT OF KERRY BAKER

Mr. BAKER. Members of the Committee, thank you.

As agreed by the organizations, I will focus my testimony on understaffing in VBA, the claims backlog, and a few other related highlights from *The Independent Budget*.

The claims backlog is undeniably growing. By the end of January, there were over 816,000 pending claims, including appeals. In the 3 years since the end of 2004, pending claims rose by an average of 63,000 cases per year.

Also, the number of cases with eight or more disabilities increased well over 100 percent from 2000 to 2006. The complex cases further slow down VBA's claims process.

Therefore, based on the estimated receipt of 920,000 claims in fiscal year 2009, *The Independent Budget* recommends Congress authorize 12,184 FTE for VA's C&P service in fiscal year 2009. That number equates to successfully processing 83 cases per year per each direct program FTE.

In addition to a staffing increase, we believe VA must attack the claims backlog using new methods and policies, especially when they follow the intent of the law, save resources, and protect the rights of disabled veterans.

One example deals with VA's policy of requiring medical opinions in cases where a claimant already submitted an opinion adequate for rating purposes.

Congress rescinded VA's prior policy of verifying a private physician's opinion with a VA examination prior to an award of benefits. Yet, VA continues to refuse to render decisions in cases where a

claimant secures a private medical opinion until after VA obtains its own opinion.

We believe these actions are an abuse of discretion, delay decisions, and prompt needless appeals. Congress should mandate the VA must decide cases based on a veteran's private medical evidence when it is adequate for rating purposes.

This small change will preserve VA's manpower and budgetary resources, reduce the backlog for needless appeals, and, most importantly, better serve disabled veterans and their families.

The law requires VA to accept lay evidence as proof of a service-connected disability if a veteran is a combat veteran. VA accepts certain military documentations as proof of combat, but only a fraction of combat veterans receive one of these qualifying medals.

Military records do not document individual combat experiences. As a result, veterans who suffer a disability in combat are forced to wait a year or more while VA conducts research to determine whether a veteran's unit engaged in combat as claimed. This results in difficulty, even impossibility in proving a veteran's personal participation in combat by official military records.

Congress should clarify its intent by defining a combat veteran for all purposes under Title 38 as one who during active military service served in a combat zone for purposes of 112 of the Internal Revenue Code 1986 or predecessor law.

This amendment would reinforce the original intent of Congress in liberalizing service connection for sick and disabled veterans who served in combat.

On behalf of *Independent Budget* VSOs, I also want to call the Committee's attention to issues involving the U.S. Court of Appeals for Veterans Claims. The greatest challenge facing the court today is similar to the VA's, the rising backlog of appeals.

However, staffing is not the court's primary dilemma. The court has shown a propensity to remand cases to the Board of Veterans Appeals based on errors alleged by VA's counsel for the first time on appeal. In this, the courts suggest that a veteran is free to present their assignments of error to the board even though that appellant may have already done so.

This leads the board to repeat the same mistakes that it had made previously. Such remands reopen the appeal to unnecessary development and further delays, overburden an already backlogged system, and exemplify far too restrictive judicial process.

Ignoring legal arguments that serve as the basis of an appeal and remanding cases on technicalities a veteran may be willing to waive merely adds to the claims backlog.

We believe solving this unacceptable situation would be simple and cost effective. Congress should require the court on a de novo basis to decide all relevant questions of law and decide all assignments of error properly presented by the appellant.

Mr. Chairman, I have only highlighted a few of the many important issues contained in our *Independent Budget* for fiscal year 2009. I commend the remainder to you, and I will be pleased to answer any questions from the Committee. Thank you.

[The prepared statement of Mr. Baker appears on p. 78.]

The CHAIRMAN. Thank you, Mr. Baker.

Representing the VFW is the Director of their National Legislative Service, Dennis Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Chairman Filner, Ranking Member Buyer, distinguished Members of the Committee, the VFW is responsible for the construction portion of the *IB*, so I will limit my remarks to that subject.

The Administration's fiscal year 2009 budget request for major and minor construction is dramatically inadequate. Despite hundreds of pages of budgetary documents that show a need for millions of dollars in construction projects, the Administration saw fit to halve the major and minor construction accounts from the 2008 levels.

The President's request for major construction is a paltry $581.6 million for 2009. This is a dramatic cut from last year's funding level of $1.1 billion. While we appreciate that this level covers eight medical facility projects, including three new previously unfunded projects, the total level of funding does not come close to meeting the *IB's* recommendation of $1.275 billion in construction money.

Only $476.6 million of the Administration's request covers Veterans Health Administration projects, significantly lower than the $1.1 billion that the *IB* has called for.

While the eight major construction projects called for in this budget may seem like a lot, the funding levels recommended for them are a tiny blip in the overall cost.

Looking at just the partially unfunded projects, the backlog, if you will, even $320 million aimed at them barely scratches the surface. Only the Lee County, Florida, outpatient clinic is funded to completion. The other four projects still require a total funding level of $1.26 billion.

The funding for the three new projects total $776.8 million out of a total construction estimate of $771 million. This is important because it means that there will be a total construction backlog of over $2 billion when the Administration prepares its request for the following fiscal year.

Both the prior year and this year's budgets desperately need funding beyond the Administration's request. These projects are necessary to ensure VA reinvests in its aging physical infrastructure.

We remain concerned about the unfulfilled promises of the Capital Asset Realignment for Enhanced Services (CARES). Former VA Secretary Anthony Principi testified before this Committee's Health Subcommittee in July of 2004 that CARES reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care.

According to VA's November 2007 testimony before that same Committee, Congress has appropriated just $2.83 billion for CARES projects, far below what is needed to which the Secretary testified.

Further, this includes nearly $1 billion for rebuilding facilities after the Gulf Coast hurricanes, amounts that we have argued that the Congress should have provided as a separate emergency fund-

ing outside of VA's regular planning process. With the fiscal year 2008 appropriation, the total is up to $3.9 billion. Better, but it is still lagging.

We are also greatly concerned about the Administration's proposed slashing of the minor construction budget. As with the major construction account, this cut is contrary to what is indicated by the information the Department provides in its budgetary documents.

For fiscal year 2009, the recommendation is just $329 million, $301 million below the fiscal year 2008 level and far below the $621 million called for in the *IB*.

VA has a long list of minor construction projects targeted for 2009. There is a list of 145 minor construction projects listed on page 795 of the 5-year capital plan. Based on the average cost for past years, VHA would require a budget of $812 million, nearly $500 million more than was actually requested.

We understand that VA has some carryover funding for minor construction to offset that balance. But even if all $267 million of that are applied to this list of projects, VHA would still require $545 million in funding instead of the $273 million the Administration has requested.

The minor construction request seems even more deficient when you factor in its role with respect to maintenance of VA facilities. VA says that 30 percent of all minor construction is targeted to correct documented facility condition assessment deficiencies.

Mr. Chairman, the *IB* is also concerned regarding nonrecurring maintenance (NRM). Those same Facility Condition Assessments reviews show the importance of NRM and that the $5 billion backlog shows how woefully deficient past NRM request and appropriations have been.

For fiscal year 2009, we are pleased to see the President request $802 million for NRM funding. This is in line with what the *IB* has called for in the past and we also applaud the allocation of a portion of these dollars outside of bureau.

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

[The prepared statement of Mr. Cullinan appears on p. 85.]

The CHAIRMAN. Thank you.

Just for the record, I would like to say that the Secretary and his first panel are still with us and I appreciate that very much. It shows a willingness to listen and respect that we have not had before.

So, Mr. Secretary, and your staff, thank you for staying for the panels that follow.

Representing AMVETS is the National Legislative Director, Raymond Kelley.

STATEMENT OF RAYMOND C. KELLEY

Mr. KELLEY. Thank you, Mr. Chairman, thank you, Ranking Member Buyer, for holding this hearing today.

As co-author of *The Independent Budget*, AMVETS is pleased to give you our best estimates on the resources necessary to carry out the responsibilities of the National Cemetery Administration.

First, I commend the NCA staff who provide the highest quality service to veterans and their families in their time of tremendous grief.

The Administration has requested approximately $181 million in discretionary funding for operations and maintenance of NCA. Of that number, $105 million is dedicated for major construction, $25 million for minor construction, as well as $32 million for the State Cemetery Grants Program.

In contrast, *The Independent Budget* recommends Congress provide $251.9 million of the operational requirements of NCA, a figure that includes $50 million toward the National Shrine Initiative.

In total, our funding recommendations represents a $71 million increase over the Administration's request.

The National Cemetery System continues to be seriously challenged. Adequate resources and developing acreage must keep pace with the increasing workload.

Currently there are 15 national cemeteries in some phase of development or expansion. The Administration's budget provides funding for only three of these projects, while NCA expects nearly 115,000 interments in 2009, an 8.7-percent increase over the current year.

Congress must also address the need of gravesite renovation and upkeep. Though there has been noteworthy progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country.

To date, $99 million has been invested in restoring the appearance of our national cemeteries, completing nearly 300 of the 928 deficiencies identified in the 2002 study on the improvements of veterans' cemeteries.

Therefore, *The Independent Budget* recommends a $50 million commitment in fiscal year 2009 and we continue to recommend Congress establish a 5-year, $250 million fund for the National Shrine so NCA can fully restore the appearance of the national cemeteries to reflect the utmost dignity and respect for those who are interred.

The State Cemetery Grants Program is an important component of NCA. It has greatly assisted States in increasing burial services to veterans, especially those living in areas where national cemeteries are underserved.

NCA admits only 80 percent of those requesting interment meet the 170,000 veterans within the 75-mile radius threshold the NCA has set for itself. This reemphasizes the importance of the State Grants Program.

Since 1978, the VA has more than doubled the acreage available and accommodated more than a 100-percent increase in burials through these grants and this year, States have indicated a plan to establish 14 new cemeteries within the next 4 years.

Therefore, to provide for these cemeteries and to reach NCA's threshold goals, *The Independent Budget* requests $42 million for the State Cemetery Grants Program in fiscal year 2009.

Also, *The Independent Budget* strongly recommends Congress to review the current burial benefits that has seriously eroded in value over the years. While these benefits were never intended to

cover the full cost of burial, they now pay for just 6 percent of what they covered when the program started in 1973.

The Independent Budget requests the plot allowance be increased from $300 to $750, to increase the allowance for the service-connected deaths from $2,000 to $4,100, and increase the nonservice-connected burial benefits from $300 to $1,270. This increase would proportionately bring these benefits back to their original value.

The NCA honors more than 2.8 million with a final resting place that commemorates their service to this Nation. Our national cemeteries are more than a final resting place. They are a memorial to those who died in our defense and hallowed ground for those who survived.

Mr. Chairman, this concludes my testimony, and I will be happy to answer any questions the Committee would have.

[The prepared statement of Mr. Kelley appears on p. 87.]

The CHAIRMAN. Thank you.

Representing the American Legion is its Director of the National Legislative Commission, Steve Robertson. Welcome.

STATEMENT OF STEVE ROBERTSON

Mr. ROBERTSON. Thank you, Mr. Chairman and Members of the Committee, for allowing the American Legion to offer its views on the President's budget request for fiscal year 2009.

Last September, National Commander Marty Conatser clearly outlined the American Legion's budget recommendations for the Department of Veterans Affairs. Since our complete written testimony is submitted for the record, I will only address some of the key concerns with the President's budget request.

The American Legion wants to thank you and your colleagues for aggressively resolving both the fiscal year 2007 and 2008 VA budgets last session. Clearly initial fiscal year 2008 budget agreed to by both bodies exceeded or met every recommendation made by the American Legion. Although it was not the final budget agreed to, it clearly reflected the specific funding needs identified by the veterans community.

The American Legion also appreciated the emergency funding provided for in Public Law 110–161 and the President's request for that additional funding.

Unfortunately, the American Legion does not believe that the current President's budget request addressed several factors that will adversely impact the budget request for 2009, such as the normal rate of inflation, which absorbs a great portion of what the President's increase recommends.

Also, as mentioned by Congressman Michaud, the change in the economy, the increased unemployment rates, this may bring a lot of veterans back to the system that were not using it last year. The surge is another example of a large influx of veterans that will be returning to the United States and going to VA facilities.

The "National Defense Authorization Act" (NDAA) recently signed extends access for OEF/OIF veterans from 2 to 5 years and also the increased medical research and treatment need for such combat-related medical conditions as traumatic brain injury and post traumatic stress disorder.

The American Legion believes that each of these factors will increase demand on VA in many areas and seriously questions VA's ability to provide timely access to these earned benefits and services.

Unfortunately, the veterans community is well aware of the adverse impact of miscalculation and continue to urge Congress to strive to achieve medical care funding that is timely, predictable, and sufficient, not just once, but every year. The American Legion looks forward to working with you and your colleagues to achieve this goal.

Mr. Chairman, the American Legion remains adamantly opposed to the President's legislative proposals to establish an annual enrollment fee and increase pharmacy co-payments for Priority Group 7 and 8 veterans.

The objective behind these proposals remains unclear, especially when many of these veterans are already enrolled in Medicare and VA is prohibited from receiving any third-party reimbursements for their nonservice medical conditions. It also does not exempt service-connected disabled veterans that are in those groups. That seems unconscionable.

How many times does a veteran need to pay the Federal Government for an earned benefit?

I am getting a little older, but my memory is still pretty sharp. I do not remember any priority veterans in basic training. I do not remember any priorities in honorable discharges. I do not remember seeing any sign that refers to the Department of Priority Veterans Affairs.

Some folks think that the veterans' community asks for a lot, but it pales in what the Nation asks of its veterans.

Thank you very much, Mr. Chairman. That concludes my remarks. I will accept any questions you have for us.

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

The CHAIRMAN. Thank you so much.

Representing the Vietnam Veterans of America is the Executive Director for Policy and Government Affairs, Rick Weidman.

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Mr. Chairman, Mr. Buyer, thank you very much for allowing VVA to share our views on the President's request for the 2009 budget this morning or this afternoon.

Our recommendation overall is $3.1 billion more than the Administration's request. Included in that would be $1.9 billion to restore Priority 8s to the system and to accommodate what we believe is a gross underestimate of the number of Global War on Terrorism veterans who will come in.

Every single year since the wars started in Afghanistan and Iraq, the VA has underestimated the number of new OIF/OEF veterans who will come into the system and we believe they have done it again this year.

Secondly, we take it very seriously of leave no veteran behind. Those who are separating from the military and have separated within the last 5 years, once they are in, they are in, even if they turn out to be Category 8 veterans. We see no reason to cast aside those who served in an earlier era and prevent them from entering

the system until, until they become indigent and/or service connected down the line.

There is no good study that we are aware of of the migration from Priority 8 to Priorities 1 and 2 and to people becoming indigent and, therefore, having access to the system. We would ask that that be required by the fiscal process as part of the 2009 appropriation to look at that and hopefully the Secretary would respond and do that on his own without being forced to.

An additional $500 million of that recommendation is for additional mental health and substance abuse services over and above the $3.9 billion that VA plans to spend in fiscal year 2009.

Additionally, it would be additional staff for the VA Vet Centers, the most cost effective, cost efficient part of the VA system that is really our forward aid stations. If you want to get more veterans in and do the outreach, if you want to do something about suicides, beef up the Vet Centers and it will help more than any other single thing.

In addition to that, we believe that there ought to be additional employment counselors hired in VA vocational rehabilitation. I am not talking about vocational rehabilitation counselors. What we are talking about is actual placement. We frankly at this point do not have the faith that the Veterans Business Outreach Program (VBOP)/Local Veteran's Employment Representatives (LVER) system is doing what needs to be done, particularly for our most profoundly disabled veterans.

Blinded veterans with the additional moneys that we are recommending could expand on what has already been done for the blind and visual recovery centers. And in addition to that, put together an education and, most importantly, a job placement program for blind veterans.

It is my understanding from talking to our friends at the Blinded Veterans of America that not a single one of the new blind veterans was placed in unsubsidized employment last year. We can do it. I have participated in a project with blind veterans in the past where we did it.

Last but by no means least is R&D, research and development. This is not the time to cut. This is the time to make them focus and get that outfit to focus much more on the wounds and maladies that accrue to individuals by virtue of military service and, if anything, increase it. We recommended $500 million. The Friends of VA Research recommended $555 million. But in any case, it needs to be increased and not decreased as it was in the President's request.

Last but by no means least, we would ask that on a bipartisan basis. The Chair and the Ranking Member, we thank you very much for your efforts last year in getting the appropriation bill for the current fiscal year to include a requirement that the Administration have 90 days to deliver unto you a plan about how they are going to complete the already legally mandated National Vietnam Veterans Longitudinal Study within 2 years.

That 90 days is up the end of March and we would hope that you would schedule a briefing with the Secretary and his people can come in and brief you on how within a 2-year period they are going to deliver that completed report to you to understand the last large

generation of combat vets, what happens over time to those people's health.

It is an invaluable tool for you to look for planning for the future, fiscal policy, as well as otherwise for Vietnam veterans for the rest of our lifetime, but it also will impact on the planning for OIF/OEF veterans.

Once again, I thank you, and I would be pleased to answer any questions you may have, sir.

[The prepared statement of Mr. Weidman appears on p. 101.]

The CHAIRMAN. Thank you.

And thank you all for your work and all the expertise that you bring to these issues and your dedication to our veterans.

Mr. Buyer.

Mr. BUYER. Thank you.

Mr. Blake, who wrote the section on IT?

Mr. BLAKE. Well, it was not me, sir, but I could say that I know who——

Mr. BUYER. Oh, I was ready for that.

Mr. BLAKE. Sir, I would be willing to take any questions that you have and attempt to answer it. I anticipated a question. Probably not the best person to answer it, but I will certainly take on the question.

Mr. BUYER. Well, then I will tell you what. You find the guy that wrote this and bring him to my office.

Mr. BLAKE. I will be glad to, sir.

Mr. BUYER. Okay. And I am going to bring General Howard with me. Okay?

This was embraced in a bipartisan fashion, this entire Committee. Okay? Now, I understand General Howard here is an agent of change. And when you are the agent of change, you are not the most popular guy in the room. You do not make friends at all when you are the agent of change.

And the goal here, I just want to share it with you because this is supposed to be the *IB's* position, the goal here is not to have that IT person whether he is at the medical center or at the VISN or at a central office, it is not his job to say no.

So this has been written in a manner as though catastrophe was about to happen. Oh, my gosh. No, it is not. This is not catastrophic. Okay?

Their job is to say yes, but make sure whatever ideas, that they work, that they are compatible. We do not want to chill innovation. Okay? That is not the desire. I just want you to know. We have gone through all of this. But I want to meet the guy who wrote this.

Mr. BLAKE. I will be glad to, sir, and I will be there as well.

Mr. BUYER. Good. All right. We will go to the next question then.

I do not think I completely understand this, advanced appropriation. So can you elaborate on the concept? How is that going to work?

Mr. BLAKE. Well, I will be the first to admit, sir, that I am learning because this was kind of driven by a process that was worked up from the DAV, but we were all kind of learning as we developed this approach.

The theory behind it, I believe, is all of the service organizations obviously are in agreement that the process is broken. That is not to say that the appropriation from 2008 was a bad one in terms of dollars. I think we all agree that it was a good appropriation. It does not change the fact that it was appropriated in January in the end, so we are talking about nearly 4 months late. So there is a significant issue with timeliness.

The thought is that with an advanced appropriation which, believe it or not, there is a portion of the Federal budget albeit not a very large one when balanced against the entire Federal budget that is done through an advanced appropriation whereby the healthcare portion or whatever, you know, if Congress was to accept this, it could be laid out in whatever fashion, but I think the thrust at least as of this time is to set the healthcare portion aside in a form of advanced appropriations so that at this point in time, we would actually be advocating for a funding level for the fiscal year 2010 portion of the healthcare budget of the VA.

That would certainly draw some immediate concerns maybe about getting that farther away from the time period in which we are talking about, things like that, but I think in the end, we are still trying to overcome the problem with—I think timeliness maybe stymies the VA in a lot of its abilities more so than what the funding levels might be, although some people disagree with me. I like to believe that even if the VA had an insufficient budget, if they knew what the budget was——

Mr. BUYER. This is an *IB* motion?

Mr. BLAKE. Yes, sir. It actually is not in the policy portion of the *IB* because this is actually kind of rolling out even now as we speak. And we have met with some of the staff from Mr. Filner's staff and we would be glad to meet with the folks from your staff as well.

Mr. BUYER. I have not poured through this. Do you take an official position on Dole-Shalala to implement——

Mr. BLAKE. I do not think we endorse full implementation of the Dole-Shalala Commission, sir.

Mr. BUYER. Go ahead.

Mr. CULLINAN. Mr. Buyer, I would speak to that just on behalf of the VFW, although I suspect others here would agree with me.

Dole-Shalala was created basically in response to what happened at Walter Reed. It had what, about 4½ months it was in existence. And originally, as we understand it, it was intended to come up with some readily achievable, practical fixes to transitioning from active-duty military to VA and accessing VA.

It was not intended to come up with broad, sweeping reforms, ideas for reform. And it certainly was not empowered, as we understand it, to come up with ideas of completely revamping the entire VA compensation system.

Now, what we would like to see is the Congress take a closer look at the congressionally chartered VDBC, the Veterans' Disability Benefits Commission, which had been in existence almost 3 years, conducted over a thousand interviews, the report bordering on 600 pages. I think it is 113 specific recommendations. We do not agree with all of them. We think that is what should be looked at first. Dole-Shalala, there are some good things in Dole-Shalala for

the most part that are being enacted now as either part of the Wounded Warrior legislation and the NDAA and also that VAs take it upon themselves even without a legislative push.

So we think that is the way to go. Take a look at the VDBC first. That is the meaty, substantive study.

Mr. BLAKE. Mr. Buyer, I would also say that we have also, not to speak for the organizations, but I think we have taken the position that it is not an all or nothing game with the Dole-Shalala Commission.

The same would even be said with the VDBC. I mean, I do not think we would want to see everything in the VDBC be legislated immediately. I mean, there are some good things and there are some bad things.

We had some kind of preliminary meetings with the Committees and their staffs already. And I do not think we can just jump off the side of the cliff quickly and think we can implement this.

And I would certainly applaud the VA for the steps they have already taken. They have addressed a number of the things that we were principally concerned about. And there is a number of legislative proposals dealing with it. And as Dennis mentioned, the NDAA has already addressed some as well.

Mr. BUYER. If I may, Mr. Chairman.

One last question I have, we have struggled since the early 1990s on the issue of burial ceremonies. It is a never-ending issue. And I thought that VSOs, that you had organizational policies.

I had a circumstance. A World War II veteran landed at Normandy, a Bronze Star recipient, prisoner of war for 9 months, he dies. He was a member of the American Legion. The Legion's post then closed. He moved away, but then he wanted to be buried where he grew up and had his business and the Legion said you are not a member of our post and they would not do his ceremony.

The President of their local auxiliary was very upset over it. I contacted Marty Umbarger, who is Major General Umbarger. He sends out a couple of soldiers. We fly a flag over the Capitol for him.

A couple of your Legionnaires heard about it and they got a couple of their buddies who are with the VFW. They put together their own ad hoc honor guard and the President of the Legion auxiliary came out and apologized to me. We put on the best ceremony we could and we did it by putting together what we thought would be the best ceremony to give him the honors.

I spoke, I spoke to the family, things that I would do, things that they did. A chaplain came. We tried to do our very best. But help me here because I helped write legislation on how to do this. I just assumed, I just thought you guys had policies. Are there? Help me out.

Mr. ROBERTSON. Mr. Buyer, I will be more than happy to field that because I went through the same thing when my father passed away.

The American Legion post in our hometown was basically defunct, so even the other VSOs in the community said, well, he is not eligible for membership in our organization, therefore, we are not going to do it. And I was able to put together a group to provide my father's burial ceremony.

But the problem is that these are local community service organizations. And if it is based upon the strength of that local community, that is one of the reasons why we make such an aggressive effort to enroll as many people that are veterans that are eligible to join our organization to bring up the next generation of pallbearers and color guards and et cetera. It is a problem nationwide.

There are some places that it is outstanding and then there are other places where it is lacking. When I was stationed in North Dakota, some of the little communities in North Dakota, you would see the burial detail would consist of whoever happened to be not on the farm that day that was a veteran. And some of them would be in uniforms and some of them would not. But it was just the idea of meeting the need for the community.

From a national organization, we outline the procedures that should be followed. But as far as putting boots on the ground, it is a challenge, especially in rural parts of the country.

Mr. BUYER. Now that I am learning this, I will go back and take another look at the law. Let us take another look at what we created because we created the procedures with regard to the military and what they can do and what they do not have to do and we rely then upon all of you. And maybe I need to go back and take another look at this.

Mr. ROBERTSON. Mr. Chairman, that law that you are talking about, what it did was allowed reimbursement for the volunteer organizations that were able to fill the billet that the Guard and Reserve and the active duty was unable to fill.

Mr. BUYER. But my assumption is that if the active force could not do it, that you will.

Mr. BLAKE. That it would happen.

Mr. ROBERTSON. It is not——

Mr. BUYER. It was my error.

Mr. ROBERTSON. It was purely a volunteer thing and we are trying to meet that commitment.

Mr. WEIDMAN. The issue in terms of national policy for Vietnam Veterans of America is that we encourage our chapters to do it. And most who have that capacity do it for any veteran whether they are a member of VVA or not, Mr. Buyer.

But the issue is not so much policy or willingness. It is organizational capacity to be able to do it. And that is often what is lacking, that they want to and they simply do not have the organizational capacity to field an honor guard or a firing squad that would be appropriate during the time a funeral is held.

Mr. BUYER. All right. Thank you.

The CHAIRMAN. Thank you, Mr. Buyer.

Mr. WEIDMAN. May I comment on just one thing, Mr. Buyer, in answer to your question earlier about the partnership looking for forward funding?

In fact, other parts of the Federal Government are forward funded. Obviously capital purchases by DoD are very forward funded and you just adjust as you move closer to the target based on the actual experience.

The United States Department of Labor, the money that they ask for for fiscal year 2009 will not begin until program year 2009 which does not begin until July 1, 2009, as opposed to October 1,

2008. In other words, it is forward funded by 9 months on the theory that they will do a better job of planning.

Now, obviously that breaks down when it comes to the Department of Labor, but we have faith that and great hopes that at the VA, they will do a better job of actually, if they have time to prepare, of getting a greater bang for the taxpayer dollars, one, and, two, getting a budget on time, therefore, you can shop for the best value.

And that is part of the theory behind it, whether it is 9 months forward funded or a complete fiscal year forward funded in terms of getting the best value for that hard-earned dollar that the taxpayer forks over to the Federal Government for delivery of goods and services that are important to the whole Nation.

The CHAIRMAN. We thank the panel.

Let me just say with the Secretary here, sometimes the hearing format and process does not always enlighten to the best extent possible. We have had some success over the last year with putting together roundtables that include VA staff, VSOs, and other stakeholders at the same table and having a discussion, for example, on various parts of this budget.

I hope, Mr. Secretary, you can cooperate again and let us have a discussion with you and your staff on different aspects of this rather than solely in a hearing format. So we will try to do that on certain parts of this budget in the future.

Again, thank you for all the work that you have done over such a long time, and we will have our third panel testify now.

Again, the organizations that are with us for panel three have done a lot of work in this area and we look forward to hearing your testimony.

The Executive Director of the Iraq and Afghanistan Veterans of America (IAVA), Mr. Paul Rieckhoff, is with us. Thank you. You are recognized.

STATEMENTS OF PAUL RIECKHOFF, EXECUTIVE DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; PAUL SULLIVAN, EXECUTIVE DIRECTOR, VETERANS FOR COMMON SENSE; CHERYL BEVERSDORF, RN, MHS, MA, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL COALITION FOR HOMELESS VETERANS; AND RICK JONES, LEGISLATIVE DIRECTOR, NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

STATEMENT OF PAUL RIECKHOFF

Mr. RIECKHOFF. Thank you, Mr. Chairman. Thank you, sir. Thank you to the Members of the Committee. And on behalf of IAVA, the Iraq and Afghanistan Veterans of America, and our tens of thousands of members nationwide, I want to thank you for the opportunity to testify today regarding the VA budget request for 2009.

From 2003 to 2004, I served as the First Lieutenant and Infantry Platoon Leader in Iraq. And when I returned home, I quickly became concerned about the lack of real support for returning troops and veterans.

In the early years of the wars, issues like traumatic brain injury, post traumatic stress disorder, and homelessness received far too little attention. But times have thankfully changed.

Last year, this Congress showed tremendous commitment to our Nation's veterans, providing the VA with its single largest budget increase in 77 years. So on behalf of the millions of veterans who rely on VA healthcare, including the almost 300,000 troops newly home from Iraq and Afghanistan, we hope you will continue to show your support for veterans' healthcare.

IAVA is one of over 60 organizations who have endorsed *The Independent Budget* and we endorse it again for 2009.

As the War in Iraq continues into its fifth year, this generation of troops and veterans face new and unique problems.

Today IAVA is releasing our annual legislative agenda. Our 2008 legislative agenda covers the entire war-fighting cycle, before, during, and after deployment. It outlines practical solutions to the most pressing problems facing Iraq and Afghanistan veterans. And this agenda is available now on our Web site, iava.org.

The cornerstone of this agenda is the new GI Bill. After World War II, nearly 8 million servicemembers took advantage of a GI Bill educational benefit. A veteran of World War II was entitled to free tuition, books, and a living stipend that completely covered the cost of education.

Today we have an opportunity to renew our social contract with our service men and women and help rebuild our military. IAVA supports reinstating a World War II style GI Bill that would cover the true cost of education and will fairly reward all veterans of Iraq and Afghanistan. And we have endorsed H.R. 2702.

Now, critics have said that the GI Bill is too expensive. The fact is the GI Bill is a bargain. The current GI Bill cost the Veterans Department $1.6 billion in 2004. Even if a World War II style GI Bill were to double that cost, it would be about what we spend in a week in the War on Terror.

And the GI Bill is more than a veterans benefit. It is also an effective recruiting tool to stimulate the economy and improve our military readiness.

The GI Bill also helped improve this country's economy after World War II. A 1988 congressional study proved that every dollar spent on educational benefits under the original GI Bill added $7 to the national economy in terms of productivity, consumer spending, and tax revenue. And many of our Nation's strongest leaders got their start thanks to the GI Bill, including Presidents Ford and Herbert Walker Bush, Senators Bob Dole, George McGovern, and Pat Moynihan. The GI Bill also educated 12 Nobel Prize winners and two dozen Pulitzer Prize winners, including Joseph Heller, Norman Mailer, and Frank McCourt.

Veterans of Iraq and Afghanistan, however, receive only a fraction of the support offered to the greatest generation. For many, including my good friend, Sergeant Todd Bowers, the burdens of student loans and mounting debt can simply become too great.

When Sergeant Bowers was activated for a second deployment to Iraq, he was forced to withdraw from his classes at George Washington University, racking up an extra semester of debt without receiving credit for his coursework.

While he was deployed to Iraq, Bowers was wounded when a sniper's round penetrated his rifle scope and sent fragments into the left side of his face. He was awarded a Purple Heart, a Navy Commendation Medal with V device for valor.

When Bowers returned home, he was not greeted as a hero by his university and credit lenders. His student loans had been sent to collection and his credit rating was ruined. Struggling to keep up with his payments, Bowers was eventually forced to leave school. But a new GI Bill does not just benefit Todd Bowers. It would benefit our entire military.

It is an important recruitment tool. For years, the military has been lowering recruiting standards and increasing bonuses. We now spend more than $4 billion annually on recruitment, yet are still struggling to meet goals.

The GI Bill is the military's single most effective recruitment tool and the number one reason why civilians join the military is to get money for college. A new GI Bill, one that puts college within reach of a new generation of veterans, would be a tremendous boom to the recruitment and also help rebuild our military after years of war.

Above all, a World War II style GI Bill would thank this generation of combat veterans for their service and their sacrifice. As President Roosevelt said in his signing statement to the original GI Bill, the GI Bill gives emphatic notice to the men and women of our Armed Forces that the American people do not intend to let them down.

For these reasons, IAVA is calling for a new GI Bill to be funded in this year's budget. Thank you for your time and I welcome your questions.

[The prepared statement of Mr. Rieckhoff appears on p. 105.]

The CHAIRMAN. Thank you.

Representing the Veterans for Common Sense (VCS), the Executive Director, Paul Sullivan.

STATEMENT OF PAUL SULLIVAN

Mr. SULLIVAN. Thank you, Chairman Filner, for inviting Veterans for Common Sense to testify about VA's 2009 budget. We appreciate the many hearings you have held and your swift action to pass the "Dignity for Wounded Warriors Act."

VCS begins our testimony with a quote from Associate Supreme Court Justice Thurgood Marshall: "Justice too long delayed is justice denied." VCS believes that VA's budget is dead on arrival because it denies justice to our Nation's 24 million veterans and their families. At a time of war, it is unconscionable for VA to ask for fewer dollars to treat more patients.

VA's budget does not address what we believe should be VA's four highest current priorities for veterans, ending homelessness, reducing suicide, providing free medical care to Iraq and Afghanistan war veterans, and eliminating the VA claims backlog.

First, VCS would like to ask Congress to establish a policy of zero tolerance for homelessness. VCS believes that 200,000 homeless veterans on our streets every night is a national disgrace. VA's budget should have contained an emergency plan to end homeless-

ness for our veterans plus prevent homelessness among Iraq and Afghanistan war veterans.

Second, VCS asks Congress to establish a policy of zero tolerance for turning away suicidal veterans. VCS believes that the epidemic of suicides among veterans justifies an emergency plan to guarantee that no suicidal veteran is ever again turned away from VA.

Third, VCS asks Congress to enact mandatory full funding for healthcare for all veterans so VA stops turning away veterans and Iraq and Afghanistan war veterans. VCS believes VA's budget should have contained a plan to guarantee 5 years of free healthcare, a new law the President signed last month.

Instead of asking for more money to treat veterans, VA went to court to fight against the new law and against free healthcare for our new war veterans. VCS believes VA has underfunded healthcare for Iraq and Afghanistan war veterans by at least $1 billion. VA's budget spends an average of $7,100 per veteran who is already in the system. However, VA's budget plan only spends about $3,900 per new veteran.

VA's budget request does not address VA's severe capacity crisis either. VA's Inspector General reported that 25 percent of all veterans waited more than 1 month to see a doctor. The situation is worse for newer war veterans. VA's internal reports leaked to a reporter showed 33 percent of Iraq and Afghanistan war veterans waited more than 1 month to see a doctor. No veteran should ever have to wait that long.

Fourth, VCS asks Congress to establish a policy of zero tolerance for VA claim delays and VA claim errors. This year, VA repeated their empty promise given every year to reduce the claims backlog by processing claims in an average of 145 days. The current average is 183 days.

VCS believes VA should have submitted a budget plan to process claims accurately within 30 days. VA should automatically approve all claims and we have much more detail on that if you want it.

VA should also establish presumptions of service connection for PTSD and TBI for our war veterans to make processing those claims faster.

Finally, in this era of the all-volunteer Army, VCS appeals once again for Congress to honor our Nation's obligation to our veterans. We can end homelessness. We can reduce suicides. VA can provide both prompt and high-quality medical care. We are cheerleaders for VA. We like VA and we believe VA can provide both prompt and accurate claims decisions.

We believe that if there is an unlimited budget for bullets and bombs for war, then there must also be mandatory full funding for our veterans' transition from the battlefield to home.

We close with this quote from former Army General and VA Administrator, Omar Bradley. I used to have this in my cube at VA. "We are dealing with veterans, not procedures, with their problems, not ours."

VA's reputation for high-quality medical care and excellent employees is jeopardized by chronic underfunding and staff shortages. Mandatory full funding for VA is the only way to eliminate the smoke and mirrors that have plagued the VA's budget process for decades. And we believe if Congress cannot fix VA, then who will?

Thank you very much, Mr. Chairman. If you have any questions, I will be more than happy to answer them.

[The prepared statement of Mr. Sullivan appears on p. 107.]

The CHAIRMAN. Thank you so much.

Representing the National Coalition for Homeless Veterans (NCHV), the President and Chief Executive Officer, Cheryl Beversdorf.

STATEMENT OF CHERYL BEVERSDORF, RN, MHS, MA

Ms. BEVERSDORF. Chairman Filner, Ranking Member Buyer, the National Coalition for Homeless Veterans appreciates the opportunity to submit testimony to the House Veterans' Affairs Committee regarding the VA budget request for fiscal year 2009.

VA officials report the partnership between the VA and community-based organizations has substantially reduced the number of homeless veterans each night by more than 25 percent since 2003, a commendable record of achievement that must be continued if this Nation is to provide the supportive services and housing options necessary to prevent homelessness among the newest generation of combat veterans from Operations Iraqi Freedom and Enduring Freedom.

Regarding VA's homeless veterans programs, Congress has established a number of programs within VA to address homelessness among veterans. The primary goal for these programs is to return homeless veterans to self-sufficiency and stable, independent living.

The major homeless veterans programs administered by VA include the Homeless Providers Grant and Per Diem Program, the HUD–VASH Program, which is the U.S. Department of Housing and Urban Development and Veterans Affairs Supportive Housing, the Multi-Family Transitional Housing Loan Guarantee Program, and the Compensated Work Therapy Transitional Residence Program.

Homeless veterans also receive primary medical care, mental health, and substance abuse services at VA medical centers and community-based outpatient clinics through the Healthcare for Homeless Veterans Program. Our testimony will focus on these homeless veteran assistance initiatives.

Regarding Grant and Per Diem, it is the Nation's largest VA program to help address the needs of homeless veterans. Last September, the U.S. Government Accountability Office (GAO) presented testimony before this Committee's Health Subcommittee regarding homeless veterans' programs and reported an additional 11,100 transitional housing beds are necessary to meet the demands of the estimated number of homeless veterans needing assistance.

Public Law 110–161 provided for $130 million, the fully authorized level to be expended for the Grant and Per Diem Program. Based on GAO's findings and VA's projected needs, NCHV has concerns about the $138 million budget request for fiscal year 2009 and believes that a $200 million authorization is needed. An increase in the funding level for the next several years would help ensure and expedite VA's program expansion targets.

Regarding special needs grants, the VA provides these to VA healthcare facilities and existing Grant and Per Diem recipients to assist them in serving homeless veterans with special needs. For these grants, Public Law 109–461 authorizes appropriations of $7 million for fiscal year 2007 through fiscal year 2011. But the increased risk of homelessness among these populations, especially women veterans, warrants funding for special needs grants above the currently authorized level. Additional Grant and Per Diem Program funding would address this need.

The HUD–VASH Program provides permanent housing and ongoing treatment services to harder to serve homeless veterans with chronic mental health and substance abuse issues. We were pleased that Public Law 110–161 included $75 million to be used for 7,500 Section 8 vouchers for homeless and disabled programs. Under this program, the VA must provide funding for supportive services to veterans receiving rental vouchers.

We believe the $7.8 million proposed in the current budget was agreed upon before the dramatic increase in HUD–VASH vouchers became law. Because each housing voucher requires approximately $5,700 in supportive services, we estimate approximately $45 million will be needed to adequately serve 7,500 or more clients in HUD–VASH housing units.

The Multi-Family Transitional Housing Loan Guarantee Program authorizes the VA to guarantee 15 loans with an aggregate value of $100 million for construction, renovation of existing property, and refinancing of existing loans to develop transitional housing projects for homeless veterans and their families.

Since 1998, when the program was authorized, only two projects have survived beyond the initial planning stages, one in Chicago and one in San Diego, and only the Chicago project has been developed.

While we believe this program seemed promising in original design and intent, a much more practical and streamlined program should be developed. We believe the resources earmarked for this program might be better allocated to support projects that can be developed and brought online more swiftly.

We are pleased to see additional funding provided for the Compensated Work Therapy, Transitional Residence Program, in the fiscal year 2009 proposed budget.

Regarding mental health programs, virtually every community-based organization providing assistance to veterans in crisis depends on the VA for access to comprehensive mental health services. We believe VA's mental health strategic plan has increased the number of services provided to veterans in crisis and believe the budget will facilitate further implementation of this plan.

We also strongly recommend more attention, and I think this is of interest to you, Mr. Chairman, that there would be an opportunity for simplifying and expanding access to community mental health clinics for OIF/OEF veterans in communities that are not well served by VA facilities.

In conclusion, I want to thank you for giving NCHV an opportunity to testify for the American's veterans in crisis, and we would be happy to answer any questions.

[The prepared statement of Ms. Beversdorf appears on p. 142.]

The CHAIRMAN. Thank you for all that you do.

Representing the National Association for Uniformed Services (NAUS) is the Legislative Director, Rick Jones. Welcome.

STATEMENT OF RICK JONES

Mr. JONES. Chairman Filner, Ranking Member Buyer, thank you very much for the opportunity to appear here today to testify on the Department of Veterans Affairs budget for fiscal year 2009.

First of all, we would like to thank you, Mr. Chairman, and the leadership of this Committee and the House itself for the years in which you pushed for *The Independent Budget* to be appropriated.

Last year's budget, the current year we are in, was just an extraordinary, astounding feat and we thank you so very much for applying the money and directing the priorities to veterans.

The VA budget, including the $3.7 billion, which was a discretionary amount for the President's decision, was released last January. And we appreciate all your effort.

As you approach issues this year, NAUS highly recommends and commends the Veterans' Disability Benefits Commission report. NAUS is pleased that its President, retired Army Major General Bill Matz, actively served on the Veterans' Disability Commission and that the final report of the VDBC has received praise from most Veterans Service Organizations.

The National Association for Uniformed Services firmly believes that the veterans healthcare system is an irreplaceable national investment. It is critical to the Nation and its veterans. The provision of quality, timely care is considered one of the most important veterans' benefits afforded.

Our citizens have also benefited from the advances made in medical care through VA medical research and VA innovations have also made a difference in the medical advancements in this country.

We endorse *The Independent Budget's* recommendation for a medical care budget of $42.8 billion. That is an increase of $3.7 billion above this year's funding level and approximately $1.6 billion more than the Administration's request. And we endorse the *IB* recommendations for the VA research as well.

We ask that you reject the fees and new charges for veterans and provide adequate resources as needed. Veterans deserve the benefits they have earned, and they deserve them because of the sacrifices they have made.

Never again should a situation occur in the VA healthcare system as occurred over the past 2 years at the James A. Haley VA Medical Center in Tampa. The National Association for Uniformed Services is informed that the Haley Medical Center was on divert status for critical patients 27 percent of the time between January 1, 2006, and October 2007. That is the equivalent of about 170 days.

VA figures were reviewed by the *St. Petersburg Times* that showed the hospital had diverted all patients regardless of condition 16 percent of the time over that period. Those conditions should never exist again. And what you did last year will help avoid that.

Current VA policy also should be overturned with regard to Priority 8 veterans. We think the ban should be lifted. Current VA policy allows enrollment of veterans returning from Iraq and Afghanistan. Once enrolled in the VA healthcare system, they are not disenrolled regardless of the category and priority they might fall into following a certain period of time.

We agree with this decision, but we question why veterans from prior conflicts or periods of service before the OIF/OEF period are not afforded the same consideration. Veterans of Korea, World War II should be allowed to have equal consideration.

Funding in the currently operating fiscal year provides VBA with the resources necessary to hire over 3,000 full-time claims processors. At the close of January, however, VBA had more than 650,000 compensation and pension claims pending. More than 26 of those were pending over 180 days.

At a recent briefing of the budget roll-out, Admiral Cooper expressed confidence that recent and continuing hiring and training efforts will allow VBA to significantly reduce that backlog. We hope the Under Secretary is correct in his estimates and we encourage you to follow that progress because the monetary benefits are important to the lives of disabled veterans and their families.

Mr. Chairman, as staunch advocates of veterans, we again thank you for the opportunity to testify and thank you for the efforts you have made over the past year. And we look forward to working with you in the new year for a robust budget for the coming fiscal year.

[The prepared statement of Mr. Jones appears on p. 145.]

The CHAIRMAN. Thank you.

And thank all of you for your interest and your expertise. We hope you will participate in the roundtables where we will look at several pieces of the budget.

I just have a specific question, Cheryl. Do I understand it right that the Per Diem Program applies to homeless shelters that have a 75 percent or more veteran population? Is that the law or is that policy?

Ms. BEVERSDORF. Yes. The requirement is for anyone to be funded under the Grant and Per Diem Program that the veteran population has to be at least 75 percent.

The CHAIRMAN. I am not sure of the rationale behind that. Why not follow the veteran? We have shelters in San Diego, for example, that may be 50 percent veteran or 20 percent veteran, but they do not get any help from the VA. Is that correct?

Ms. BEVERSDORF. Well, that is why I mentioned non-VA clinics in my testimony. I think the VA is interested in introducing legislation that would provide supportive services to homeless veterans in non-VA facilities. There could be a contractual arrangement for veterans who are too far away from a VA facility. Veterans could receive VA supportive services in non-VA facilities and not have to pay for these services.

The CHAIRMAN. Thank you. And thank you for keeping this issue in front of us at all times.

Ms. BEVERSDORF. Thank you.

The CHAIRMAN. And, Paul, thank you for your statements on the GI Bill. We intend, as I said earlier, to make that a top priority and look forward to working with you on that.

Mr. Buyer.

Mr. BUYER. Mr. Chairman, I remember the Sepulveda bill that we had. I thought there was a requirement in that bill, though, that it be 100-percent veterans homeless. Was that right? Was there?

The CHAIRMAN. I do not think so. That was a contract to serve a certain population.

Mr. BUYER. Stay on that land.

The CHAIRMAN. Yes.

Mr. BUYER. Okay. All right. Thanks. You are right. Thanks.

Mr. Jones, regarding the questions on the claims backlog and claims processing, you commented on the number of additional personnel.

Over the years, I think what is getting exhaustive to me is this is not necessarily a problem that we can throw money at and we can throw people at. And I think Admiral Cooper went right at it when he started testing people and learned that there was such a low rate of individuals who could pass these tests.

And training is the issue. So if we have individuals in here who are not qualified, there is no question as to why we have so many appeals and so many backlogs. And we have a training issue.

I do not want to throw more people in if we are not going to get them adequately trained. And I think Admiral Cooper is getting his arms around that one. Would you concur?

Mr. JONES. I agree fully. And the other element, of course, is the IT element that you have been working so hard on over the years. Hiring, training, and technology.

Mr. BUYER. Okay. I asked the other panel the question with regard to the Secretary's testimony that his number one priority is the implementation of Dole-Shalala. Do any of you have comments with regard to the Secretary's testimony?

Mr. JONES. Well, the Dole-Shalala, I would comment, is very narrowly focused. It was focused solely on combat-injured veterans. There was comment on the previous panel, I believe, about the Veterans' Disability Benefits Commission, which was more broadly focused and in being more broadly focused, it includes all veterans who are part of the effort in defending freedom and ensuring that our way of life remains vital.

So we would like to have you more focused, although it is very important on Dole-Shalala, we would like to have you more focused on the Veterans' Disability Benefits Commission, perhaps merging those areas that can be merged. There were some disagreements between the two.

One of those disagreements was that on the age of 65, benefits from VA would end from the Dole-Shalala. At that point, Social Security benefits would take place. The Veterans' Disability Benefits Commission disagreed with that and stated that VA benefits should be for life.

So with regard to Dole-Shalala, it was a very narrowly focused commission.

Mr. BUYER. Well, there are many ways to go about this. The Chairman and I have had discussions. He believes in a comprehensive approach and that is what you are talking about.

Mr. JONES. Yes, sir.

Mr. BUYER. And I would endorse an incremental approach, do what we can. You know, we have an opportunity to strike and hopefully we can proceed with something, you know.

Does anybody else have any comment?

Mr. RIECKHOFF. I would agree with you, sir. I think it is important to see what we can agree on and get things done, but at the same time recognizing that we do face comprehensive challenges and that we are facing mammoth generational challenges that are unprecedented. And so I hate to see us throw the baby out with the bath water, but I think there is obviously going to be battles to be fought.

But to be honest with you, what I am encouraged by is the fact that Dole-Shalala and the VDBC have created momentum in this country of put veterans' issues on the front page and we will hopefully give you all the support that you need to make this a top tier priority. And I think that is critical at a time where veterans are concerned about being pushed to the back pages or not getting the attention that they deserve.

Mr. BUYER. You know, I can fully embrace and understand Senator Dole's desire to address the combat veteran, right? It is the dimension in which he sees the world. It is also part of our warrior ethos of taking care of others who, you know, are less well off than we are and we put them ahead of us. And I can understand that.

I recall politically, and then I will talk about the other side of this, when I chaired Personnel and I had $25 billion. Okay? What am I going to do with $25 billion? And what did I do? I knew exactly what to do, concurrent receipt. I said this thing had not been done for a long time, so I blew the lid off that and said we would do it for only the 100-percent combat veteran.

And the following year, I was bastardized. I was attacked. It was unmerciful that I did not do it for everyone, that there was inequity. And so I have never forgotten that.

And I know what Senator Dole and Secretary Shalala have asked of me and, yes, I want to do what we can. But, boy, I have never forgotten what hell I went through because of my desire only to help them and claims I did not care about everybody else.

And I can see why doing the comprehensive approach protects you against that type of thing. I mean, the veteran community can be a pretty tough community, you know, when they get together and how they can use language sometimes.

I am just speaking openly about our challenges and how we want to proceed with it. Thank you for your testimony.

I yield back, Chairman.

The CHAIRMAN. Again, these issues are really important and we are going to spend some time on each one of them in a different kind of setting. I thank you all for being here. I thank the VA for participating in the whole day's hearing. And this Committee is adjourned.

[Whereupon, at 4:30 p.m., the Committee was adjourned.]

A P P E N D I X

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

Welcome everyone to the hearing on the Department of Veterans Affairs Budget Request for Fiscal Year 2009.

This hearing marks the first time Secretary Peake has come before this Committee, and I cannot think of a more important subject than the VA's fiscal year 2009 budget request.

I would like to welcome our other witnesses, representing organizations that have a direct stake in the VA's budget, and thank you for your hard work and diligence in helping to ensure the VA's budget is sufficient to meet the needs of our veterans.

Ensuring veterans are provided the benefits and services we have promised them as a Nation is an issue that I, and the Members of this Committee, take very seriously. We must make sure we provide the resources needed by our servicemembers returning from Iraq and Afghanistan, and we must make sure resources are available for our veterans from previous conflicts. This is not cheap, but the service and sacrifice of our veterans is real, and VA's budget must provide realistic funding levels to meet these needs.

The VA has requested an increase for VA medical care of $2 billion, for a total of $42.2 billion, including collections. We applaud this increase, but we have serious concerns that this increase may not be enough. *The Independent Budget* has recommended an additional $1.6 billion.

I believe that no veteran should have to wait for a healthcare appointment simply because the VA does not have the resources to care for that veteran. We must make sure there is sufficient funding in FY 2009 to meet the mental health needs of our veterans, and to effectively deal with the issue of homeless veterans, which is a national tragedy. We must also make sure the resources are available for our women veterans, and to meet the unique needs of our returning servicemembers.

We look forward to hearing how this budget will assist the VA in working with the Department of Defense to make certain situations like those found last year at Walter Reed do not occur again, and that bureaucracies and jurisdictional issues do not serve as roadblocks in getting the healthcare and benefits that our servicemembers and veterans need.

I am, however, extremely disappointed that the VA has once again submitted a budget that assumes the continuation of the enrollment ban on Priority 8 veterans. We were promised a detailed report by January 1st of this year, listing the resources needed by the VA to lift this ban. We are still waiting for this report, and this information.

The ability of the Secretary to deny enrollment to a group of veterans was provided to the VA in order to address unexpected and unforeseen circumstances—it was never meant by Congress to provide the VA with the ability to ban groups of veterans year after year after year.

I am also disappointed the VA has once again brought forward legislative proposals to increase fees and co-payments for certain veterans. The Administration's proposals to institute enrollment fees and increase pharmacy co-payments have been rejected year after year by Congress. I would like the VA to explain to this Committee why they have offered these proposals again, and the policy reasons for deeming the proposed receipts from these proposals "mandatory" dollars.

Although the Administration has requested an increase for medical care, this increase has come at the expense of other VA programs. The VA's FY 2009 budget recommends a 5.5-percent increase for medical care, while recommending cuts in VA major and minor construction of nearly 44 percent; nearly 49 percent for grants for construction of State extended care facilities; nearly 8 percent for VA medical and prosthetic research; slightly more than 7 percent for the National Cemetery Administration; 19 percent for grants for construction of State veteran cemeteries; and 5 percent for the Office of Inspector General. The VA's FY 2009 budget recommends

an increase of nearly 6 percent in general operating expenses, the budget account that funds, among other items, VA claims processors. The VA also requests an increase in information technology systems of slightly more than 24 percent.

We must make sure that we are providing the resources needed to address the claims backlog and speed up the process for veterans to receive the benefits they have earned. We must also carefully consider the VA's IT request to make certain these dollars are spent wisely.

This Committee will seriously weigh the VA's budget request for FY 2009 and will make our recommendations to the Budget Committee at the end of this month. We will work closely with our colleagues on the Appropriations Committee to ensure veterans get the benefits and services they have earned, and we will work to ensure that the veterans' funding achievements we accomplished last year are continued this year.

We provided historic increases last year, and we will continue to make sure our veterans are cared for in the coming years.

Prepared Statement of Hon. Stephanie Herseth Sandlin

Thank you to everyone for being here to discuss the Department of Veterans Affairs budget request for fiscal year 2009.

I would like to take this opportunity to congratulate you Secretary Peake on your recent appointment to lead the Department of Veterans Affairs.

Mr. Secretary, as you may know, I am the Chairwoman of the Economic Opportunity Subcommittee. I look forward to working with you to ensure our service men and women have the benefits they have earned and deserve to successfully transition to civilian life. Most notably, I look forward to working with you to update the Montgomery GI Bill to ensure educational benefits reflect the increased mission tempo and high cost of a secondary education of the 21st century.

Although the President's budget provides increased funding for the VA, I do not believe it is sufficient to meet the needs of our veterans. In particular, I am worried that this budget is not honest in its assessment of the cost associated with treating both the current veteran population and the newest generation of veterans—many of whom are returning home from the wars in Iraq and Afghanistan with PTSD, TBI, and other injuries that will require a lifetime of care.

Finally, I am disappointed that the budget again proposes annual enrollment fees and increasing pharmacy co-payments. We should not be shifting the burden for veterans' healthcare to veterans themselves. I look forward to working with my colleagues in a bipartisan manner toward eliminating this tax on veterans and addressing the other shortfalls of this budget proposal.

Again, I want to thank everyone for taking the time to be here to discuss these important matters.

Prepared Statement of Hon. James B. Peake, M.D.
Secretary, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Committee, good afternoon. I am happy to be here and I am deeply honored that the President has given me the opportunity to serve as Secretary of Veterans Affairs. I look forward to working with you to build on VA's past successes to ensure veterans continue to receive timely, accessible delivery of high-quality benefits and services earned through their sacrifice and service in defense of freedom.

I am here today to present the President's 2009 budget proposal for VA. The request totals nearly $93.7 billion—$46.4 billion for entitlement programs and $47.2 billion for discretionary programs. The total request is $3.4 billion above the funding level for 2008. The President's ongoing commitment to those who have faithfully served this country in uniform is clearly demonstrated through this budget request for VA. Resources requested for discretionary programs in 2009 are more than double the funding level in effect when the President took office 7 years ago.

The President's request for 2009 will allow VA to achieve performance goals in four areas critical to the achievement of our mission:

- Provide timely, accessible, and high-quality healthcare to our highest priority patients—veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special healthcare needs;

- Advance our collaborative efforts with the Department of Defense (DoD) to ensure the continued provision of world-class healthcare and benefits to VA and DoD beneficiaries, including progress toward the development of secure, interoperable electronic medical record systems;
- Improve the timeliness and accuracy of claims processing; and
- Ensure the burial needs of veterans and their eligible family members are met and maintain veterans' cemeteries as national shrines.

Ensuring a Seamless Transition from Active Military Service to Civilian Life

One of our highest priorities is to ensure that veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom receive everything they need to make their transition back to civilian life as smooth and easy as possible. We will take all measures necessary to provide them with timely benefits and services, to give them complete information about the benefits they have earned through their courageous service, and to implement streamlined processes free of bureaucratic red tape.

We will provide timely, accessible, and high-quality medical care for those who bear the permanent physical scars of war as well as compassionate care for veterans who suffer from less visible but equally serious and debilitating mental health issues, including traumatic brain injury (TBI) and post traumatic stress disorder (PTSD). Our treatment of those with mental health conditions will include veterans' family members who play a critical role in the care and recovery of their loved ones.

The President's top legislative priority for VA is to implement the recommendations of the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission). The Commission's report provides a powerful blueprint to move forward with ensuring that service men and women injured during the Global War on Terror continue to receive the healthcare services and benefits necessary to allow them to return to full and productive lives as quickly as possible. VA has initiated studies to determine appropriate payment levels for quality of life, transition assistance, and loss of earnings. The next step is for Congress to pass the President's legislation, which will modernize the disability compensation system. VA is working closely with officials from DoD on the recommendations of the Dole-Shalala Commission that do not require legislation to help ensure veterans achieve a smooth transition from active military service to civilian life.

For example, VA and DoD signed an agreement in October 2007 to provide Federal recovery coordinators to ensure medical services and other benefits are provided to seriously wounded, injured, and ill active duty servicemembers and veterans. VA hired the first recovery coordinators, in coordination with DoD, and they are located at Walter Reed Army Medical Center, National Naval Medical Center, and Brooke Army Medical Center. They will coordinate services between VA and DoD and, if necessary, private-sector facilities, while serving as the ultimate resource for families with questions or concerns about VA, DoD, or other Federal benefits.

In November 2007, VA and DoD began a pilot disability evaluation system for wounded warriors at the major medical facilities in the Washington, DC area—Washington VA Medical Center, Walter Reed Army Medical Center, National Naval Medical Center, and Malcolm Grow Medical Center. This initiative is designed to eliminate the duplicative and often confusing elements of the current disability processes of the two Departments. Key features of the disability evaluation system pilot include one medical examination and a single disability rating determined by VA. The single disability examination is another improvement resulting from the recommendations of the Dole-Shalala Commission and is aimed at simplifying benefits, healthcare, and rehabilitation for injured servicemembers and veterans.

VA will continue to work with Congress, DoD, and other Federal agencies to aggressively move forward with implementing the Dole-Shalala Commission recommendations.

Medical Care

The President's 2009 request includes total budgetary resources of $41.2 billion for VA medical care, an increase of $2.3 billion over the 2008 level and more than twice the funding available at the beginning of the Bush Administration. Our total medical care request is comprised of funding for medical services ($34.08 billion), medical facilities ($4.66 billion), and resources from medical care collections ($2.47 billion). We have included funds for medical administration as part of our request for medical services. Merging these two accounts will improve and simplify the execution of our budget and will make it easier for us to respond rapidly to unanticipated changes in the healthcare environment throughout the year. We appreciate Congress providing us with the authority to transfer funding between our medical

care accounts as this helps ensure we operate a balanced medical program. We will evaluate the potential need for adjustments to our medical accounts during 2008.

Information technology (IT) plays a vital role in direct support of our medical care program and VA is requesting a significant increase in IT funding in 2009, much of which will help ensure we continue to provide timely, safe, and high-quality healthcare services. The most critical component of our medical IT program is the continued operation and improvement of our electronic health record system, a Presidential priority which has been recognized nationally for increasing productivity, quality, and patient safety. We must continue the progress we have made with DoD to develop secure, interoperable electronic medical record systems which is a critical recommendation in the Dole-Shalala Commission report. The availability of medical data to support the care of patients shared by VA and DoD will enhance our ability to provide world-class care to veterans and active duty members, including our wounded warriors returning from Afghanistan and Iraq.

Workload

During 2009, we expect to treat about 5,771,000 patients. This total is nearly 90,000 (or 1.6 percent) above the 2008 estimate. Our highest priority patients (those in priorities 1–6) will comprise 67 percent of the total patient population in 2009, but they will account for 84 percent of our healthcare costs.

We expect to treat about 333,000 veterans in 2009 who served in Operation Enduring Freedom and Operation Iraqi Freedom. This is an increase of 40,000 (or 14 percent) above the number of veterans from these two campaigns that we anticipate will come to VA for healthcare in 2008, and 128,000 (or 62 percent) more than the total in 2007.

Funding for Major Healthcare Initiatives

In 2009 we are requesting nearly $1.3 billion to meet the needs of the 333,000 veterans with service in Operation Enduring Freedom and Operation Iraqi Freedom whom we expect will come to VA for medical care. This is an increase of $216 million (or 21 percent) over our resource needs to care for these veterans in 2008.

The Department's resource request includes $3.9 billion in 2009 to continue our effort to improve access to mental health services across the country. This is an increase of $319 million, or 9 percent, above the 2008 level. These funds will help ensure VA continues to realize the aspirations of the President's New Freedom Commission Report, as embodied in VA's Mental Health Strategic Plan, to deliver exceptional, accessible mental healthcare. The Department will place particular emphasis on providing care to those suffering from PTSD as a result of their service in Operation Enduring Freedom and Operation Iraqi Freedom. An example of our firm commitment to provide the best treatment available to help veterans recover from these mental health conditions is our increased outreach to veterans of the Global War on Terror, as well as increased readjustment and PTSD services. Our strategy for improving access includes increasing mental healthcare staff and expanding our telemental health program that allows us to reach about 20,000 additional patients with mental health conditions each year.

Our 2009 request includes $762 million for non-institutional long-term care services, an increase of $165 million, or 28 percent, over 2008. By enhancing veterans' access to non-institutional long-term care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes surrounded by their families. This includes adult day healthcare, home-based primary care, purchased skilled home healthcare, homemaker/home health aide services, home respite and hospice care, and community residential care. During 2009 we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 61,000. This represents a 38-percent increase above the level we expect to reach in 2008.

VA's medical care request includes nearly $1.5 billion to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. This is $134 million, or 10 percent, above the funding level in 2008. This increase in resources for prosthetics and sensory aids will allow the Department to meet the needs of the growing number of injured veterans returning from combat in Afghanistan and Iraq.

Requested funding for the Civilian Health and Medical Program of the VA (CHAMPVA) totals just over $1 billion in 2009, an increase of $145 million (or 17 percent) over the 2008 resource level. Claims paid for CHAMPVA benefits are expected to grow by 9 percent (from 7.0 million to 7.6 million) between 2008 and 2009 and the cost of transaction fees required to process electronic claims is rising as well.

Our budget request contains $83 million for facility activations. This is $13 million, or 19 percent, above the resource level for activations in 2008. As VA completes projects within our Capital Asset Realignment for Enhanced Services (CARES) program, we will need increased funding to purchase equipment and supplies for newly constructed and leased buildings.

Quality of Care

The resources we are requesting for VA's medical care program will allow us to strengthen our position as the Nation's leader in providing high-quality healthcare. VA has received numerous accolades from external organizations documenting the Department's leadership position in providing world-class healthcare to veterans. For example, our record of success in healthcare delivery is substantiated by the results of the December 2007 American Customer Satisfaction Index (ACSI) survey. Conducted by the National Quality Research Center at the University of Michigan Business School and the Federal Consulting Group, the ACSI survey found that customer satisfaction with VA's healthcare system was higher than the private sector for the eighth consecutive year. The data revealed that patients at VA medical centers recorded a satisfaction level of 83 out of a possible 100 points, or 6 points higher than the rating for care provided by the private-sector healthcare industry.

In December 2007 the Congressional Budget Office (CBO) issued a report highlighting the success of VA's healthcare system. In this report—*The Health Care System for Veterans: An Interim Report*—the CBO identified organizational restructuring and management systems, the use of performance measures to monitor key processes and health outcomes, and the application of health IT as three of the major driving forces leading to high-quality healthcare delivery in VA. In October 2007, the Institute of Medicine released a report—*Treatment of PTSD: An Assessment of the Evidence*—that states VA's use of exposure-based therapies for the treatment of PTSD is effective. This confirms the Department's own conclusions and bolsters our efforts to continue to effectively treat veterans of the Global War on Terror who are suffering from PTSD and other mental health conditions.

These external acknowledgments of the superior quality of VA healthcare reinforce the Department's own findings. We use two primary measures of healthcare quality—clinical practice guidelines index and prevention index. These measures focus on the degree to which VA follows nationally recognized guidelines and standards of care that the medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the clinical practice guidelines index, which focuses on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to grow to 86 percent in 2009, or a 1 percentage point rise over the level we expect to achieve in 2008. As an indicator aimed at primary prevention and early detection recommendations dealing with immunizations and screenings, the prevention index will also grow by 1 percentage point above the estimated 2008 level, reaching 89 percent in 2009.

Access to Care

In April 2006 there were over 250,000 unique patients waiting more than 30 days for their desired appointment date for healthcare services. As of January 1, 2008, we had reduced the waiting list to just over 69,000. Our budget request for 2009 provides the resources necessary for the Department to virtually eliminate the waiting list by the end of next year. Improvements in access to healthcare will result in part from the opening of 64 new community-based outpatient clinics in 2008 and 51 more in 2009 (bringing the total number to 846).

The Department will expand its telehealth program which is a critical component of VA's approach to improve access to healthcare for veterans living in rural and remote areas. Other strategies include increasing the number of community-based outpatient clinics and enhancing VA's participation in the National Rural Development Partnership that serves as a forum for identifying, discussing, and acting on issues affecting those residing in rural areas. In 2009 the Department's Office of Rural Health will conduct studies to evaluate VA's rural health programs and develop policies and additional programs to improve the delivery of healthcare to veterans living in rural and remote areas.

Medical Collections

The Department expects to receive nearly $2.5 billion from medical collections in 2009, which is $126 million, or more than 5 percent, above our projected collections for 2008. About $8 of every $10 in additional collections will come from increased third-party insurance payments, with almost all of the remaining collections resulting from growing pharmacy workload. We will continue several initiatives to strengthen our collections processes, including expanded use of both the Consolidated Patient Account Center to increase collections and improve operational per-

formance, and the Insurance Card Buffer system to improve third-party insurance verification. In addition, we will enhance the use of real-time outpatient pharmacy claims processing to facilitate faster receipt of pharmacy payments from insurers and will expand our campaign to increase the number of payers accepting electronic coordination of benefits claims.

Legislative Proposals

The President's 2009 budget includes seven legislative proposals totaling $42 million. One of these proposals expands legislative authority to cover payment of specialized residential care and rehabilitation in VA-approved medical foster homes for veterans of Operation Enduring Freedom and Operation Iraqi Freedom who suffer from TBI. Another proposal would reduce existing barriers to the early diagnosis of human immunodeficiency virus (HIV) infection by removing requirements for separate written informed consent for HIV testing among veterans. This change would ensure that patients treated by VA receive the same standard of HIV care that is recommended to non-VA patients.

The 2009 budget also contains three legislative proposals which ask veterans with comparatively greater means and no compensable service-connected disabilities to assume a modest share of the cost of their healthcare. They are exactly the same as proposals submitted but not enacted in the 2008 budget. The first proposal would assess Priority 7 and 8 veterans with an annual enrollment fee based on their family income:

Family Income	**Annual Enrollment Fee**
Under $50,000	None
$50,000–$74,999	$250
$75,000–$99,999	$500
$100,000 and above	$750

The second legislative proposal would increase the pharmacy co-payment for Priority 7 and 8 veterans from $8 to $15 for a 30-day supply of drugs. And the last provision would equalize co-payment treatment for veterans regardless of whether or not they have insurance.

These legislative proposals have been identified in VA's budget request for several years. The proposals are consistent with the priority system of healthcare established by Congress, a system which recognizes that priority consideration must be given to veterans with service-disabled conditions, those with lower incomes, and veterans with special healthcare needs.

These proposals have no impact on the resources we are requesting for VA medical care as they do not reduce the discretionary medical care resources we are seeking. Our budget request includes the total funding needed for the Department to continue to provide veterans with timely, accessible, and high-quality medical services that set the national standard of excellence in the healthcare industry. Instead, these three provisions, if enacted, would generate an estimated $2.3 billion in revenue from 2009 through 2013 that would be deposited into a mandatory account in the Treasury.

One of our highest legislative priorities is to establish the position of Assistant Secretary for Acquisition, Logistics, and Construction. The person occupying this new position would serve as VA's Chief Acquisition Officer, a position required by the Services Acquisition Reform Act of 2003. This will elevate the importance of these critical functions to the level necessary to coordinate their policy direction across the Department's programs and other government agencies. An Assistant Secretary with focused policy responsibility for acquisition, logistics, and construction would ensure these vital activities receive the visibility they need at the highest levels of VA. Legislation to accomplish this was introduced in the Senate on October 4, 2007, as S. 2138. We would appreciate Congress' support of this legislation.

Medical Research

VA is requesting $442 million to support VA's medical and prosthetic research program. Our request will fund nearly 2,000 high-priority research projects to expand knowledge in areas critical to veterans' healthcare needs, most notably research in the areas of mental illness ($53 million), aging ($45 million), health serv-

ices delivery improvement ($39 million), cancer ($37 million), and heart disease ($33 million).

One of our highest priorities in 2009 will be to continue our aggressive research program aimed at improving the lives of veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom. The President's budget request for VA contains $252 million devoted to research projects focused specifically on veterans returning from service in Afghanistan and Iraq. This includes research in TBI and polytrauma, spinal cord injury, prosthetics, burn injury, pain, and post-deployment mental health. Our research agenda includes cooperative projects with DoD to enhance veterans' seamless transition from military treatment facilities to VA medical facilities, particularly in the treatment of veterans suffering from TBI.

The President's request for research funding will help VA sustain its long track record of success in conducting research projects that lead to clinically useful interventions that improve the health and quality of life for veterans as well as the general population. Recent examples of VA research results that have direct application to improved clinical care include the use of a neuromotor prosthesis to help replace or restore lost movement in paralyzed patients, continued development of an artificial retina for those who have lost vision due to retinal damage, use of an inexpensive generic drug (prazosin) to improve sleep and reduce trauma nightmares for veterans with PTSD, and advancements in identifying a new therapy to prevent or slow the progression of Alzheimer's disease.

In addition to VA appropriations, the Department's researchers compete for and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2009. Through a combination of VA resources and funds from outside sources, the total research budget in 2009 will be almost $1.85 billion.

General Operating Expenses

The Department's 2009 resource request for General Operating Expenses (GOE) is $1.7 billion. Within this total GOE funding request, nearly $1.4 billion is for the management of the following non-medical benefits administered by the Veterans Benefits Administration (VBA)—disability compensation; pensions; education; housing; vocational rehabilitation and employment; and insurance. The 2009 budget request provides VBA over two times the level of discretionary funding available when the President took office and underscores the priority this Administration places on improving the timeliness and accuracy of claims processing. Our request for GOE funding also includes $328 million to support General Administration activities.

Compensation and Pensions Workload and Performance Management

A major challenge in improving the delivery of compensation and pension benefits is the steady and sizeable increase in workload. The volume of claims receipts is projected to reach 872,000 in 2009—a 51-percent increase since 2000.

The number of active duty servicemembers as well as Reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom is one of the key drivers of new claims activity. This has contributed to an increase in the number of new claims, and we expect this pattern to persist at least for the near term. An additional reason that the number of compensation and pension claims is climbing is the Department's commitment to increase outreach. We have an obligation to extend our reach as far as possible and to spread the word to veterans about the benefits and services VA stands ready to provide.

Disability compensation claims from veterans who have previously filed a claim comprise about 54 percent of the disability claims received by the Department each year. Many veterans now receiving compensation suffer from chronic and progressive conditions, such as diabetes, mental illness, cardiovascular disease, orthopedic problems, and hearing loss. As these veterans age and their conditions worsen, VA experiences additional claims for increased benefits.

The growing complexity of the claims being filed also contributes to our workload challenges. For example, the number of original compensation cases with eight or more disabilities claimed increased by 168 percent during the last 7 years, reaching over 58,500 claims in 2007. Over one-quarter of all original compensation claims received last year contained eight or more disability issues. In addition, we expect to continue to receive a growing number of complex disability claims resulting from PTSD, TBI, environmental and infectious risks, complex combat-related injuries, and complications resulting from diabetes. Claims now take more time and more resources to adjudicate. Additionally, as VA receives and adjudicates more claims, this results in a larger number of appeals from veterans and survivors, which also in-

creases workload in other parts of the Department, including the Board of Veterans' Appeals and the Office of the General Counsel.

The Veterans Claims Assistance Act of 2000 has significantly increased both the length and complexity of claims development. VA's notification and development duties have grown, adding more steps to the claims process and lengthening the time it takes to develop and decide a claim. Also, the Department is now required to review the claims at more points in the adjudication process.

VA will address its ever-growing workload challenges in several ways. For example, we will enhance our use of information technology tools to improve claims processing. In particular, our claims processors will have greater online access to DoD medical information as more categories of DoD's electronic records are made available through the Compensation and Pension Records Interchange project. We will also strengthen our investment in Virtual VA, which will reduce our reliance upon paper-based claims folders and enable accessing and transferring electronic images and data through a Web-based application. Virtual VA will also dramatically increase the security and privacy of veteran data. The Department will continue to move work among regional offices in order to maximize our resources and enhance our performance. Also, this year we will complete the consolidation of original pension claims processing to three pension maintenance centers which will relieve regional offices of their remaining pension work. In addition, we will further advance staff training and other efforts to improve the consistency and quality of claims processing across regional offices.

Using resources available in 2008, we are aggressively hiring additional staff. By the beginning of 2009, we expect to complete a 2-year effort to hire about 3,100 new staff. This increase in staffing is the centerpiece of our strategy to achieve our 145-day goal for processing compensation and pension claims in 2009. This represents a 38-day improvement (or 21 percent) in processing timeliness from 2007 and a 24-day (or 14 percent) reduction in the amount of time required to process claims this year.

In addition, we anticipate that our pending inventory of disability claims will fall to about 298,000 by the end of 2009, a reduction of more than 94,000 (or 24 percent) from the pending count at the close of 2007. At the same time we are improving timeliness, we will also increase the accuracy of the compensation claims we adjudicate, from 88 percent in 2007 to 92 percent in 2009.

Education and Vocational Rehabilitation and Employment Performance

With the resources provided in the President's 2009 budget request, key program performance will improve in both the education and vocational rehabilitation and employment programs. The timeliness of processing original education claims will improve by 13 days during the next 2 years, falling from 32 days in 2007 to 19 days in 2009. During this period, the average time it takes to process supplemental claims will improve from 13 days to just 10 days. These performance improvements will be achieved despite an increase in workload. The number of education claims we expect to receive will reach about 1,668,000 in 2009, or 9 percent higher than last year. In addition, the rehabilitation rate for the vocational rehabilitation and employment program will climb to 76 percent in 2009, a gain of 3 percentage points over the 2007 performance level. The number of program participants is projected to rise to 91,700 in 2009, or 5 percent higher than the number of participants in 2007.

Funding for Initiatives

Our 2009 request includes $10.8 million for initiatives to improve performance and operational processes throughout VBA. Of this total, $8.7 million will be used for a comprehensive training package covering almost all of our benefits programs. A little over one-half of the resources for this training initiative will be devoted to compensation and pension staff while nearly one-quarter of the training funds will be for staff in the vocational rehabilitation and employment program. These training programs include extensive instruction for new employees as well as additional training to raise the skill level of existing staff. Our robust training program is a vital component of our ongoing effort to improve the quality and consistency of our claims processing decisions and will enable us to be more flexible and responsive to changing workload demands.

National Cemetery Administration

Results from the December 2007 ACSI survey conducted by the National Quality Research Center at the University of Michigan and the Federal Consulting Group revealed that for the second consecutive time VA's national cemetery system received the highest rating in customer satisfaction for any Federal agency or private

sector corporation surveyed. The Department's cemetery system earned a customer satisfaction rating of 95 out of a possible 100 points. These results highlight that VA's cemetery system is a model of excellence in providing timely, accessible, and high-quality services to veterans and their families.

The President's 2009 budget request for VA includes $181 million in operations and maintenance funding for the National Cemetery Administration (NCA), which is 71 percent above the resources available to the Department's burial program when the President took office. The resources requested for 2009 will allow us to meet the growing workload at existing cemeteries by increasing staffing and funding for contract maintenance, supplies, and equipment, open new national cemeteries, and maintain our cemeteries as national shrines. We will perform 111,000 interments in 2009, or 11 percent more than in 2007. The number of developed acres (7,990) that must be maintained in 2009 will be 8 percent greater than in 2007.

Our budget request includes an additional $5 million to continue daily operations and to begin interment operations at six new national cemeteries—Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Sarasota, Florida; and southeastern Pennsylvania. Establishment of these six new national cemeteries is directed by the National Cemetery Expansion Act of 2003. We plan to open fast track burial sections at five of the six new cemeteries in late 2008 or early 2009, with the opening of the cemetery in southeastern Pennsylvania to follow in mid-2009.

The President's resource request for VA provides $9.1 million in cemetery operations and maintenance funding to address gravesite renovations as well as headstone and marker realignment. When combined with another $7.5 million in minor construction, VA is requesting a total of $16.6 million in 2009 to improve the appearance of our national cemeteries which will help us maintain cemeteries as shrines dedicated to preserving our Nation's history and honoring veterans' service and sacrifice.

With the resources requested to support NCA activities, we will expand access to our burial program by increasing the percent of veterans served by a burial option within 75 miles of their residence to 88 percent in 2009, which is 4.6 percentage points above our performance level at the close of 2007. In addition, we will continue to increase the percent of respondents who rate the quality of service provided by national cemeteries as excellent to 98 percent in 2009, or 4 percentage points higher than the level of performance we reached last year.

Capital Programs (Construction and Grants to States)

The President's 2009 budget request includes just over $1 billion in capital funding for VA, $5 million of which will be derived from the sale of assets. Our request for appropriated funds includes $581.6 million for major construction projects, $329.4 million for minor construction, $85 million in grants for the construction of State extended care facilities, and $32 million in grants for the construction of State veterans cemeteries.

The 2009 request for construction funding for our healthcare programs is $750.0 million—$476.6 million for major construction and $273.4 million for minor construction. All of these resources will be devoted to continuation of the Capital Asset Realignment for Enhanced Services (CARES) program. CARES will renovate and modernize VA's healthcare infrastructure, provide greater access to high-quality care for more veterans, closer to where they live, and help resolve patient safety issues. Some of the construction funds in 2009 will be used to expand our polytrauma system of care for veterans and active duty personnel with lasting disabilities due to polytrauma and TBI. This system of care provides the highest quality of medical, rehabilitation, and support services.

Within our request for major construction are resources to continue five medical facility projects already underway:

- Denver, Colorado ($20.0 million)—replacement medical center near the University of Colorado Fitzsimons campus.
- Lee County, Florida ($111.4 million)—new building for an ambulatory surgery/outpatient diagnostic support center.
- Orlando, Florida ($120.0 million)—new medical center consisting of a hospital, medical clinic, nursing home, domiciliary, and full support services.
- San Juan, Puerto Rico ($64.4 million)—seismic corrections to the main hospital building.
- St. Louis, Missouri ($5.0 million)—medical facility improvements and cemetery expansion.

Major construction funding is also provided to begin three new medical facility projects:

- Bay Pines, Florida ($17.4 million)—inpatient and outpatient facility improvements.
- Tampa, Florida ($21.1 million)—polytrauma expansion and bed tower upgrades.
- Palo Alto, California ($38.3 million)—centers for ambulatory care and polytrauma rehabilitation center.

In addition, we are moving forward with plans to develop a fifth Polytrauma Rehabilitation Center in San Antonio, Texas with the $66 million in funding provided in the 2007 emergency supplemental.

Minor construction is an integral component of our overall capital program. In support of the medical care and medical research programs, minor construction funds permit VA to address space and functional changes to efficiently shift treatment of patients from hospital-based to outpatient care settings; realign critical services; improve management of space, including vacant and underutilized space; improve facility conditions; and undertake other actions critical to CARES implementation. Further, minor construction resources will be used to comply with the energy efficiency and sustainability design requirements mandated by the President.

We are requesting $130.0 million in construction funding to support the Department's burial program—$105.0 million for major construction and $25.0 million for minor construction. Within the funding we are requesting for major construction are resources for gravesite expansion and cemetery improvement projects at three national cemeteries—New York (Calverton, $29.0 million); Massachusetts ($20.5 million); and Puerto Rico ($33.9 million).

VA is requesting $5 million for a new land acquisition line item in the major construction account. These funds will be used to purchase land as it becomes available in order to quickly take advantage of opportunities to ensure the continuation of a national cemetery presence in areas currently being served. All land purchased from this account will be contiguous to an existing national cemetery, within an existing service area, or in a location that will serve the same veteran population center.

Information Technology

The President's 2009 budget provides more than $2.4 billion for the Department's IT program. This is $389 million, or 19 percent above our 2008 budget, and reflects the realignment of all IT operations and functions under the management control of the Chief Information Officer.

IT is critical to the timely, accessible delivery of high-quality benefits and services to veterans and their families. Our healthcare and benefits programs can only be successful when directly supported by a modern IT infrastructure and an aggressive program to develop improved IT systems that will meet new service delivery requirements. VA must modernize or replace existing systems that are no longer adequate in today's rapidly changing healthcare environment. It is vital that VA receives a significant infusion of new resources to implement the IT-related recommendations presented in the Dole-Shalala Commission report.

Within VA's total IT request of more than $2.4 billion, 70 percent (or $1.7 billion) will be for IT investment (non-payroll) costs while the remaining 30 percent (or $729 million) will go for payroll and administrative requirements. Of the $389 million increase we are seeking for IT, 86 percent will be devoted to IT investment. The overwhelming majority ($271 million) of the IT investment funds will support VA's medical care program, particularly VA's electronic health record system.

VA classifies its IT investment functions into two major categories—those that directly impact the delivery of benefits and services to veterans (i.e., veteran facing) and those that indirectly affect veterans through administrative and infrastructure support activities (i.e., internal facing). For 2009, our $1.7 billion request for IT investment is comprised of $1.3 billion in veteran facing activities and $418 million in internal facing IT functions. Within each of these two major categories, IT programs and initiatives are further differentiated between development functions and operations and maintenance activities.

The increase in this budget of 94 full-time equivalent staff will provide enhanced support in two critical areas—information protection and IT asset management. Additional positions are requested for information security: testing and deploying security measures; IT oversight and compliance; and privacy, underscoring our commitment to the protection of veteran and employee information. The increase in IT asset management positions will bring expertise to focus on three primary functions—inventory management, materiel coordination, and property accountability.

Our 2009 budget request contains $93 million in support of our cyber security program to continue our commitment to make VA the gold standard in data security within the Federal Government. We continue to take aggressive steps to ensure the safety of veterans' personal information, including training and educating our employees on the critical responsibility they have to protect personal and health information. We are progressing with the implementation of the Data Security—Assessment and Strengthening of Controls Program established in May 2006. This program was established to provide focus to all activities related to data security.

As part of our continued operation and improvement of the Department's electronic health record system, VA is seeking $284 million in 2009 for development and implementation of the Veterans Health Information Systems and Technology Architecture (Health*e*Vet-VistA) program. This includes a health data repository, a patient scheduling system, and a reengineered pharmacy application. Health*e*Vet-VistA will equip our healthcare providers with the modern tools they need to improve safety and quality of care for veterans. The standardized health information from this system can be easily shared between facilities, making patients' electronic health records available to all those providing healthcare to veterans.

Until Health*e*Vet-VistA is operational, we need to maintain the VistA Legacy system. This system will remain operational as new applications are developed and implemented. This approach will mitigate transition and migration risks associated with the move to the new architecture. Our budget provides $99 million in 2009 for the VistA Legacy system.

In support of our benefits programs, we are requesting $23.8 million in 2009 for VETSNET. This will allow VA to complete the transition of compensation and pension payment processing off of the antiquated Benefits Delivery Network. This will enhance claims processing efficiency and accuracy, strengthen payment integrity and fraud prevention, and position VA to develop future claims processing efficiencies, such as our paperless claims processing strategy. To further our transition to paperless processing, we are seeking $17.4 million in 2009 for Virtual VA which will reduce our reliance on paper-based claims folders through expanded use of electronic images and data that can be accessed and transferred electronically through a Web-based platform.

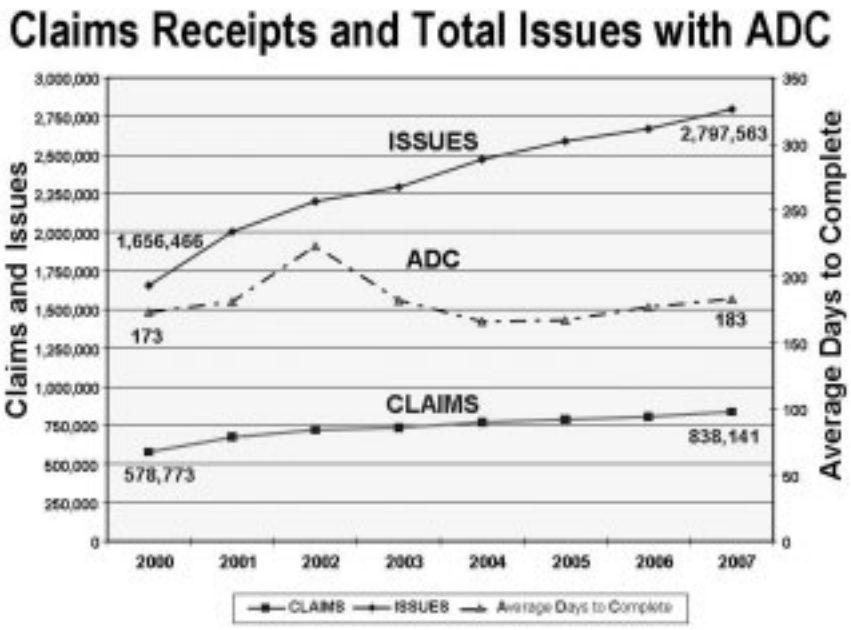
We are requesting $42.5 million for the Financial and Logistics Integrated Technology Enterprise (FLITE) system. FLITE is being developed to address a longstanding internal control material weakness and will replace an outdated, noncompliant core accounting system that is no longer supported by industry. Our 2009 budget also includes $92.6 million for human resource management application investments, including the Human Resources Information System which will replace our current human resources and payroll system.

Summary

Our 2009 budget request of nearly $93.7 billion will provide the resources necessary for VA to:

- Provide timely, accessible, and high-quality healthcare to our highest priority patients—veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special healthcare needs;
- Advance our collaborative efforts with DoD to ensure the continued provision of world-class healthcare and benefits to VA and DoD beneficiaries, including progress toward the development of secure, interoperable electronic medical record systems;
- Improve the timeliness and accuracy of claims processing; and
- Ensure the burial needs of veterans and their eligible family members are met and maintain veterans' cemeteries as national shrines.

I look forward to working with the Members of this Committee to continue the Department's tradition of providing timely, accessible, and high-quality benefits and services to those who have helped defend and preserve liberty and freedom around the world.



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

Mr. Chairman and Members of the Committee, as one of the four co-authors of *The Independent Budget*, Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) healthcare system for FY 2009.

PVA, along with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, is proud to come before you this year to present the 22nd edition of *The Independent Budget*, a comprehensive budget and policy document that represents the true funding needs of the Department of Veterans Affairs. *The Independent Budget* uses commonly accepted estimates of inflation, healthcare costs and healthcare demand to reach its recommended levels. This year, the document is endorsed by 54 veterans' service organizations, and medical and healthcare advocacy groups.

Last year proved to be a difficult year for the appropriations process. The year started with an incomplete appropriation for FY 2007. Congress eventually completed the FY 2007 funding bills in February, placing the Department of Veterans Affairs (VA) in a very difficult position. While the funding levels provided for FY 2007 were very good, the fact that the bill was not completed for nearly 5 months after the start of that fiscal year is wholly unacceptable. Congress then followed that action up by providing more than $1.8 billion in supplemental funding for the VA.

Unfortunately, the FY 2008 appropriations process did not go any smoother. Due to political wrangling over the Federal budget, the VA did not receive its appropriation until December. We were very disappointed that the VA was forced to endure this situation for the 13th time in the last 14 years. This was particularly disappointing in light of the fact that the Administration guaranteed that the bill would be signed into law and because the bill was completed before the start of the fiscal year on October 1.

The appropriations bill was eventually enacted, but it included budgetary gimmicks that *The Independent Budget* has long opposed. While the maximum appropriation available to the VA would match or exceed our recommendations, the vast majority of this increase was contingent upon the Administration making an emergency funding request for this additional money. Fortunately, the Administration recognized the importance of this critical funding and requested it from Congress. This emergency request provided the VA with $3.7 billion more than the Administration requested for FY 2008.

For FY 2009, the Administration requests $41.2 billion for veterans' healthcare. This included approximately $2.5 billion from medical care collections. Although this represents another step forward in achieving adequate funding for the VA, it still falls short of the recommendations of *The Independent Budget*.

For FY 2009, *The Independent Budget* recommends approximately $42.8 billion for total medical care budget authority, an increase of $3.7 billion over the FY 2008 operating budget level established by P.L. 110–161, the Omnibus Appropriations bill, and approximately $1.6 billion above the Administration's FY 2009 request. It is important to note that our budget recommendations reflect a distinct change from past years as it reinforces the long-held policy that medical care collections should be a supplement to, not a substitute for real dollars. The Administration, year-after-year, chooses to include medical care collections as part of its overall funding authority for Medical Services. However, we believe that the cost of medical care services should be provided for entirely through direct appropriations. In order to develop this recommendation, we used the maximum appropriation amount included in P.L. 110–161 for VA medical care and added the projected medical care collections to that amount to formulate our baseline.

The medical care appropriation in past years has included three separate accounts—Medical Services, Medical Administration, and Medical Facilities—that comprise the total VA healthcare funding level. However, for FY 2009, the Administration's Budget Request recommends consolidating Medical Services and Medical Administration into a single account. In order to properly reflect this change in our recommendations, the separate accounts for Medical Services and Medical Administration must be added together. For FY 2009, *The Independent Budget* recommends approximately $38.2 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$32,574,528,000
Increase in Patient Workload	$ 1,045,470,000
Policy Initiatives	$ 1,000,000,000
Medical Administration	$ 3,625,762,000
Total FY 2007 Medical Services	$38,245,760,000

In order to develop our current services estimate, we first added the estimated collections for FY 2008 to the Medical Services appropriation for FY 2008. This best reflects the total budget authority that the VA will use to provide healthcare services. This amount was then increased by relevant rates of inflation. We also use the Obligations by Object in the President's budget submission in order to set the framework for our recommendation. We believe this method allows us to apply more accurate inflation rates to specific subaccounts within the overall account. Our inflation rates are based on 5-year averages of different inflation categories from the Consumer Price Index—All Urban Consumers (CPI–U) published by the Bureau of Labor Statistics every month.

Our increase in patient workload is based on a projected increase of 120,000 new unique patients—Category 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $792 million. The increase in patient workload also includes a projected increase of 85,000 new Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans at a cost of approximately $253 million.

The policy initiatives include $325 million for improvement of mental health services and traumatic brain injury care. This amount represents the growing trend both within the Administration and the Congress to enhance the mental health services within the VA. Furthermore, it reinforces our belief that resources should be provided to the VA to allow them to be the lead for providing these specialized services, not outside healthcare organizations. We also recommend $250 million for long-term care services. The policy portion of *The Independent Budget* further explains the shortfall that the VA has in meeting the Average Daily Census mandated by the Millennium Health Care Act. We also recommend that the VA be appropriated $325 million for funding the fourth mission which encompasses homeland security and emergency preparedness initiatives. Currently, the VA already spends approximately this amount, but this funding is drawn directly out of the Medical Services account. Finally, we recommend $100 million to support centralized prosthetics funding.

As mentioned previously, our Medical Administration recommendation must be added to our Medical Services recommendation to properly reflect the format of the FY 2009 budget submission. As such, *The Independent Budget* recommends approximately $3.6 billion for Medical Administration for FY 2009.

Finally, for Medical Facilities *The Independent Budget* recommends approximately $4.6 billion. This amount includes an additional $250 million for nonrecurring maintenance for the VA to begin addressing the massive backlog of infrastructure needs.

Although *The Independent Budget* healthcare recommendation does not include additional funding to provide for the healthcare needs of Category 8 veterans being denied enrollment into the system, we believe that adequate resources should be provided to overturn this policy decision. During FY 2008, the VA estimated that a total of over 1,500,000 Category 8 veterans would have been denied enrollment into the VA healthcare system. Despite the fact that we have not seen any solid empirical data to substantiate this continued growth rate in denied Category 8 veterans, the VA continues to project higher and higher numbers of Category 8 veterans denied enrollment into the healthcare system. Based on the projected increase in this population of veterans over the last 5 years, *The Independent Budget* estimates that more than 1,870,000 will have been denied enrollment by FY 2009. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, *The Independent Budget* estimates that the actual total cost to reopen the system will be approximately $1.4 billion in order to meet this new demand. For the sake of discussion, if the projected collections for this group of veterans were to be considered in this estimation, the actual cost in appropriated dollars would be approximately $456 million. We believe that the system should be reopened to these veterans and that adequate funding should be provided in addition to our medical care recommendation.

Although not proposed to have a direct impact on veterans' healthcare, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription drug co-payments from $8 to $15 and an indexed enrollment fee based on veterans' incomes. These proposals will simply add additional financial strain to many veterans, including PVA members and other veterans with catastrophic disabilities. Although the VA does not overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans will leave the system and more than 1,000,000 veterans will choose not to enroll. It is astounding that this Administration would continue to recommend policies that would push veterans away from the best healthcare system in the world. Congress has soundly rejected these proposals in the past and we call on you to do so once again.

For medical and prosthetic research, *The Independent Budget* is recommending $555 million. This represents a $75 million increase over the FY 2008 appropriated level established in the Omnibus Appropriations Act and $113 million over the Administration's request for FY 2009. We are particularly pleased that Congress has recognized the critical need for funding in the medical and prosthetic research account, and we urge Congress to again overrule VA's request, one that will seriously erode VA's crucial biomedical research programs. Research is a vital part of veterans' healthcare, and an essential mission for our national healthcare system. VA research has been grossly underfunded in contrast to the growth rate of other Federal research initiatives. At a time of war, the government should be investing more, not less, in veterans' biomedical research programs.

The Independent Budget recommendation also includes a significant increase in funding for information technology (IT). For FY 2009, we recommend that the VA IT account be funded at approximately $2.165 billion. This amount includes approximately $121 million for an Information Systems Initiative to be carried out by the Veterans Benefits Administration. This initiative is explained in greater detail in the policy portion of *The Independent Budget*.

We remain concerned that the major and minor construction accounts are significantly underfunded in the FY 2009 budget request. The Administration's request slashes funding for major construction from the FY 2008 appropriations level of $1.1 billion to $582 million. The minor construction account is also significantly reduced from the appropriated level of $631 million to only $329 million. These funding levels do little to help the VA offset the rising tide of necessary infrastructure upgrades. Without the necessary funding to address minor construction needs, these projects will become major construction problems in short order. For FY 2009, *The Independent Budget* recommends approximately $1.275 billion for major construction and $621 million for minor construction. The minor construction recommendation includes $45 million for research facility construction needs.

Finally, Mr. Chairman, as you know, the whole community of national veterans service organizations strongly supports an improved funding mechanism for VA healthcare. However, if the Congress cannot support mandatory funding, there are alternatives which could meet our goals of timely, sufficient, and predictable funding.

Congress could change VA's medical care appropriation to an advance appropriation which would provide approval 1 year in advance, thereby guaranteeing its timeliness. Furthermore, by adding transparency to VA's healthcare enrollee projection model, we can focus the debate on the most actuarially-sound projection of veterans' healthcare costs to ensure sufficiency.

Under this proposal, Congress would retain its discretion to approve appropriations; retain all of its oversight authority; and most importantly, there would be no PAYGO problems.

We ask this Committee in your views and estimates for FY 2009 to recommend to the Budget Committee either mandatory funding or this new advance appropriations approach to take the uncertainties out of healthcare for all of our Nation's wounded, sick and disabled veterans.

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

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

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

Mr. Chairman and Members of the Committee:

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

As you know, Mr. Chairman, the *IB* is a budget and policy document that sets forth the collective views of DAV, AMVETS, Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars of the United States (VFW). Each organization accepts principal responsibility for production of a major component of our *Independent Budget*—a budget and policy document on which we all agree. Reflecting that division of responsibility, my testimony focuses primarily on the variety of Department of Veterans Affairs' (VA) benefits programs available to veterans.

In preparing this 22nd *Independent Budget*, the four partners draw upon our extensive experience with veterans' programs, our firsthand knowledge of the needs of America's veterans, and the information gained from continuous monitoring of workloads and demands upon, as well as the performance of, the veterans benefits and services system. Consequently, this Committee has acted favorably on many of our recommendations to improve services to veterans and their families. We ask that you give our recommendations serious consideration again this year.

The Veterans Benefits Administration is Still Understaffed and Overwhelmed

To improve administration of VA's benefits programs, the *IB* recommends Congress provide the Veterans Benefits Administration (VBA) with enough staffing to support a long-term strategy for improvement in claims processing and for other programs under jurisdiction of the VBA. Included in our recommendations are new resources needed for training programs and information technologies; however, this testimony primary focuses on solving VA's staffing shortages as well as other initiatives to manage the increase in new claims and reduce the out-of-control claims backlog. In total, if Congress accepts our recommendations, VBA will be better positioned to serve all disabled veterans and their families.

Understaffing and Claims Backlog

Mr. Chairman, the claims' backlog is unquestionably growing. Rather than making headway and overcoming the protracted delays in the disposition of its claims, VA continues to lose ground on its claims backlog. According to VA's weekly workload report, as of January 26, 2008, there were 816,211 pending compensation and pension (C&P) claims, which include appeals. Putting this number into perspective, at the end of 2004, 2005, 2006, and 2007, the total number of pending claims was 620,926; 680,432; 752,211; and 809,707 respectively. Therefore, in the 3 years from the end of 2004 to the end of 2007, the total number of pending C&P claims rose by 188,781 for an average of 62,929 additional pending claims per year. The VA's pending claims rose by 6,504 just from the end of 2007 to January 26, 2008—less than 1 month. At this rate, VA's caseload will pass 1 million claims in 3 years. With

the wars in Iraq and Afghanistan still raging, together with the mass exodus from military service that usually occurs following cessation of combat operations, new and re-opened claims received by VA are more likely to increase than decrease. A caseload topping 1 million claims will truly be a demoralizing moment for America—the time to act is now.

Throughout the foregoing years, many promises were made in public; yet VBA staffing has essentially remained nearly flat at between 9,200 to 9,500 full-time employees (FTE)—9,287 in FY 2006; 9,445 in FY 2007; and 9,559 in FY 2008. (The FY 2008 figure does not currently take into account increased staffing levels authorized in the most recent appropriations bill for 2008.) While we do not suggest additional resources as the solitary answer to the claims backlog, the current VBA staffing levels have proven year after year to be significantly below the levels needed to halt the growth in the claims backlog, much less sufficient to begin reducing the backlog. There is no proverbial silver bullet to solving VA's challenges. Various policy changes can and should be implemented that may collectively have a positive impact on reducing VA's claims backlog while also improving services to VA's clientele. Nonetheless, implementing any policy change will utterly fail without a significant increase in VBA staffing that is at least on parity with VA's increased receipt of new and reopened claims as well as its ever-growing claims backlog,

Based on an estimated receipt of 920,000 claims in FY 2009, Congress should authorize 12,184 FTE for FY 2009. That number equates to 83 cases per year per each direct program FTE. The *IB* veterans' organizations realize that 83 claims per FTE are below VA's historical projections per FTE. Nonetheless, an infusion of new personnel into VBA's workforce will inevitably result in a reduced output per FTE for a significant length of time. These newly allotted employees will be unable to process claims at rates equal to experienced employees. Additionally, senior staff within VBA will be forced to frequently halt production of their own workload in order to provide necessary training to inexperienced employees. We nonetheless strongly encourage the VA to provide adequate training to ensure that claims are decided properly the first time. Therefore, the reduction in workload per FTE is unavoidable.

Additionally, VBA's new claims per year continue to increase from one year to the next despite VA's 2008 budget assertion that such claims were going to decline. For example, VBA received 771,115 new rating claims in FY 2004 and 838,141 new claims in FY 2007, equaling an average increase of 16,756 additional claims per year. During this same period, VA received the following Benefits Delivery at Discharge (BDD) claims: 39,885 in FY 2004; 37,832 in FY 2005; 40,074 in FY 2006; and 37,370 in FY 2007, for a total 155,164 new beneficiaries that had never before been on VA rolls. At this rate, the average number of new BDD claims per year is 38,791 for a total of 232,746 new claims through the BDD process by the end of FY 2009. These figures do not include servicemembers filing claims through either the military's physical disability evaluation systems, or those discharging via end-of-service contracts who then come to VA on their own to files claims after discharge.

The significance of these new beneficiaries is that large portions of VA's workload increase via new claims each year are re-opened claims rather than claims from veterans who have never filed for VA benefits. Therefore, the increase in brand new beneficiaries into the system will inevitably increase further the number of re-opened claims, ultimately causing the total number of claims received by VA each year to continue growing, contrary to VA's FY 2008 budget estimate. VA's 2009 budget submission reveals the VA added 277,000 beneficiaries to its C&P rolls in 2007, which further proves this point.

The complexity of the workload has also continued to grow. Veterans are claiming greater numbers of disabilities and the nature of disabilities such as post traumatic stress disorder (PTSD), complex combat injuries, diabetes and related conditions, and environmental diseases are becoming increasingly more complex. For example, the number of cases with 8 or more disabilities increased 135 percent from 21,814 in 2000 to 51,260 in 2006.[1] Such complex cases will only further slow down VBA's claims process.

We believe that adequate staffing is essential to any meaningful strategy to get claims processing and backlogs under control. In its budget submission for FY 2007, VBA projected its production based on an output of 109 claims per direct program FTE. We have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, resulting in compromised decisions, higher error and appeal rates, and ultimately more overload on

[1] Fiscal Year 2008 Budget Submission, Volume II, *National Cemetery Administration, Benefits Programs, and Departmental Administration*, Benefits Summary, Department of Veterans Affairs, Pg. 6A–2 (*Retrieved* Feb. 2, 2008, from <*http://www.va.gov/budget/summary/index.htm*>).

the system. In addition to recommending staffing levels more commensurate with the workload, we have maintained that VA should invest more in training adjudicators and that it should hold them accountable for higher standards of accuracy. Nearly half of VBA adjudicators responding to survey questions from VA's Office of Inspector General admitted that many claims are decided without adequate record development. (The Board of Veterans' Appeals (Board) and the Court of Appeals for Veterans Claims' (Court's) remand rate clearly demonstrate this.) The Inspector General saw an incongruity between their objectives of making legally correct and factually substantiated decisions, with management objectives of maximizing output to meet production standards and reduce backlogs. Nearly half of those surveyed reported that it is generally, or very difficult, to meet production standards without compromising quality. Fifty-seven percent reported difficulty meeting production standards while attempting to ensure they have sufficient evidence for rating each case and thoroughly reviewing the evidence. Most attributed VA's inability to make timely and high-quality decisions to insufficient staff. In addition, they indicated that adjudicator training had not been a high priority in VBA.

Therefore, we believe it prudent to recommend staffing levels based on an output of 83 cases per year for each direct program FTE. With an estimated 920,000 incoming claims in FY 2009, that effort would require 11,084 direct program FTEs in fiscal year 2009. With support FTE added, this would require C&P to be authorized 12,184 total FTE for FY 2009.

Adjudicating veterans' claims is a labor-intensive system of personal decision-making, with lifelong consequences for disabled veterans. During Congressional hearings, VA is routinely forced to defend VBA budgets that it knows to be inadequate to the task. The priorities and goals of Congress, the Administration, and the VA must be on par with the necessity for a long-term strategy to fulfill VBA's mission and confirm the Nation's moral obligation to disabled veterans.

Overdevelopment of Claims

Numerous developmental procedures in the VA claims' process collectively add to the enormous backlog of cases. While many of these procedures are mandatory, they are often over-utilized. This unnecessarily delays claims for months—when this occurs in, or leads to, the appeals process, claims are delayed for many years. There is no single answer to solving the claims backlog. Therefore, in addition to staffing increases, Congress and VA must attack the problem using alternative methods, particularly when those alternative methods are parallel with the intent of the law, work to save departmental resources, and protect the rights of disabled veterans.

For example, rather than making timely decisions on C&P claims when evidence development may be complete, the VA routinely *continues* to develop claims. These actions lend validity to many veterans' accusations that whenever VA would rather not grant a claimed benefit, VA intentionally overdevelops cases to obtain evidence against the claim. Despite these accusations, a lack of adequate training is just as likely the cause of such overdevelopment.

Such actions result in numerous appeals, followed by needless remands from the Board and/or the Court. In many of these cases, the evidence of record supports a favorable decision on the appellant's behalf yet the appeal is remanded nonetheless. These unjustified remands usually do nothing but perpetuate the hamster-wheel reputation of veterans' law. Numerous cases exemplify this scenario; a list can be provided upon request. One such example is summarized in the *IB* submission. For the sake of brevity, we will not repeat the summary here, but urge the Committee to review the example titled *Improvements in the Claims Process*, which can be found in the Compensation and Pension section of the General Operating Expenses chapter.

This example deals with VA requesting unnecessary medical opinions in cases where the claimant has already submitted one or more medical opinions that are adequate for rating purposes. VA claimants desiring to secure their own medical evidence, including a fully informed medical opinion, are entitled by law to do so. If a claimant does secure an adequate medical opinion, there is no need in practicality or in law for VA to seek its own opinion. Congress enacted title 38, United States Code, section 5125 for the express purpose of eliminating the former 38 Code of Federal Regulations, section 3.157(b)(2) requirement that a private physician's medical examination report be verified by an official VA examination report prior to an award of VA benefits. Section 5125 states:

> For purposes of establishing any claim for benefits under chapter 11 or 15 of this title, a report of a medical examination administered by a private physician that is provided by a claimant in support of a claim for benefits under that chapter *may* be accepted without a requirement for confirmation by an examination by a physician employed by the Veterans Health Admin-

istration if the report is sufficiently complete to be adequate for the purpose of adjudicating such claim. [Emphasis added]

Therefore, Congress codified section 5125 to eliminate unnecessary delays in the adjudication of claims and to avoid costs associated with unnecessary medical examinations. Notwithstanding the elimination of title 38, Code of Federal Regulations, section 3.157, and the enactment of title 38 United States Code section 5125, VA consistently refuses to render decisions in cases wherein the claimant secures a private medical examination and medical opinion until a VA medical examination and medical opinion are obtained. Such actions are an abuse of discretion, which delay decisions and prompt needless appeals. When claimants submit private medical evidence *that is adequate for rating purposes*, Congress should mandate that VA must decide the case based on such evidence rather than delaying the claim by arbitrarily and unnecessarily requesting additional medical examinations and opinions from the agency. Such enactment will preserve VA's manpower and budgetary resources; help reduce the claims backlog and prevent needless appeals; and most importantly, better serve disabled veterans and their families.

Standard for Determining Combat Veteran Status

Title 38, United States Code, section 1154(b) requires VA to accept lay or other evidence as sufficient proof of service connection of a disease or injury if a veteran alleges that disease or injury occurred in or was aggravated during combat. While VA recognizes the receipt of certain medals as proof of combat, only a fraction of those who participate in combat receive a qualifying medal. Further, military personnel records usually do not document actual combat experiences. As a result, veterans who suffer a disease or injury resulting from combat are forced to provide evidence that may not exist or wait a year or more while the VA conducts research to determine whether a veteran's unit engaged in combat.

Congress should amend title 38, United States Code, section 1154(b) to clarify military service as treatable service in which a member is considered to have engaged in combat for purposes of determining combat-veteran status. Such clarification would properly allow for utilization of nonofficial evidence as proof of in-service occurrence for service connection of combat-related diseases or injuries.

This type of legislation would remove a barrier to the fair adjudication of claims for disabilities incurred or aggravated by military service in combat zone. Under existing law, veterans who can establish that they "engaged in combat" are not required to produce official military records to support their claim for disabilities related to such service. This legislation would not alter the law's current requirement that a veteran confirm a disability through official diagnosis. Further, it would not alter the requirement that a veteran show a nexus between a claimed disability and military service. The only alteration from current law would be a relaxed standard of proof, consistent with Congress' original intent, required to establish a veteran as one who engaged in combat. This relaxed standard of proof would then only apply to those who serve in a combat zone.

Many veterans disabled by their service in Iraq and Afghanistan, and those who served in earlier conflicts are unable to benefit from liberalizing evidentiary requirements found in the current version of section 1154(b). This results because of difficulty, even impossibility, in proving personal participation in combat by official military documents.

Impositions put forth by VA General Counsel opinion 12–99 require veterans to establish by official military records or decorations that they "personally participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality." Oversight visits by Congressional staff to VA regional offices found claims denied under this policy because those who served in combat zones were not able to produce official military documentation of their personal participation in combat via engagement with the enemy. The only possible resolution to this problem without amending section 1154(b) is for the military to record the names and personal actions of every single soldier, sailor, airman, and Marine involved in every single event—large or small—that constitutes combat and/or engagement with the enemy on every single battlefield. Such recordkeeping is impossible.

Numerous veterans have been and continue to be harmed by this defect in the law. In numerous cases, extensive delays in claims processing occur while VA adjudicators attempt to obtain official military documents showing participation in combat: documents that may never be located.

The Senate noted in 1941, in the report on the original bill that the absence of an official record of care or treatment in many of such cases is explained by the conditions surrounding the service of combat veterans. Congress emphasized that the establishment of records for non-combat veterans was a simple matter compared to the combat veteran—either the veteran carried on despite his disability to avoid

having a record made lest he or she be separated from his or her organization or, as in many cases, the records themselves were lost. Likewise, many records are simply never generated.

Congress should clarify its intent by amending title 38, United States Code, section 1154(b), with respect to defining a veteran who engaged in combat for all purposes under title 38, as a veteran who during active service served in a combat zone for purposes of section 112 of the Internal Revenue Code 1986 or a predecessor provision of law.

Information Technology

Mr. Chairman, in addition to boosting its staffing, we believe VBA must continue to upgrade its information technology infrastructure and revise its training tools to stay abreast of modern business practices, to maintain efficiency, and to meet increasing workload demands. With the continually changing environment in claims processing and benefits administration, anything less is a recipe for failure.

In recent years, however, Congress has actually reduced significantly the funding for such VBA initiatives. In fiscal year 2001, Congress provided $82 million for VBA initiatives. In FY 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and, in 2006, $23 million, despite VBA's undeniable challenges.

With restored investments in its initiatives, VBA could complement staffing increases for higher workloads with a support infrastructure designed to increase operational effectiveness. VBA could resume an adequate pace in its development and deployment of information technology solutions, as well as upgrade and enhance training systems, to improve operations and service delivery.

Court of Appeals for Veterans Claims

The Congressional mandate that VA claimants receive the benefit of the doubt in appropriate cases is the cornerstone of veterans' benefits derived from military service. Yet, the Court has ignored the intent of Congress by creating a judicial roadblock that completely isolates claimants from their statutory right to the benefit of the doubt.

Title 38, United States Code, section 5107(b) grants claimants the benefit of the doubt as a matter of law with respect to any benefit under laws administered by the Secretary of Veterans Affairs (Secretary) when there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter. Yet, the Court has been affirming any BVA denial when the record contains only minimal evidence necessary to show a "plausible basis" for such finding. This renders a claimant's statutory right to the benefit of the doubt futile because claims can be denied and the denial upheld when supported by far less than a preponderance of the evidence.

Congress tried to correct this situation by amending the law with the enactment of the Veterans Benefits Improvement Act of 2002[2] to require the Court to consider whether Board findings were consistent with the benefit-of-the-doubt rule. The intended effect of section 401 of the Veterans Benefits Act of 2002 has not been upheld by the court.[3]

Prior to the enactment of Veterans Benefits Act, the Court's case law provided (1) that the court was authorized to reverse a finding of fact when the only permissible view of the evidence of record was contrary to that found by the Board, and (2) that a finding of fact must be affirmed where there was a *plausible basis* in the record for the Board's determination. However, Congress added new language to section 7261(b)(1) that mandates the Court to review the record before the Secretary pursuant to section 7252(b) of title 38 and "take due account of the Secretary's application of section 5107(b) of this title. . . ."[4] The Secretary's obligation under section 5107(b), as referred to in section 7261(b)(1), is as follows:

> (b) BENEFIT OF THE DOUBT—The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.

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[2] Pub. L. No. 107–330, 401, 116 Stat. 2820, 2832.

[3] Section 401 of the Veterans Benefits Act, effective December 6, 2002, amended title 38, United States Code, sections 7261(a)(4) and (b)(1).

[4] *See* 38 U.S.C. § 7261(b)(1).

Prior to enactment of Veterans Benefits Act section 401, the Court characterized the benefit-of-the-doubt rule as mandating that "when . . . the evidence is in relative equipoise, the law dictates that [the] veteran prevails" and that, conversely, a VA claimant loses only when "a fair preponderance of the evidence is against the claim."[5] Nonetheless, such characterizations have historically proven to be nothing more than meaningless rhetoric.

Reading amended sections 7261(a)(4) and 7261(b)(1) together, which must be done in order to determine the effect of the Veterans Benefits Act section 401 amendments, reveals the Court is now directed, as part of its scope-of-review responsibility under section 7261(a)(4), to undertake three actions in deciding whether adverse Board findings are clearly erroneous and, if so, what the court should hold as to that finding. The plain meaning of the amended subsections (a)(4) and (b)(1) require the Court (1) to review all evidence before the Board; (2) to consider the application of the benefit-of-the-doubt rule in view of that evidence; and (3) if after carrying out actions (1) and (2), the Court concludes that an adverse Board finding is clearly erroneous and therefore unlawful, to set it aside or reverse it.

Therefore, as the foregoing discussion illustrates, Congress intended the Veterans Benefits Act section 401 amendments to fundamentally alter the Court's review of Board decisions. This is evident by the plain meaning of the amended language and the amendment's unequivocal legislative history. Congress intended the Court to take a more proactive and less deferential role in its judicial review. For example, Congress specifically intended the Court "to examine the record of proceedings—that is, the record on appeal—before the Secretary and BVA. Section 401 also provides special emphasis during the judicial process to the 'benefit of the doubt' provisions of section 5107(b) as the Court makes findings of fact in reviewing BVA decisions. The combination of these changes is intended to provide for more searching appellate review of BVA decisions, and thus give full force to the benefit-of-the-doubt provision."[6,7] This language is consistent with the existing section 7261(c), which precludes the Court from conducting trial *de novo* when reviewing VA decisions—receiving evidence not part of the record before the Board.

Perhaps the most dramatic of the three Court actions directed by section 401 was the mandate that the Court "take due account of the Secretary's application of section 5107(b)," *i.e.*, the "benefit-of-the-doubt rule." It is against this more relaxed standard of review that, through the Veterans Benefits Act section 401, Congress has now required the Court to review the entire record on appeal and to examine the Secretary's determination as to whether the evidence presented was in *equipoise* on a particular conclusion. The foregoing notwithstanding, the Court's *equipoise* review is no better after the Veterans Benefits Act section 401 than it was before section 401 was enacted. The Court has ignored Congress' intent.

In light of this background, the section 401 mandate supersedes the previous Court practice of upholding a factual finding unless the only permissible view of the evidence is contrary to that found by the Board. Likewise, section 401 overrules the requirement that a Board finding of fact must be affirmed where there is a "*plausible basis*" in the record for the determination. Yet, the nearly impenetrable "plausible basis" standard continues to prevail to this very date as if Congress never amended section 7261. The former Ranking Minority Member of this Committee, spoke in strong support of this amendment and explained that "the bill . . . clarifies the authority of the [Court] to reverse decisions of the [BVA] in appropriate cases and requires the decisions be based upon the record as a whole, taking into account the pro-veteran rule known as the benefit of the doubt."[8]

Ultimately, the Board sits in near splendid isolation to arbitrarily weigh evidence and unfairly determine its probative value. Such determinations are the lynchpin in claims for benefits by disabled veterans. Regardless of the quantity and quality of evidence in favor of a claimant's case, a Board's conclusion that an infinitesimal amount of unfavorable evidence, however much lacking in quality, outweighs and is more probative than an immeasurable amount of high-quality evidence is practically untouchable by the Court. Worse yet, it is the Court's own doing. Essentially, when the Board renders this type of decision that turns on the weighing of such evidence, the Court is precluded from even considering the benefit-of-the-doubt rule. Evidence must first be in *equipoise*, or balance, for the benefit of the doubt to apply. As soon as the Board finds the slightest *plausible basis* that a claimant's evidence

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[5] *Gilbert v. Derwenski*, 1 Vet.App. 49, 54–55 (1990).

[6] 148 CONG. REC. S11334 (remarks of Sen. Rockefeller).

[7] 148 CONG. REC. S11337, H9003 (daily ed. Nov. 18, 2002) (explanatory statement printed in Congressional Record as part of debate in each body immediately prior to final passage of compromise agreement).

[8] 148 CONG. REC. H9003.

preponderates against the claim, the favorable and unfavorable evidence is no longer in balance. Unless the Court finds such a ruling to be clearly erroneous, meaning there is no plausible basis regardless of how trivial such basis may be, the Court cannot overturn the ruling. Consequently, if the Court cannot overturn the ruling, it can never reach a review of the Board's application of the benefit of the doubt. The Court has therefore created a barrier between itself and a VA claimant's statutory right to the benefit of the doubt—a barrier moveable only by Congress.

Congress should not allow any Federal court to ignore its legislative power, particularly one charged with the protection of rights afforded to our Nation's disabled veterans and their families. To ensure the Court enforces the benefit-of-the-doubt rule, Congress should replace the clearly erroneous standard with a requirement that the Court will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

Solving the Court's Backlog

The Board and the Court add substantially to the claims backlog by needlessly and frequently remanding numerous cases on appeal. In many of these appeals, the evidence of record fully supports a favorable decision on the appellant's behalf, yet the appeal is remanded nonetheless. These unjustified remands deprive the appellant, usually for many additional years, to benefits awardable based on facts already of record.

The greatest challenge facing the Court is identical to the VA—the backlog of cases. The Court has shown a reluctance to reverse errors committed by the Board. Rather than addressing an allegation of error raised by an appellant, the Court has a propensity to vacate and remand cases to the Board based on an allegation of error made by the VA's counsel for the first time on appeal, such as an inadequate statement of reasons or bases in a Board decision. Another example occurs when the VA argues, again for the first time on appeal, for remand by the Court because VA failed in its duty to assist the claimant in developing the claim notwithstanding an express finding by the Board that all development is complete and where the appellant accepts, and does not challenge such finding by the Board. Such actions are particularly noteworthy because the VA has no legal authority to appeal a Board decision to the Court.[9]

Consequently, the Court will generally decline to review alleged errors raised by an appellant that actually serve as the basis of the appeal. Instead, the Court remands the remaining alleged errors on the basis that an appellant is free to present those errors to the Board even though an appellant may have already done so, leading to the possibility of the Board repeating the same mistakes on remand that it had previously. Such remands leave errors properly raised to the Court unresolved; reopen the appeal to unnecessary development and further delay; overburden an already backlogged system; exemplify far too restrictive judicial restraint; and inevitably require an appellant to invest many more months and perhaps years of his or her life in order to receive a decision that the Court should have rendered on initial appeal. As a result, an unnecessarily high number of cases are appealed to the Court for the second, third, or fourth time.

In addition to postponing decisions and prolonging the appeal process, the Court's reluctance to reverse Board decisions provides an incentive for VA to avoid admitting error and settling appeals before they reach the Court. By merely ignoring arguments concerning legal errors rather than resolving them at the earliest stage in the process, VA contributes to the backlog by allowing a greater number of cases to go before the Court. If the Court would reverse decisions more frequently, VA would be discouraged from standing firm on decisions that are likely to be overturned or settled late in the process.

To remedy this unacceptable situation, Congress should amend title 38, United States Code section 7261 to require the Court on a *de novo* basis, to: (1) decide all relevant questions of law; (2) interpret constitutional, statutory, and regulatory provisions; and (3) determine the meaning or applicability of the terms of an action of the Secretary. The Court's jurisdiction should also be amended to require it to decide all assignments of error properly presented by an appellant.

General

The benefit programs are effective for their intended purposes only to the extent VBA can deliver benefits to entitled veterans and dependents in a timely fashion. However, in addition to ensuring that VBA has the resources necessary to accom-

[9] 38 U.S.C.A., § 7252(a) (West 2002) ("The Court of Appeals for Veterans Claim shall have exclusive jurisdiction to review decisions of the Board of Veterans' Appeals. The Secretary may not seek review of any such decision.")

plish its mission in that manner, Congress must also make adjustments to the programs from time to time to address increases in the cost of living and needed improvements. We invite your attention to the *IB* itself for the details of those issues, but the following summarizes a number of recommendations to adjust rates and improve the benefit programs administered by VBA:

- Cost-of-living adjustments for compensation, specially adapted housing grants, and automobile grants, with provisions for automatic annual increases in the housing and automobile grants based on increases in the cost of living.
- A presumption of service connection for hearing loss and tinnitus for combat veterans and veterans who had military duties involving high levels of noise exposure who suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma.
- Removal of the provision that makes persons who first entered service before June 30, 1985, ineligible for the Montgomery GI Bill, along with other improvements to the program.
- No increase in, and eventual repeal of, funding fees for VA home loan guaranty.
- Increase in the maximum coverage and adjustment of the premium rates for Service-Disabled Veterans' Life Insurance.
- Increase in the maximum coverage available in policies of Veterans' Mortgage Life Insurance.
- Legislation to restore protections for veterans' benefits against awards to third parties in divorce actions.
- Legislation to increase Dependency and Indemnity Compensation for certain survivors of veterans, and to no longer offset DIC with Survivor Benefit Plan payments.

We hope the Committee will review these recommendations and give them consideration for inclusion in your legislative plans and will support their funding in the Congressional Budget Resolution for FY 2009, as well as subsequent appropriations.

Mr. Chairman, thank you for inviting DAV and other member organizations of *The Independent Budget* to testify before you today.

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

MR. CHAIRMAN AND MEMBERS OF THIS COMMITTEE:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today. The VFW works alongside the other members of *The Independent Budget (IB)*—AMVETS, Disabled American Veterans and Paralyzed Veterans of America—to produce a set of policy and budget recommendations that reflect what we believe would meet the needs of America's veterans. The VFW is responsible for the construction portion of the *IB*, so I will limit my remarks to that portion of the budget.

The Administration's fiscal year 2009 budget request for major and minor construction is woefully inadequate, especially in light of the Administration's own supporting documents. Despite hundreds of pages of budgetary documents that show a need for millions of dollars in construction projects, the Administration saw fit to halve the major and minor construction accounts from the FY 2008 levels, failing to meet the future needs of our veterans. We look to you in Congress to correct this, and to advance VA's construction priorities so that future generations of veterans—those currently serving in the deserts of Iraq and the mountains of Afghanistan—can have a first-rate VA healthcare system that lives up to their needs.

MAJOR CONSTRUCTION

The President's request for major construction is a paltry $581.6 million for FY 2009. This is a dramatic cut from last year's funding level of $1.1 billion. While we appreciate that this level covers eight medical facility projects, including three new previously unfunded projects, the total level of funding does not come close to meeting the ***IB*'s recommendation of $1.275 billion** in construction projects. Four hundred seventy-six point six million dollars of the Administration's request covers Veterans Health Administration projects, significantly lower than the $1.1 billion that the *IB* has called for.

In determining our recommendations, we follow VA's prioritization process as VA discusses in its annual 5-Year Capital Plan, which is included in Volume III of the Department's budget submission.

VA determines its budget year priorities in two phases. First, partially funded projects from previous years are ordered by fiscal year and priority order. Second, newly evaluated projects from the current budget year are listed in priority order. These are combined, with the first category receiving priority over the second.

For the current year's process, VA had seven partially unfunded projects at the top of the list and chose to provide funding for five of those projects. They also began to provide funding for the top three new projects as ranked in the current fiscal year: Bay Pines, FL; Tampa, FL; and Palo Alto, CA. We certainly appreciate the progress on new construction projects as last year's funding request did not call for any new projects. We also appreciate the focus on construction and improvements to VA's polytrauma centers. We believe, however, that more can and must be done.

While the eight major construction projects might sound like a lot, the funding levels recommended for them are a tiny blip in the overall costs of those projects. If we look at just the partially unfunded projects—the backlog, if you will—even the $320 million aimed at them barely scratches the surface. Only the Lee County, Florida, outpatient clinic is funded to completion. The other four projects still require a total future funding level of $1.26 billion. The funding for the three new projects totals $76.8 million out of a total construction estimate of $771 million. This is important because it means that there will be a total construction backlog of over $2 billion when the Administration prepares its request for the following fiscal year. It is increasingly unlikely that the top priority construction projects—likely to include this year's number four priority project in Seattle, Washington, or improvements in Dallas, Texas, or Louisville, Kentucky—will be funded in future years while VA's meager construction budget is earmarked only to prior projects, as was the case with last year's funding request.

I would refer you to the table on page 7–12 of VA's 5-Year Capital Plan for the full list of projects VA considered funding in the current year. The increase in funding that we are calling for could be applied to those prior year projects we referred to previously, or to the FY 2009 scored projects. Both categories desperately need funding beyond the Administration's request. Even an increase of about $31 million would allow VA to begin the first stages of construction on priority projects 4–6, which typically requires 10% of the total cost estimate.

These projects are necessary to ensure that VA properly reinvests in its aging physical infrastructure. VA's facilities average over 50 years old, and VA has historically recapitalized at a rate far below hospital industry standards. From 1996–2001, for example, VA recapitalized at a rate of just 0.64% per year. This corresponds with an assumed building life of 155 years, far beyond any reasonable expectations. VA has made progress since then, but more clearly must be done, especially if we are to live up to the promise of CARES and modernize the system so that veterans now and into the future will have first-rate healthcare in clean, safe, modern and comfortable facilities.

We remain concerned about the unfulfilled promise of CARES. Upon completion of the CARES decision document, former VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans' Affairs in July 2004. His testimony noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care."

According to VA's November 2007 testimony before that same Committee, Congress has appropriated just $2.83 billion for CARES projects, far below the need to which the Secretary had testified. Further, this includes a sizeable amount for rebuilding facilities after the Gulf Coast hurricanes—amounts we have argued that Congress should have provided as separate emergency funding, outside of VA's regular planning process. With the FY 2008 appropriation, the total is up to $3.9 billion—better, but still lagging.

With just $581 million requested for major construction in FY 2009, which is far below VA's demonstrated needs, it is clear that VA is falling short. After that 5-year de facto moratorium on construction while CARES was ongoing and without additional funding coming forth, VA and veterans have an even greater need than they did at the start of the CARES process. Accordingly, we urge action to live up to the Secretary's words by making a steady investment in VA's capital infrastructure to bring the system up to date with the 21st century needs of veterans.

MINOR CONSTRUCTION

We also are greatly concerned with the Administration's proposed slashing of the minor construction budget. As with the major construction account, this cut is contrary to the information the Department provides in the total budget document. For FY 2009, the recommendation is just $329 million, $301 million *below* the FY 2008 level and far below the **$621 million called for in *The Independent Budget***.

Two hundred seventy-three million dollars of the request is targeted for VHA facilities and $18 million—about 5 percent of the total—is allocated for staff offices to accommodate the consolidation of VA's information technology programs.

VA has a long list of minor construction projects targeted for FY 2009. There is a list of 145 minor construction projects listed on page 7–95 of the 5-Year Capital Plan. Although there is no cost specifically associated with them, we can estimate the cost using the average cost of the scored projects from FY 2008, which can be found on page 7–90. For the FY 2008 projects listed, the average price per project is $5.6 million. If you multiply that cost per project by the 145 proposed FY 2009 projects, VHA would require a budget of $812 million, nearly $500 million more than they have actually requested. We understand that VA has some carryover funding for minor construction to offset some of that balance, but even if all $267 million of that were applied to this list of projects, VHA would still require $545 million in funding instead of the $273 the Administration has requested.

The minor construction request seems even more deficient when you factor in its role with respect to the maintenance of VA's facilities. Every medical center is surveyed at least once every 3 years and given a thorough assessment of all component systems. These reviews comprise the Facility Condition Assessment (FCA), and the scores are used, in part, to produce the condition index of the facility, one of the benchmark statistics in VA's Real Property Scorecard. The majority of funding for projects and systems found to be deficient through the FCA is nonrecurring maintenance (NRM), but VA says that 30% of all minor construction is targeted to correct documented FCA deficiencies. In FY 2007, VA notes that its FCA backlog was well over $5 billion in projects. Congress has done a good job to improve some of these deficiencies—notably the $550 supplemental that was targeted toward FCA problems—but more must be done if VA is going to properly maintain its facilities.

NONRECURRING MAINTENANCE

Those FCA reviews show the importance of NRM, and the $5 billion backlog shows how woefully deficient past NRM requests and appropriations have been. It is sad that it took the unconscionable situation at Walter Reed—a non-VA facility—to demonstrate the importance of the account. We certainly applaud VA's efforts post-Walter Reed to assess the maintenance of its infrastructure and Congress' immediate response, but it should not have come to that. The problems with the lack of NRM funding have been repeatedly pointed out in *The Independent Budget*, and we continue to ask Congress and the Administration to do more.

For FY 2009, we are pleased to see that the President has requested $802 million for NRM funding. This is in line with what the *IB* has called for in the past. For justification of our number, we continue to cite the Price Waterhouse review of VA's facility management programs that cited industry standards to claim that VA should be spending between 2 and 4 percent of its plant replacement value on NRM. VA accepted this recommendation and adopted it as part of its Asset Management Plan. That VA document noted that VA's plant replacement value was approximately $40 billion, and accordingly, the NRM budget should be between $800 million and $1.6 billion.

With the near-$5 billion backlog in FCA-observed maintenance needs, the proposed $802 million is surely on the low end. That amount would allow VA to perform maintenance at current levels, but not to dip into the backlog. Accordingly, we would like Congress to increase funding for this account, as has been done in the past. We need to eliminate the backlog to ensure that veterans have healthcare in clean, safe, and efficient locations, and that VA properly cares for its infrastructure to ensure that it lasts for years into the future.

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

Prepared Statement of Raymond C. Kelley
National Legislative Director, American Veterans (AMVETS)

Chairman Filner, Ranking Member Buyer, and Members of the Committee:

AMVETS is honored to join our fellow veterans service organizations and partners at this important hearing on the Department of Veterans Affairs budget request for

fiscal year 2009. My name is Raymond C. Kelley, National Legislative Director of AMVETS, and I am pleased to provide you with our best estimates on the resources necessary to carry out a responsible budget for VA.

AMVETS testifies before you as a co-author of *The Independent Budget*. This is the 22nd year AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars have pooled our resources to produce a unique document, one that has stood the test of time.

In developing *The Independent Budget*, we believe in certain guiding principles. Veterans should not have to wait for benefits to which they are entitled. Veterans must be ensured access to high-quality medical care. Specialized care must remain the focus of VA. Veterans must be guaranteed timely access to the full continuum of healthcare services, including long-term care. And, veterans must be assured accessible burial in a State or national cemetery in every State.

The VA healthcare system is the best in the country and responsible for great advances in medical science. VHA is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected ailments. The delivery care system provides a wide array of specialized services to veterans like those with spinal cord injuries, blindness, traumatic brain injury, and post traumatic stress disorder.

Looking at the numbers alone, the VA budget would appear to be one that would garner only praise and be a model for years to come. However, the budget was signed into law 5 months after the start of the new fiscal year, marking the 13th time in 14 years the VA had to work from continuing resolutions to maintain the system. Also, the budget was contingent on $3.7 billion in emergency funding that was signed into law less than 1 month ago. This is an unacceptable way of funding a department that is as fluid in nature as the VA.

Mr. Chairman, as you know, we strongly support mandatory funding for VA healthcare. However, if the Congress cannot support mandatory funding, there are alternatives which could meet our goals of timely, sufficient, and predictable funding.

Congress could change VA's medical care appropriation to an advance appropriation which would provide approval 1 year in advance, thereby guaranteeing its timeliness. Furthermore, by adding transparency to VA's healthcare enrollee projection model, we can focus the debate on the most actuarially sound projection of veterans healthcare costs to ensure sufficiency.

Under this proposal, Congress would retain its discretion to approve appropriations; retain all of its oversight authority; and most importantly, there would be no PAYGO problems.

We ask this Committee in your views and estimates to recommend to the Budget Committee either mandatory funding or this new advance appropriations approach to take the politics out of healthcare for all of our Nation's wounded, sick and disabled veterans.

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

The National Cemetery Administration

The Independent Budget acknowledges the dedicated and committed NCA staff who continue to provide the highest quality of service to veterans and their families despite funding shortfalls, aging equipment, and increasing workload. The devoted staff provides aid and comfort to grieving veterans' families in a very difficult time, and we thank them for their consolation.

The NCA currently maintains more than 2.8 million gravesites at 131 national cemeteries in 39 States and Puerto Rico. VA estimates that about 24 million veterans are alive today. They include veterans from World War I through the Global War on Terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from more than 105,000 in 2008 to 115,000 in 2009.

The NCA is responsible for five primary missions: (1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, State, or private cemeteries upon appropriate application; (3) to administer the State Grant Program in the establishment, expansion, or improvement of State veterans cemeteries; (4) to award a Presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

NCA Budget Request

The Administration requests $181 million for the NCA for fiscal year 2009. The members of *The Independent Budget* recommend that Congress provide $252 million and 51 additional FTE for continuing operations and workload increases of NCA. 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.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the Nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

In accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress to fully fund the National Shrine Initiative by providing $50 million in FY 2009 budget and a commitment of $250 million over a period of 5 years to restore and improve the condition and character of NCA cemeteries.

It should be noted that the NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but critical underfunding does not allow NCA to remove the backlog of improvements that need to be met. To date, NCA has invested $99 million to the initiative, making nearly 300 improvements. Additionally, $28.2 million will be invested in restoration in 2008. This money is the full amount of supplemental funding that was given to NCA in FY 2008, a fact that should be a wake-up call of the importance of the National Shrine Initiative. Even with the funding that has been spent on these improvements, new areas requiring restoration are identified. By enacting a 5-year program with dedicated funds and an ambitious schedule, the national cemetery system can provide veterans and their families with the utmost dignity, respect, and compassion.

The State Cemetery Grants Program

The State Cemetery Grants Program (SCGP) complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist States in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100-percent increase in burials through this program.

To help provide reasonable access to burial options for veterans and their eligible family members, *The Independent Budget* recommends $42 million for the SCGP for fiscal year 2009. The availability of this funding will help States establish, expand, and improve State-owned veterans' cemeteries.

States have intentions of beginning construction of 24 new State cemeteries in 2008. Many States have difficulties meeting the requirements needed to build a national cemetery in their respective State. The large land areas and spread out population in these areas make it difficult to meet the "170,000 veterans within 75 miles" national veterans cemetery requirement. Recognizing these challenges, VA has implemented several incentives to assist States in establishing a veterans cemetery. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration.

Burial Benefits

There has been serious erosion in the value of the burial allowance benefits over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a small fraction of what they covered in 1973, when the Federal Government first started paying burial benefits for our veterans.

In 2001 the plot allowance was increased for the first time in more than 28 years, from $150 to $300, which covers approximately 6 percent of funeral costs. *The Independent Budget* recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973.

In the 108th Congress, the burial allowance for service-connected deaths was increased from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. *The Independent Budget* recommends increasing the service-connected burial benefit from $2,000 to $4,100, bringing it back up to its original proportionate level of burial costs.

The nonservice-connected burial allowance was last adjusted in 1978, and also covers just 6 percent of funeral costs. *The Independent Budget* recommends increasing the nonservice-connected burial benefit from $300 to $1,270.

The NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 2.8 million soldiers who died in every war and conflict are honored by burial in a VA national cemetery. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans; they are hallowed ground to those who died in our defense, and a memorial to those who survived.

Mr. Chairman, this concludes my testimony. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Prepared Statement of Steve Robertson
Director, National Legislative Commission, American Legion

Mr. Chairman and Members of the Committee:

The American Legion would like to begin this hearing by expressing our gratitude to you and your colleagues for your work on the FY 2008 budget for the Department of Veterans Affairs (VA). From the very beginning of the 110th Congress, there was a great deal of fiscal work to be accomplished. In essence, you and your colleagues had to put together two VA appropriations budgets during the first session.

The American Legion supported the Budget Resolution for the first time in many, many years. The American Legion supported the original version of the Military Construction, Veterans' Affairs, and Related Appropriations for FY 2008, passed overwhelmingly with bipartisan support in both chambers; however, we were also very pleased when President Bush requested the additional $3.7 billion provided in Public Law 110–161. Needless to say, last year was an unusual appropriations cycle.

The veterans' community continues to request an annual VA appropriation that is timely, predictable, and sufficient to meet the growing demands on VA. Every VA program is specifically designed to address the various needs of America's veterans and their families. Some programs date back to past proprieties of an earlier era of veterans such as the greatest piece of social legislation ever enacted, the Servicemen's Readjustment Act of 1944 (the GI Bill of Rights). Newer areas of concern include improved diagnosis and treatment of traumatic brain injury. Some programs are individual entitlements that are funded through mandatory appropriations, while the balance are subject to the annual discretionary appropriations battle in Congress. But all represent the thanks of a grateful Nation.

The American Legion does not support the 2009 policy proposals contained in the FY 2009 budget submission that seek to impose an annual enrollment fee and practically double the current co-payment for pharmaceuticals. The American Legion has opposed these proposals in the past and we once again call on the Members of this Committee to join us in defeating any proposal that seeks to balance the VA budget on the backs of America's veterans.

Mr. Chairman, The American Legion welcomes the opportunity to present recommendations on the FY 2009 VA appropriations and other appropriations that fall under the jurisdiction of this Committee. The American Legion appreciates the efforts of the Secretary of Veterans Affairs and his capable leadership staff to produce a budget request that reflects the fiscal needs of VA to provide timely access to the earned benefits provided to those who served in the Armed Forces of the United States. In a Nation of over 300 million citizens and a host of visitors, only 24 million veterans have accepted the challenge of military service. Some veterans were placed in harm's way, but all accepted the oath of enlistment. All were prepared to give "the last full measure of devotion."

Last September, The American Legion National Commander Marty Conatser testified before you and your colleagues to outline budget recommendations for FY 2009 and address some legislative concerns as well. To briefly recap, here is a table that reflects the final VA appropriations for FY 2008, The American Legion's budget request for FY 2009, and the President's budget request for FY 2009:

Discretionary Funding Programs	Final FY 2008 P.L. 110–161	Legion's FY 09 Request	President's Request FY 09
Total Medical Care	**$36.7 billion**	**$38.4 billion**	**$38.7 billion**
Medical Services	$29.1 billion		$34 billion
Medical Administration	$3.2 billion		
Medical Facilities	$4.1 billion		$4.6 billion
Medical/Prosthetics Research	$480 million	$476 million	$442 million
Major Construction	$1.1 billion	$560 million	$582 million
Minor Construction	$579 million	$485 million	$329 million
CARES		$1 billion	
State Extended Care Facilities Grants Program	$165 million	$275 million	$85 million
State Veterans' Cemetery Construction Grants Program	$39 million	$45 million	$32 million
National Cemetery Administration	$195 million	$228 million	$181 million
General Operating Expenses	$1.6 billion	$2.8 billion	$1.7 billion
Information Technology	$2 billion	$2.3 billion	$2.4 billion

VETERANS AFFAIRS AND REHABILITATION

The American Legion breaks down its Veterans Affairs and Rehabilitation testimony into three sections that mirror the major organizational segments of the Department of Veterans Affairs (VA). In these separate sections The American Legion will discuss our legislative budget priorities regarding the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA).

Veterans Health Administration

The distinction of the VA as the Nation's leader in providing safe, high-quality healthcare in the healthcare industry (both public and private), has been recognized by several reputable sources:

- The medical journal ***Neurology*** commented, "The VA has achieved remarkable improvements in patient care and health outcomes, and is a cost-effective and efficient organization" (2007).
- Harvard University's Kennedy School of Government presented VA with the highly coveted ***"Innovations in American Government"*** for its advanced electronic health records and performance measurement system (2006).
- The ***Journal of the American Medical Association (JAMA)*** noted VA's healthcare system has "... quickly emerged as a bright star in the constellation of safety practice, with systemwide implementation of safe practices, training programs and the establishment of four patient-safety research centers" (2005).
- The recent book by Phillip Longman entitled ***Best Care Anywhere: Why VA Health Care is Better Than Yours*** (2007).

Veterans' Healthcare Benefit Enrollment Discrimination

All veterans eligible to receive benefits from VA should have access to the VA healthcare system. The American Legion opposes any enrollment policy that disallows any eligible veteran, who was prepared to give his or her life for this country, access to what is often described as the best healthcare in the Nation. Honorable military service, whether for a single enlistment period or for a 30-year career, is not merely another period of employment in an individual's personal history. It is a defining portion of one's life.

Maintaining the quality of care that VA is currently known for should be a national priority. But that quality of care is being denied to an ever-increasing number of America's veterans. FY 2009 budget request continues the suspension of enrollment of new Priority Group 8 veterans due to the increased demands for services. According to VA, the number of Priority Group 8 veterans denied enrollment in the VA healthcare system at the end of FY 2007 was 386,767. The American Legion believes this number is significantly higher because it does not include those veterans who have not attempted to use the VA because they are aware of the suspension. Given the recruiting and retention problems the armed forces face, it is clear that

denying earned benefits to eligible veterans does not solve the problems created by an inadequate Federal budget.

As the Global War on Terrorism wages on, fiscal resources for VA will continue to be stretched and this Nation's veterans will continue to beg elected officials for moneys to sustain a viable VA. A viable VA is one that cares for all veterans, not just the most severely wounded. More importantly, VA is often the first experience veterans have with the Federal Government after leaving military service. This Nation's veterans have never let this country down; it is time for Congress to do its best not to let them down.

All veterans, who are eligible to receive benefits from VA, should have timely access to the VA healthcare system. Honorable military service is evidence of an individual's commitment to this Nation. In return for honorable military service, the ***thanks of a grateful Nation*** should not simply be a conditional benefit that can easily be restricted or denied by political or bureaucratic whim, but should be regarded as an earned right in recognition for faithful service to this country.

Quality, timely and accessible VA healthcare is the ongoing cost of war. It is unconscionable to send the young men and women in the armed forces to every corner of the globe and then limit the funding to take care of their injuries suffered in service to this country. VA was created to take care of the unique needs of a very specific population, those veterans that wore the uniforms of the armed forces. Once those uniforms are off, these veterans should be able to depend upon the VA healthcare system for their healthcare needs—regardless of the type or severity of their injuries. Many veterans will need healthcare for the rest of their lives. The American Legion expects the VA healthcare system to ensure and provide the very best healthcare for this Nation's heroes. The American Legion strongly supports the reinstatement of enrollment for Priority Group 8 veterans.

Mandatory Funding of VA Medical Care

The American Legion believes the time for mandatory funding for veterans' healthcare is now. Congress should act to ensure that we, as a Nation, will always provide the funding necessary to ensure veterans, who seek timely access to quality healthcare through the VA healthcare delivery system, are provided the healthcare they earned.

A new generation of young Americans is now deployed around the world, answering the Nation's call to arms. Like so many brave men and women who honorably served before them, these new veterans are fighting for freedom, liberty and security of us all. Also like those who served before them, today's veterans deserve the respect of a grateful Nation when they return home.

Previous generations of wartime veterans were welcomed at VA medical facilities until the 1980s. Unfortunately, without urgent changes in healthcare funding, these new veterans will soon discover their battles are not yet over. This Nation's newest heroes will be fighting for the life of the VA healthcare system. Just as the veterans of the 20th century did, they will be forced to fight for the care they are eligible to receive.

The American Legion believes that the Veterans Health Administration's (VHA) recurring fiscal difficulties will only be solved when its funding becomes a mandatory appropriation item. As a mandatory appropriation, law would guarantee VA healthcare funding for all eligible enrollees—and it will be a patient-based, rather than a budget-driven, annual appropriation.

The American Legion continues to support legislation that establishes a system of capitation-based funding for VHA. This new funding system would provide all of VHA's funding, except that of the State Extended Care Facilities Construction Grant Program which would be separately authorized and funded as a discretionary appropriation.

Although VHA continues to struggle to maintain its global preeminence with a 21st century integrated healthcare delivery system, it is handicapped by funding methods that were developed in the 19th century for a now antiquated, inpatient delivery system. No modern healthcare organization can be expected to survive with such an inconsistent and inadequate budget process. The American Legion's position on VA healthcare funding is that healthcare rationing for veterans must end. It is time to guarantee healthcare funding for all veterans seeking VA healthcare.

Third-Party Reimbursements

The Balanced Budget Act of 1997, P.L. 105–33, established the VA Medical Care Collections Fund (MCCF). The law requires that money collected or recovered from third-party payers after June 30, 1997, be deposited into this fund. The MCCF is a depository for collections from third-party insurance, outpatient prescription copayments and other medical charges and user fees. The funds collected may be used

to provide VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Federal Government.

The American Legion supported legislation to allow VA to bill, collect and reinvest third-party reimbursements and co-payments. However, The American Legion has adamantly opposed the scoring of MCCF as an offset to annual discretionary appropriations because almost all of these funds derive from the treatment of nonservice-connected medical conditions. Historically, these collection goals far exceed VA's ability to collect accounts receivable.

Once again, the President's budget request for FY 2009 raises the bar on MCCF from $2.3 billion to $2.5 billion. VA's ability to capture these funds is critical to its ability to provide quality and timely healthcare to veterans. Miscalculations of VA required funding levels results in real budgetary shortfalls. Seeking an annual emergency supplemental appropriation is not the most cost-effective means of funding the Nation's model healthcare delivery system.

Government Accountability Office (GAO) reports have described the continuing problems in VHA's ability to capture insurance data in a timely and accurate manner and have raised concerns about VHA's ability to maximize its third-party collections. GAO visited three VA medical centers and found the following concerns: VA lacked the ability to verify insurance; VA could not accept partial payment as full payment; VA had inconsistent compliance with collections followup; VA failed to ensure documentation by VA physicians was sufficient; VA had insufficient automation; and, VA had a shortage of qualified billing coders. All of these concerns are key deficiencies contributing to the collections shortfalls. VA should implement all available remedies to maximize its collections of accounts receivable.

The American Legion opposes offsetting annual VA discretionary funding by the arbitrarily set MCCF goal, especially since VA is prohibited from collecting any third-party reimbursements from the Nation's largest Federally-mandated health insurer, Medicare.

Medicare Reimbursements

Veterans contribute to the Medicare Trust Fund, as do most American workers, without choice, throughout their working lives. Veterans also paid these contributions when they served on active-duty. However, when a veteran is treated at a VA medical facility, VA is prohibited from collecting Medicare reimbursements for the treatment of allowable, nonservice-connected medical conditions. Since over half of VA's enrolled patient population is Medicare-eligible, this prohibition constitutes a multi-billion dollar annual subsidy to the Medicare Trust Fund. No other Federal healthcare provider is prohibited from receiving Medicare reimbursements. The American Legion supports allowing Medicare reimbursement to VHA to pay for the treatment of allowable, nonservice-connected medical conditions of enrolled Medicare-eligible veterans.

Medical Construction and Infrastructure Support

Major Construction

The CARES process identified more than 100 major construction projects in 37 States, the District of Columbia, and Puerto Rico. Construction projects are categorized as 'major' if the estimated cost is over $7 million. Now that VA has a plan to deliver healthcare through 2022, it is up to Congress to provide adequate funds.

The CARES plan calls for, among other things, the construction of new hospitals in Orlando, FL, and Las Vegas, NV, and replacement facilities in Louisville, KY, and Denver, CO, for a cost estimated to be well over $1 billion for these four facilities. VA has not had this type of progressive construction agenda in decades. Major construction money can be significant and proper utilization of funds must be well planned. Recently, Congress approved funding for a new Veterans Affairs medical center in Denver. It is our hope that funding will be provided for Louisville and Las Vegas as well.

In addition to the cost of the proposed new facilities are the many construction issues that have been virtually "put on hold" for the past several years due to past inadequate funding and the moratorium placed on construction spending by the CARES process. One of the most glaring shortfalls is the neglect of the buildings sorely in need of seismic correction. This is an issue of safety. The delivery of healthcare in seismically unsafe buildings cannot be tolerated and funds must be allocated to not only construct the new facilities, but also to pay for much needed upgrades at existing facilities. Gambling with the lives of veterans, their families and VA employees is absolutely unacceptable.

The American Legion believes that VA has effectively shepherded the CARES process to its current state by developing the blueprint for the future delivery of VA

healthcare—it is now time for Congress to adequately fund the implementation of this crucial undertaking.

The American Legion recommends $560 million for major construction in FY 2009. Although the President's budget request for FY 2009 calls for major construction to be $582 million, The American Legion also recommends an additional $1 billion specifically designated for approved CARES major construction.

Minor Construction

VA's minor construction program has also suffered significant neglect over the past several years. Maintaining the infrastructure of VA's buildings is no small task. Because the buildings are old, renovations, relocations and expansions are quite common. When combined with the added cost of the CARES program recommendations, it is easy to perceive that a major increase over the previous funding level is crucial and overdue.

The American Legion recommends $485 million for minor construction in FY 2009.

Veterans Benefits Administration

The President's annual budget request is a detailed outline of the mandatory and discretionary funding needed by the Veterans Benefits Administration (VBA). Given VBA's many challenges and responsibilities, which include the annual expenditures for compensation, pension, and related benefit payments, it is imperative that Congress ensure that VBA's programs have the personnel and other resources necessary to operate efficiently and can provide quality and timely service. The budget debate process and oversight hearings provide opportunities to evaluate how well VBA is, in fact, performing its missions and whether the needs and expectations of its stakeholders are being met.

For several years, VBA has endeavored to implement its long-term strategic plans to hire and train a new cadre of adjudicators, to continue the computer modernization program, and to institute a variety of procedural and programmatic changes intended to improve the claims adjudication process. However, external factors, such as the enactment of legislation providing new benefits and medical care services and precedent setting legal decisions by the Federal courts, continue to play a major role in changing VBA's plans, policies, and operations. VBA's efforts to address these varied and complex issues have profound budgetary and operational implications.

One of the most significant challenges plaguing VBA is the sheer size of the backlog of pending disability claims and appeals. These claims are usually multi-issue cases arguing complex medical and legal issues that must be resolved. The American Legion believes the backlog is a symptom of unresolved systemic problems that adversely affect the adjudication and appeals process. These unresolved problems further contribute to the ever-growing backlog. These problems include: frequent decisionmaking errors at all levels of the decisionmaking process; failure by VA personnel to comply with the *Veterans' Claims Assistance Act of 2000* (*VCAA*); lack of personal accountability by VA employees and managers; ineffective quality control and quality assurance programs; inadequate personnel training; and, an unreliable work measurement system. VBA is faced with a serious dilemma. While endeavoring to address these thorny issues, it is also aggressively trying to process claims faster. From the results, it does not appear VBA has found a way to successfully balance these competing priorities.

As of January 5, 2008, there were more than 406,000 rating cases pending in the VBA system. Of these, 105,693 (26 percent) have been pending for more than 180 days. There are more than 163,000 appeals pending at VA regional offices, with more than 147,000 requiring some type of further adjudicative action. Additionally, there are currently more than 30,000 appeals pending at the Board of Veterans' Appeals and more than 19,000 remands pending at the Appeals Management Center.

As previously noted, The American Legion remains deeply concerned by the problems arising from the VBA's general lack of compliance with its 'duty to notify' and its 'duty to assist' requirements directed by the VCAA. This legislation is one of the most significant, pro-veteran improvements 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 VBA terms a VCAA letter, this letter, in fact, is generally not very informative about what particular evidence is needed by VBA to grant the benefit sought by the veteran. In addition, these VCAA letters are usually long and confusing, not very specific to the evidence needed from claimants, and written in bureaucratic language instead of 'plain English.' Rather than helping claimants with the development of the claim, these letters frequently generate more questions, more telephone calls, and more correspondence to veterans' service officers or the

VA regional office. Clearly, the VCAA letter currently in use by VBA today only serves to delay rather than facilitate the claims process.

The VBA's work measurement system may directly or indirectly affect the VBA's failure to reduce the claims backlog. The VBA's work measurement system is the means by which both individual employee and station performance is tracked and evaluated. This system is also relied upon in determining staffing needs at the station, region, and service levels in support of VBA's annual budget request. A serious problem can arise if the data developed by the work measurement system is neither accurate nor reliable in reporting the actual amount of work accomplished. This produces a distorted view of the way the VBA adjudication process is operating and what the true staffing needs are, both locally and systemwide.

The American Legion believes VBA's current work measurement system is seriously flawed. It does not provide VBA and Congress the needed information on how long it actually takes to properly process a claim and how many staff are required to perform this process in a timely manner. The American Legion advises that this work data is also subject to frequent manipulation and abuse, thus, its accuracy and reliability is open to serious question as are the conclusions and decisions drawn from this work data. In the view of The American Legion, the development and implementation of a new work measurement system should be one of VBA's highest priorities. The American Legion fully understands and appreciates the major challenges facing VBA in the upcoming year, but as a major stakeholder in VBA's benefit programs we are committed to ensuring that VBA provides the best quality and timely service to our Nation's veterans and their families.

National Cemetery Administration

Approximately 24 million veterans are living today. Nearly 690,000 veteran deaths are estimated to occur in 2009. VA estimates that approximately 111,000 will request interment in national cemeteries. Considering the growing cost of burial services and the excellent quality of service the National Cemetery Administration (NCA) provides, The American Legion foresees that this percentage will be much greater. Congress must therefore provide sufficient *major construction* appropriations to permit NCA to accomplish its stated goal of ensuring that burial in a national or State cemetery is a realistic option for our Nation's veterans by locating cemeteries within 75 miles of 90 percent of eligible veterans. The American Legion recommends $228 million be appropriated for the National Cemetery Administration for FY 2009.

National Cemetery Expansion

According to VA, it takes approximately 20 to 30 full-time equivalents (FTEs), to operate a national cemetery (depending on the size and workload at a particular facility) and it takes approximately 8 to 10 FTEs to operate a newly opened cemetery (cemeteries are opened to interments long before completion of the full site). Thus, it seems reasonable that at least 50 new FTEs will be needed to operate the six new cemeteries NCA is planning to bring online in FY 2008. It is likely, therefore, that these new cemeteries will need the full 20 to 30 FTEs in FY 2009. The average VA employee salary with benefits is $63,709. The American Legion recommends that funding for an additional 120–150 employees be included in the FY 2009 budget.

National Shrine Commitment

Maintaining cemeteries as national shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning veterans' headstones and markers to renovate their gravesites. The work that has been done by VA so far has been outstanding; however, adequate funding is the key to maintaining this very important commitment. The American Legion supports NCA's goal of completing the National Shrine Commitment within 5 years. This commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must be increased to reflect the true requirements of the NCA to fulfill this commitment.

VA has assessed burial sections and sites, roadways, buildings, and historic structures and has identified 928 potential improvement projects at an estimated cost of $280 million. October 2007 marked the end of the 5-year plan, but still much work needs to be done. With the addition of six new cemeteries and the addition of six more cemeteries that are fast tracked to come online this year, resources will be strained. The American Legion recommends that $52 million be appropriated to the National Shrine Commitment in order to fulfill this commitment to the Nation's veterans.

State Cemetery Construction Grants Program

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. There are 60 operational State cemeteries and two more under construction. Since NCA concentrates its construction resources on large metropolitan areas, it is unlikely that new national cemeteries will be constructed in all of the States. Therefore, individual States are encouraged to pursue applications for the State Cemetery Grants Program. Fiscal commitments from the States are essential to keep the operations of State cemeteries on track. NCA estimates it costs about $300,000 per year to operate a State cemetery.

Determining an "average cost" to build a new State cemetery or to expand an existing one is very difficult. Many factors influence cost, such as location, size and the availability of public utilities. The American Legion believes States will increasingly use the State Cemetery Grants Program to fulfill the needs of their veteran populations that are still not well served by the "75-mile service area/170,000 veteran population" threshold that currently serves as the VA benchmark for establishing a new national cemetery. New State cemeteries and expansions and improvements of existing State cemeteries are therefore likely to increase. With increasing costs, especially given the high cost of land in urban areas, and with increasing demand, The American Legion recommends the amount of funding for the State Cemetery Grants Program be substantially increased. The American Legion recommends $45 million for the State Cemetery Grants Program in FY 2009.

ECONOMICS

THE GI BILL AND VETERANS' EDUCATION BENEFITS

The American Legion has a proud history of developing the *Servicemen's Readjustment Act of 1944* (Public Law 78–346), also known as the *GI Bill of Rights*, which served to assist 18 million veterans of WWII in gaining employment after military service and assisting in the creation of the American middle class.

Accordingly, The American Legion supports passage of major enhancements to the *All-Volunteer Force Education Assistance Program*, better known as the *Montgomery GI Bill* (*MGIB*). The current make-up of the operational military force requires that adjustments be made to support all armed forces servicemembers. The American Legion supports legislation that will allow members of the Reserve Components to earn credits for education while mobilized, just as active-duty troops do, and be able to use those credits after they leave military service. Two of the top priorities of any veterans' education legislation are equity and portability of benefits. However, it is also clear that the current dollar value of benefits must be increased to meet the greater costs of today's higher education.

In the 20 years since the MGIB went into effect on June 30, 1985, the Nation's security needs have changed radically from a fixed Cold War to a dynamic Global War on Terrorism. In 1991, the Active-Duty Force (ADF) of the military stood at 2.1 million; today it stands at 1.4 million. Between 1915 and 1990 the Reserve Force (RF) was involuntarily mobilized only nine times. Today the Nation's Reserve Forces are no longer a strategic force but are an operational force mobilized continuously and working side-by-side with active-duty units all over the world.

The Department of Defense (DoD) reported as of August 2007 that in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) there have been:

- 2.4 million deployment events;
- 1.6 million servicemembers have been deployed;
- 540,000 servicemembers have had more than one deployment;
- 443,000 National Guard and Reservists have been mobilized and deployed to Iraq or Afghanistan since 2001, for an average of 18 months per mobilization;
- Out of 540,000 servicemembers with more than one deployment, 103,909 are members of the Reserve Components; and
- 'Stop-loss' (a policy that prevents troops from leaving the service when their enlistment end date has arrived) has been imposed on more than 50,000 troops.

The American Legion recommends that the dollar amount of the entitlement should be indexed to the average cost of college education including tuition, fees, textbooks and other supplies for commuter students at an accredited university, college or trade school for which they qualify and that the educational cost index should be reviewed and adjusted annually.

The American Legion supports a monthly, tax-free subsistence allowance indexed for inflation as part of the educational assistance package.

The American Legion recommends reauthorizing and funding State Approving Agencies to assure current staffing and activities and to assure that there is no harm to veterans receiving education payments.

STATE APPROVING AGENCIES

The American Legion is deeply concerned with the timely manner that veterans, especially returning wartime veterans, receive their education benefits. Annually, approximately 300,000 servicemembers (90,000 of them belonging to the National Guard and Reserve) return to the civilian sector and use their earned education benefits from the VA.

Any delay in receipt of education benefits or approval of courses taken at institutions of higher learning can adversely affect a veteran's life. A recent GAO report entitled "*VA Student Financial Aid; Management Actions Needed to Reduce Overlap in Approving Education and Training Programs and to Assess State Approving Agencies*" (GAO–07–384) focuses on the need to "ensure that Federal dollars are spent efficiently and effectively."

GAO recommends that VA should require State Approving Agencies (SAAs) to track and report data on resources spent on approval activities, such as site visits, catalog review, and outreach in a cost-efficient manner. The American Legion agrees. Additionally, GAO recommended that VA establish outcome-oriented performance measures to assess the effectiveness of SAA efforts. The American Legion fully agrees. In response, VA Deputy Secretary Mansfield plans to establish a working group with SAA to create a reporting system for approval activities and develop outcome-oriented measures with a goal of implementation in the FY 2009 budget cycle.

Finally, GAO recommended that VA should collaborate with other agencies to identify any duplicate efforts and use the agency's administrative and regulatory authority to streamline the approval process. The American Legion agrees. VA Deputy Secretary Mansfield responded that VA would initiate contact with appropriate officials at the Departments of Education and Labor to help identify any duplicate efforts.

SEC. 301 of P.L. 107–330 created increases in the aggregate annual amount available for State approving agencies for administrative expenses from FY 2003–FY 2007 to the current funding level of $19 million. The American Legion fully supports reauthorization of SAA funding.

The American Legion strongly recommends keeping SAA funding at $19 million in FY 2009 to assure current staffing and activities.

VA HOME LOAN GUARANTY PROGRAM

Since the home loan program was enacted as part of the original *Servicemen's Readjustment Act of 1944* (the GI Bill), VA has guaranteed more than 18 million home loans totaling nearly $914 billion for veterans to purchase or construct a home, or to refinance another home loan on more favorable terms. In the 5-year period from 2001 through 2006, VA has assisted more than 1.4 million veterans in obtaining home loan financing totaling almost $197 billion. About half of these loans, just over 730,000, were to assist veterans to obtain a lower interest rate on an existing VA guaranteed home loan through VA's *Interest Rate Reduction Refinancing Loan Program*.

The VA funding fee is required by law and is designed to sustain the VA Home Loan Program by eliminating the need for appropriations from Congress. Congress is not required to appropriate funding for this program; however, because veterans must now 'buy' into the program, it no longer serves the intent of helping veterans afford a home. The funding fee makes the VA Home Loan Program less beneficial when compared to a standard, private loan, in some aspects. The current rate for mortgages is approximately 5.7 percent. The funding fee would be *in addition* to the rate given by the lender. A $300,000 loan would generate a fee in addition to any rate the veteran would achieve. The funding fee mandates the participant to buy into the program; however, that goes directly against the intention of the law: to provide veterans a resource for obtaining a home. Approximately 80 percent of all VA Home Loan participants must pay the funding fee and the current funding fee paid to VA to defray the cost of the home loan has had a negative effect on many veterans who choose not to participate in this highly beneficial program.

The American Legion supports the elimination of the VA Home Loan funding fee and urges Congress to appropriate funding to sustain the VA Home Loan Guaranty Program.

The American Legion reaffirms its strong support for VA's Loan Guaranty Program. The American Legion also supports any administrative and/or legislative ef-

forts that will improve and strengthen the VA Home Loan Guaranty Program's ability to serve America's veterans.

Homeless Providers Grant and Per Diem Program

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem Program under the *Homeless Veterans Comprehensive Service Programs Act of 1992* (P.L. 102–590). Grants from the Grant and Per Diem Program are offered annually (as funding permits) by the VA to fund community agencies providing service to homeless veterans. VA can provide grants and per diem payments to help public and nonprofit organizations establish and operate supportive housing and/or service centers for homeless veterans.

Funds are available for assistance in the form of grants to provide transitional housing (up to 24 months) with supportive services, supportive services in a service center facility for homeless veterans not in conjunction with supportive housing, or to purchase vans.

The American Legion strongly supports funding the Grant and Per Diem Program for a 5-year period instead of annually and supports increasing the funding level to $200 million annually.

Department of Labor Veterans' Employment and Training Service (DoL–VETS)

VETS is and should remain a national program with Federal oversight and accountability. The American Legion is eager to see this program grow and especially would like to see greater expansion of entrepreneurial-based, self-employment opportunity training.

The mission of VETS is to promote the economic security of America's veterans. This mission is executed by assisting veterans in finding meaningful employment. The American Legion believes that by strengthening American veterans, we in turn strengthen America. Annually, DoD discharges approximately 250,000 servicemembers. Recently separated service personnel will seek immediate employment or, increasingly, have chosen some form of self-employment.

In order for the VETS program to assist these veterans to achieve their goals, it needs to:

- Improve by expanding its outreach efforts with creative initiatives designed to improve employment and training services for veterans;
- Provide employers with a labor pool of quality applicants with marketable and transferable job skills;
- Provide information on identifying military occupations that require licenses, certificates or other credentials at the local, State, or national levels;
- Eliminate barriers to recently separated service personnel and assist in the transition from military service to the civilian labor market;
- Strive to be a proactive agent between the business and veterans' communities in order to provide greater employment opportunities for veterans; and
- Increase training opportunities, support and options for veterans who seek self-employment and entrepreneurial careers.

The American Legion believes staffing levels for DVOP specialists and LVERs should match the needs of the veterans' community in each State and not be based solely on the fiscal needs of the State government.

Contrary to the demands placed upon VETS, funding increases for VETS since 9/11 does not reflect the large increase in servicemembers requiring these services due to the Global War on Terrorism. In support of this fact, the inflation rate from January 2002 to January 2008 is 15.93 percent and yet for State grants alone, funding has only increased a meek 2.5 percent ($158 million to $162 million) in the same timespan.

The President's budget request for FY 2009 will allow for an increase of 1 percent for State grants, the mechanism for funding DVOPs and LVERs. However, this does not meet the inflation rate and approximately 100 positions have the potential to be eliminated again next year.

More services and programs are needed and yet since 2002 the VETS program has only received a modest 4-percent increase. Transition assistance, education, and employment are each a pillar of financial stability. They will prevent homelessness, allow the veteran to compete in the private sector, and let our Nation's veterans contribute their military skills and education to the civilian sector. By placing veterans in suitable employment earlier, the country benefits from increased income tax revenue and reduced unemployment compensation payments, thus greatly offsetting the cost of Transitional Assistance Program (TAP) training. The American Legion recommends full funding for DoL–VETS.

Homelessness (DoL–VETS)

The American Legion notes that there are approximately 200,000 homeless veterans on the street each night. This number, compounded with 300,000 servicemembers entering the private sector each year since 2001 with at least a third of them potentially suffering from mental illness, requires intensive efforts. Numerous programs to prevent and assist homeless veterans are available.

The Homeless Veterans Reintegration Program (HVRP) is a competitive grant program. Grants are awarded to States or other public entities and nonprofit organizations, including faith-based organizations, to operate employment programs that reach out to homeless veterans and help them become gainfully employed. The purpose of the HVRP is to provide services to assist in reintegrating homeless veterans into meaningful employment within the labor force and to stimulate the development of effective service delivery systems that will address the complex problems facing veterans. HVRP is the only nationwide program focused on assisting homeless veterans to reintegrate into the workforce.

The competition for these grants is intense as they have one of the highest cutoff score thresholds to be in the competitive range for any grant program. Amazingly, 243 grants did fall into the competitive range but there was only enough funding to award 145 submissions. The HVRP program could only award $39 million for FY 2007 but had to deny 98 fully qualified nominations. These 98 additional qualified programs would require an additional $30 million. The American Legion recommends $70 million for this highly successful grant program.

Training

The National Veterans' Employment and Training Services Institute (NVTI) was established to ensure a high level of proficiency and training for staff that provide veterans employment services. NVTI provides training to Federal and State government employment service providers in competency based training courses. Current law requires all Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representatives (LVER) personnel to be trained within 3 years of hiring. The American Legion recommends that these personnel should be trained within 1 year. The American Legion further recommends $6 million in funding to NVTI.

Veterans Workforce Investment Program (VWIP)

VWIP grants support efforts to ensure veterans' lifelong learning and skills development in programs designed to serve the most-at-risk veterans, especially those with service-connected disabilities, those with significant barriers to employment, and recently separated veterans. The goal is to provide an effective mix of interventions, including training, retraining, and support services, that lead to long term, higher wage and career potential jobs. The American Legion recommends $20 million in funding for VWIP.

Employment Rights and Veterans' Preference

The *Uniformed Services Employment and Reemployment Rights Act* (*USERRA*) protects civilian job rights and benefits of veterans and members of the armed forces, including National Guard and Reserve members. USERRA also prohibits employer discrimination due to military obligations and provides reemployment rights to returning servicemembers. VETS administers this law, conducts investigations for USERRA and Veterans' Preference cases, conducts outreach and education, and investigates complaints by servicemembers.

Since September 11, 2001, nearly 600,000 National Guard and Reserve members have been activated for military duty. During this same period, DoL–VETS has provided USERRA assistance to over 410,000 employers and servicemembers.

Veterans' Preference is authorized by the *Veterans' Preference Act of 1944*. The *Veterans' Employment Opportunity Act of 1998* (*VEOA*) extended certain rights and remedies to recently separated veterans. VETS was given the responsibility to investigate complaints filed by veterans who believe their Veterans' Preference rights have been violated and to conduct an extensive compliance assistance program.

Numerous Federal agencies and government contractors and subcontractors are unlawfully circumventing Veterans' Preference. The use of multiple certificates in the hiring process is unjustly denying veterans opportunity for employment. Whereas figures show a decline in claims by veterans of OIF/OEF compared to Gulf War I, the reality is that employment opportunities are not being broadcast. Federal agencies as well as contractors and subcontractors are required by law to notify OPM of job opportunities but more often than not these vacancies are never made available to the public. VETS program investigates these claims and corrects unlawful practices.

The American Legion also supports the strongest Veterans' Preference laws possible at all levels of government. The American Legion is deeply concerned with the protection of the veteran and the prevention of illegal and egregious hiring practices. Currently, veterans are filing corrective action claims after the noncompliance employment event occurs and therefore may become financially disadvantaged. Concurrent measures and continuous oversight must be emplaced to protect veterans from unfair hiring practices, not just reactionary investigations. The American Legion recommends funding of $61 million for program management that encompasses USERRA and VEOA.

Veteran/Service-Connected Disabled Veteran-Owned Businesses

The American Legion views small businesses as the backbone of the American economy. It is the driving force behind America's past economic growth and will continue to be the major factor for growth as we move further into the 21st century. Currently, more than 9 out of every 10 businesses are small firms, which produce almost one-half of the Gross National Product. Veterans' benefits have always included assistance in creating and operating veteran-owned small businesses.

The impact of deployment on self-employed National Guard and Reservists is severe with a reported 40 percent of all veteran-owned businesses suffering financial losses and in some cases bankruptcies. Many other small businesses have discovered they are unable to operate and suffer some form of financial loss when key employees are activated. The Congressional Budget Office in its report, "*The Effects of Reserve Call-Ups on Civilian Employers*," stated that it "expects that as many as 30,000 small businesses and 55,000 self-employed individuals may be more severely affected if their Reservist employee or owner is activated." Additionally, the Office of Veterans' Business Development within the Small Business Administration (SBA) remains crippled and ineffective due to a token funding of $750,000 per year. This amount, which is less than the office supply budget for the SBA, is expected to support an entire nation of veteran entrepreneurs. The American Legion feels that this pittance is an insult to American veteran businessowners, undermines the spirit and intent of the *Veterans Entrepreneurship (TVC) and Small Business Development Act of 1999* (P.L. 106–50) and continues to be a source of embarrassment for this country.

The American Legion strongly supports increased funding for the Small Business Administration's Office of Veterans' Business Development to provide enhanced outreach and community-based assistance to veterans and self-employed members of the Reserves and National Guard.

Additionally, the American Legion supports allowing the Office of Veterans' Business Development to enter into contracts, grants, and cooperative agreements to further its outreach goals. The Office of Veterans' Business Development must be authorized to develop a nationwide community-based service delivery system specifically for veterans and members of Reserve components of the United States military.

The American Legion further recommends that funding for the SBA Office of Veterans' Business Development be increased to $2.3 million in FY 2009.

CONCLUSION

The American Legion is extremely concerned about the budgetary process when Congress does not pass appropriations bills before the start of the new fiscal year. The failure to pass a proper budget has a significant impact on the veterans' community and the healthcare delivery provided to veterans. As a result of the failure of Congress to pass VA appropriations in a timely manner, all long- and short-range planning is adversely affected. VA medical facility administrators are asked to use a "crystal ball" to make prudent management decisions—not knowing when and how much funding they will have available to finish the fiscal year. Such fiscal irresponsibility spawns gross mismanagement decisions, rationing of care, and unacceptable delays and backlogs across the program areas—medical care, facility maintenance, administration, construction, and State grants programs. It is our hope that Congress will move to quickly pass this budget so that we can properly take care of our troops and our veterans.

The American Legion appreciates the opportunity to present its views and estimates on programs that will affect veterans, servicemembers and their families. We ask that this Committee take into consideration the recommendations of The American Legion as your colleagues formulate the FY 2009 Budget Resolution. We also ask the Committee not to forget the sacrifices and contributions made by America's veterans and their families as the budget priorities are determined for FY 2009.

Prepared Statement of Richard F. Weidman
Executive Director for Policy and Government Affairs
Vietnam Veterans of America

Chairman Filner, Ranking Member Buyer and distinguished Members of the Committee, on behalf of VVA National President John Rowan and all of our officers, Board of Directors, and members, I thank you for giving Vietnam Veterans of America (VVA) the opportunity to testify today regarding the President's fiscal year 2009 budget request for the Department of Veterans Affairs. VVA thanks each of you on this distinguished panel, on both sides of the aisle, for your strong leadership on issues and concerns of vital concern to veterans and their families.

I want to thank you for recognizing that caring for those who have donned the uniform in our name is part of the continuing cost of the national defense. Caring for veterans, the essential role of the VA and, for specific services other Federal entities such as the Department of Labor, the Small Business Administration, and the Department of Health and Human Services, must be a national priority. This is poignantly clear when we visit the combat-wounded troops at Walter Reed Army Medical Center and Bethesda Naval Hospital.

Mr. Chairman, I know you have been a long-time supporter of legislation to achieve assured funding. You have always understood the need for such a mechanism to correct the problems in the current system of funding. As we have this discussion in regard to the FY'09 budget for the VA, the readily apparent need for this legislation has never been more pressing. We look forward to working with you to ensure its enactment, or another reform measure that will move us toward our common goal of predictable and timely funding for VA healthcare that is sufficient to truly meet the needs of all veterans.

VVA wishes to note at the outset that the annual exercise of debating the merits of the President's proposed budget is flawed. Medical center directors should not have to be held in limbo as Congress reworks and adjusts this budget and perhaps misses, yet again, the start of the next Federal fiscal year. These public servants can be more effective, more efficient, and better managers of the public trust if they can properly plan for the funding they need to carry out their mission of caring for their patients. We hope that this can be avoided this year and ask that you seriously consider an immediate alternative to the broken system we currently have and reaching our goal of assured funding.

To rectify this situation, VVA and the other members of The Partnership for Veterans' Health Care Budget Reform are developing a proposal that would give the VA leeway its managers need to properly plan for the requisites of their patient load. We will have more for you as this proposal is tightened up.

Overview

Concerning the proposal at hand, the President's FY'09 budget for the VA, we must again take exception to the attempt by the Administration to tax Priority 7 and 8 veterans with an annual fee just for signing into the VA healthcare system; and for almost doubling the co-payment for prescription pharmaceuticals. To us this is further evidence of the attempt to rid the system of as many "higher income" veterans as possible. We trust that you will see the folly in this, and will reject outright any attempt to enact these measures into the law of the land.

We are pleased, however, that the Administration has again refrained from citing phantom "management efficiencies" in the numbers in this budget proposal. Managers are in general well-paid. Effective, caring managers should take rightful pride in the jobs they do. Inefficient managers need to be sanctioned and, if necessary, transferred or removed.

We are pleased, too, that this proposal calls for an increased outlay for research and development. Traumatic brain injuries, or TBI, needs to be better understood for treatment to be more effective. Other mental health issues, too, that are afflicting too many of our returning troops, need to be better understood. Research, for which VA scientists and epidemiologists can be justifiably proud, benefit not only troops who are forever changed by their experiences in combat but the general populace as well.

We are less than sanguine, however, about the claim that "one of VA's highest priorities in 2009 will be to continue an aggressive research program to improve the lives of veterans returning from service in [Iraq and Afghanistan by devoting $252 million] to research projects focused specifically on veterans returning" from service in these two hot spots. It is our understanding that data collecting on maladies and diseases troops are returning with is not happening. It's almost as if our government does not want to know about these ailments so that it won't be burdened with Dependency Indemnity Compensation (DIC) payments.

We are pleased that the spirit of cooperation between the VA and the Department of Defense may actually be bearing fruit. In 2009, VA and DoD will complete the pilot of a new disability evaluation system for wounded returnees at major medical facilities in the Washington, D.C. area. We hope that what results from this effort "to eliminate the duplicative and often confusing elements of the current disability process of the two Departments" will lead to less confusion and a single, viable disability rating determined by the VA.

We are concerned, however, that there still will not be enough resources to deal with the flood of troops and veterans returning to our shores and presenting with a range of mental health issues. The VA ramped down for several years the numbers of mental health professionals it employed. Now, seeing the error of its ways, it is hurriedly hiring clinicians. The question is: Will there be enough of them to meet the challenge?

We are more than a little skeptical that, as the VA touts, the budget will provide resources "to virtually eliminate the patient waiting list by the end of 2009." When have we heard this before?

On the benefits side of the ledger, we find it ludicrous to believe that this budget "will allow VA to improve the timeliness with which compensation and pension claims are processed." Are VA planners perhaps a bit overly optimistic that they can reduce the average time it takes to process a claim to 145 days, 32 days quicker than the average 177 days it currently takes? No, the Veterans Benefits Administration requires a complete overhaul, one that introduces a new way of thinking about vetting veterans who make claims for compensation and pension benefits.

On the whole, this budget proposal is a better start than we have had in many a year, but the overall request for additional resources is just too low. With concerted work however it can be the most viable budget and appropriations document we have had in many years, of which we all can be proud.

Veterans Health Administration

Last year, VVA recommended an increase of $6.9 billion to the expected fiscal year 2007 appropriation for the medical care business line. Congress was very generous and we actually came close to that figure if one includes the supplemental funding of about $1.8 billion for veterans' healthcare. We recognize that the budget recommendation VVA is making again this year is also extraordinary, but with troops still in the field, years of underfunding of healthcare organizational capacity, renovation of an archaic and dilapidated infrastructure, updating capital equipment, and several cohorts of war veterans reaching ages of peak healthcare utilization, these are extraordinary times.

VVA asks that you continue ramping up the resources available to rebuild the organizational capacity to the point where the VA can really meet the needs of an increasing workload. Frankly, we believe that VA has (again) underestimated the projected workload for the next fiscal year. Instead of a growth of about 40,000 new veterans of the Global War on Terror (GWOT), VVA estimates that the increase will be at least equal to last year's increase of 90,000 new veterans entering the system, and probably will be in excess of 100,000 new GWOT veterans, particularly if the VA starts doing a better job of outreach, reduces wait times as called for in their plan, and continues to make gains in adding needed staff capacity.

In contrast to what is clearly needed, we believe the Administration's fiscal year 2009 request for $2.34 billion more than the FY 2008 appropriation is not adequate.

The increase the Administration has requested for medical care does not quite keep pace with inflation (due to increased energy costs, rising pharmaceutical costs, and other costs VA cannot control), but it will not allow VA to continue the needed pace of enhancing its healthcare and mental healthcare services for returning veterans, restore needed long-term care programs for aging veterans, or allow working-class veterans to return to their healthcare system. VVA's recommendation of a $5.24 billion increase over FY 2008 would accommodate these goals.

The advances of VA in recent years in improving the veterans' healthcare system are well known, and often elucidated by all of us, particularly VA officials. However, these advances have come with a cost. For years, the veterans' healthcare system has been falling behind in meeting the healthcare needs of some veterans. At the beginning of 2003, the former Secretary of Veterans Affairs made the decision to bar so-called Priority 8 veterans from enrolling. In most cases, these veterans are not the well-to-do—they are working class veterans or veterans living on fixed incomes who earn as little as $28,000 a year. It is not uncommon to hear about such veterans choosing between getting their prescription drug orders filled or paying their utility bills. The decision to "temporarily" bar these veterans is still standing, and it is still troubling to thoughtful Americans. As of this week, VA officials estimated that as many as 250,000 additional veterans are shut out of the system until they

become indigent or eventually are granted service connection for one or more of their conditions that originated in military service. No one knows the size of the "migration" from the wilderness of Priority 8 to a category where these veterans can enter the system at some point when they are much sicker and/or poorer, because the VA has not tried to track it (at least not in a public way that we know of). However, VVA believes that it is a significant number.

It is time to live up to the promise and obligation and to "Leave No Veteran Behind" by restoring access to so-called Priority 8 veterans who are now on the outside and looking in. Of the recommended increase, $1.3 billion is for restoration of the Priority 8 veterans by the end of the second quarter of FY 2009. It will take VA at least 3 to 6 months to add the organizational capacity to ensure that the system is not overwhelmed all at once.

Congress is to be commended for turning back many legislative requests for enrollment fees and outpatient cost increases in the past, which would have jeopardized access to care for hundreds of thousands of veterans. Hard-fought Congressional add-ons, such as the $3.6 billion added to veterans' healthcare for fiscal year 2007, and the more than $11 billion all told in calendar year 2008, now place us at a position where it is not only feasible to re-open the system to all veterans who have earned the right to access to this care, but it would be wrong to continue to shut them out.

Medical Services

For medical services for fiscal year 2009, VVA recommends $44.3 billion including collections. This is approximately $3.1 billion more than the Administration's request for fiscal year 2009. VVA is making its budget recommendations based on reopening access to the millions of veterans disenfranchised by the Department's policy decision of early 2003 that was supposed to be "temporary." The former Ranking Member of this Committee, Lane Evans, discovered that a quarter million Priority 8 veterans had applied for care in fiscal year 2005. Similar numbers of veterans have likely applied in each of the years since their enrollment was barred. Our budget allows 1.5 million new Priority 7 and 8 veterans to enroll for care in their healthcare system. While this may sound like too great a lift for the system, use rates for Priority 7 and 8 veterans are much lower than for other priority groups. Based on our estimates, it may yield only an 8% increase in demand at a cost of about $1.9 billion to the system for additional personnel, supplies and facilities.

The decade long diminishment of VA mental health programs that we experienced in the 1990s leveled out by 2001, and VA slowly started to rebuild capacity that has been accelerated in recent years. However, we must continue to restore capacity to deal with mental disorders, particularly with post traumatic stress disorder and the often attendant co-morbidity of substance abuse. In particular, substance abuse treatment needs to be expanded greatly, and be more reliant on evidence-based medicine and practices that are shown to actually be fruitful. The 21 day revolving door or the old substance abuse wards is not something we should return to, but rather treatment modalities that can be proven to work, and restore veterans of working age to the point where they can obtain and sustain meaningful employment at a living wage, and therefore re-establish their sense of self-esteem.

VVA also urges that additional resources explicitly be directed in the appropriation for FY 2009 to the National Center for PTSD for them to add to their organizational capacity under the current fine leadership. The signature wounds of this war may well be PTSD and traumatic brain injury and a complicated amalgam of both conditions. VVA believes that if we provide enough resources, and hold VA managers accountable for how well those resources are applied, that these fine young veterans suffering these wounds can become well enough again to lead a happy and productive life.

Up until recently, VA has not made enough progress in preparing for the needs of troops returning from Iraq and Afghanistan—particularly in the area of mental healthcare. In addition to the funds VVA is recommending elsewhere, we specifically recommend an increase of an additional $500 million over and above the $3.9 billion that VA now says they will allocate to assist VA in meeting the mental healthcare needs of all veterans. These funds should be used to develop or augment with permanent staff at VA Vet Centers (Readjustment Counseling Service or RCS), as well as PTSD teams and substance use disorder programs at VA medical centers and clinician who are skilled in treating both PTSD and substance abuse at the CBOC, which will be sought after as more troops (including demobilized National Guard and Reserve members) return from ongoing deployments. VVA also urges that the Secretary be required to work much more closely with the Secretary of Health and Human Services, and the States, to provide counseling to the whole family of those returning from combat deployments by means of utilizing the community mental

health centers that dot the Nation. Promising work is now going on in Connecticut and possibly elsewhere in this regard that could possibly be a model. In addition, VA should be augmenting its nursing home beds and community resources for long-term care, particularly at the State veterans' homes.

To allow the staffing ratios that prevailed in 1998 for its current user population, VA would have to add more than 15,000 direct care employees—MDs, nurses, and other medical specialists—at a cost of about $2 billion. This level, because the system can and should be more efficient now, would allow us to end the shame of leaving veterans out in the cold who want and are in vital need of healthcare at VA, and who often have no other option.

Vet Centers

VA received an additional $20 million in the Supplemental Appropriation for the war that was signed into law on March 7, 2007 specifically to increase the number of staff in the Readjustment Counseling Service (RCS) by 250 FTEE. Whether it was VHA or OMB that held these funds back, the funds were not released to the RCS to hire additional staff for the VA Vet Centers until mid-August. The Vet Centers are the most cost effective, cost efficient program operated by VA, but which just plain does not have enough staff. Because of the late arrival of the money the RCS could not hire any new staff, but used the funds for other things, such as vehicles to do rural outreach.

The additional 250 staff members for the previously existing Vet Centers are still very much needed, over and above the 100 peer counselors and approximately 50 mental health professionals they have already hired as additional staff in the past 2 years.

Medical Facilities

For medical facilities for fiscal year 2009, VVA recommends a level of commitment that is at least equal to fiscal year 2008. Maintenance of the healthcare system's infrastructure and equipment purchases are often overlooked as Congress and the Administration attempt to correct more glaring problems with patient care. In FY 2006, in just one example, within its medical facilities account VA anticipated spending $145 million on equipment, yet only spent about $81 million. VA undertook an intensive process known as CARES (Capital Asset Realignment to Enhance Services) to "right size" its infrastructure, culminating in a May 2004 policy decision that identified approximately $6 billion in construction projects. While for the reasons noted above the VA has consistently underestimated future needs by using a fatally flawed formula, thus far Congress and the Administration have only committed $3.7 billion of this all-too-conservative needed funding. We urge the Congress to continue the process of upgrading the physical plant of medical facilities at least at the rate funding at the FY 2008 level for the next several years.

In a system in which so much of the infrastructure would be deemed obsolete by the private sector (in a 1999 report GAO found that more than 60% of its buildings were more than 25 years old), this has and may again lead to serious trouble. We are recommending that Congress provide an additional $1.5 billion to the medical facilities account to allow them to begin to address the system's current needs. We also believe that Congress should fully fund the major and minor construction accounts to allow for the remaining CARES proposals to be properly addressed by funding these accounts with a minimum of remaining $2.3 billion.

Medical and Prosthetic Research

For medical and prosthetic research for fiscal year 2008, VVA recommends $500 million. This is approximately $50 million more than the Administration's request for fiscal year 2009. VA research has a long and distinguished portfolio as an integral part of the veterans' healthcare system. Research funding serves as a means to attract top medical schools into valued affiliations and allows VA to attract distinguished academics to its direct care and teaching missions.

VA's research program is distinct from that of the National Institutes of Health because it was created to respond to the unique medical needs of veterans. In this regard, it should seek to fund veterans' pressing needs for breakthroughs in addressing environmental hazard exposures, post-deployment mental health, traumatic brain injury, long-term care service delivery, and prosthetics to meet the multiple needs of the latest generation of combat-wounded veterans.

Further, VVA brings to your attention that VA medical and prosthetic research is not currently funding a single study on Agent Orange or other herbicides used in Vietnam, despite the fact that more than 300,000 veterans are now service-connected disabled as a direct result of such exposure in that war. This is unacceptable.

Mr. Chairman, finally I thank this Committee and the Appropriations Committee for using the power of the purse in the FY 2008 Appropriations Act to compel VA

to obey the law (Public Law 106–419) and conduct the long-delayed National Vietnam Veterans Longitudinal Study. VVA asks that you schedule a hearing and/or a Members briefing for the second half of March for VA to outline their plan as to how they are going to complete this much needed study for delivery of the final results to the Congress by April 1, 2010, as a comprehensive mortality and morbidity study of Vietnam veterans, the last large cohort of combat veterans prior to those now serving in OIF/OEF.

Veterans Benefits Administration

The Veterans Benefits Administration (VBA) continues to need additional resources and enhanced accountability measures. VVA recommends an additional 300 over and above the roughly 700 new staff members that are requested in the President's proposed budget for all of VBA.

Compensation & Pension

VVA recommends adding 100 staff members above the level requested by the President for the Compensation & Pension Service (C&P) specifically to be trained as adjudicators. Further, VVA strongly recommends adding an additional $60 million specifically earmarked for additional training for all of those who touch a veterans' claim, institution of a competency-based examination that is reviewed by an outside body that shall be used in a verification process for all of the VA personnel, veteran service organization personnel, attorneys, county and State employees, and any others who might presume to at any point touch a veterans' claim.

Vocational Rehabilitation

VVA recommends that you seek to add an additional 200 specially trained vocational rehabilitation specialists to work with returning servicemembers who are disabled to ensure their placement into jobs or training that will directly lead to meaningful employment at a living wage. It still remains clear that the system funded through the Department of Labor simply is failing these fine young men and women when they need assistance most in rebuilding their lives.

It is also unclear as to whether VA actually added several hundred of these employment placement specialists for disabled veterans specifically called for in last year's funding measure, and whether they are effective in assisting disabled veterans, particularly profoundly disabled veterans to obtain decent jobs.

VVA has always held that the ability to obtain and sustain meaningful employment at a living wage is the absolute central event of the readjustment process. Adding additional resources and much, much greater accountability to the VA vocational rehabilitation process is absolutely essential if we as a Nation are to meet our obligation to these Americans who have served their country so well, and have already sacrificed so much.

Accountability at VA

There is no excuse for the dissembling and lack of accountability in so much of what happens at the VA. It is certainly better than it used to be, but there is a long way to go in regard to cleaning up that corporate culture to make it the kind of system that it can be with existing resources, and even largely the same personnel as they currently have onboard. It can be cleaned up and done right the first time, if there is the political will to hold people accountable for doing their job properly.

Thank you again, Mr. Chairman. We look forward to working with you and this distinguished Committee to obtain an excellent budget for the VA in this fiscal year, and to ensure the next generation of veterans' well-being by enacting assured funding. I will be happy to answer any questions you and your colleagues may have.

Prepared Statement of Paul Rieckhoff
Executive Director, Iraq and Afghanistan Veterans of America

Mr. Chairman and Members of the House Veterans' Affairs Committee, on behalf of Iraq and Afghanistan Veterans of America and our tens of thousands of members nationwide, I thank you for the opportunity to testify today regarding the VA budget request for 2009.

From April 2003–February 2004, I served as a First Lieutenant and Infantry Platoon Leader in Iraq. When I returned home, I quickly became concerned about the lack of real support for returning troops and veterans. In the early years of the wars, issues like traumatic brain injury, post traumatic stress disorder, and homelessness received far too little attention.

But times have changed. Last year, this Congress showed tremendous commitment to our Nation's veterans, providing the VA with its single largest budget increase in 77 years. On behalf of the millions of veterans who rely on VA healthcare, including almost 300,000 troops newly home from Iraq and Afghanistan, we hope you will continue to show your support for veterans' healthcare. IAVA is one of the over 60 organizations who have endorsed *The Independent Budget*, and we endorse it again for FY2009.

As the war in Iraq continues into its fifth year, this generation of troops and veterans faces new and unique problems. Today, IAVA is releasing our annual *Legislative Agenda*. Our *Legislative Agenda* covers the entire war fighting cycle—before, during and after deployment—and outlines practical solutions to the most pressing problems facing Iraq and Afghanistan veterans. Our *Legislative Agenda* is available at IAVA's Web site, www.iava.org.

The cornerstone of our 2008 Legislation Agenda is a new GI Bill. After World War II, nearly 8 million servicemembers took advantage of GI Bill education benefits. A veteran of WWII was entitled to free tuition, books and a living stipend that completely covered the cost of education.

Today we have the opportunity to renew our social contract with our service men and women, and help rebuild our military. IAVA supports reinstating a World War II-style GI Bill that will cover the true cost of education and will fairly reward all combat veterans of Iraq and Afghanistan. We have endorsed **H.R. 2702**.

Critics have said the GI Bill is too expensive. The fact is, a new GI Bill is a bargain. The current GI Bill cost the Veterans' Affairs Department $1.6 billion in 2004. Even if a World War II-style GI Bill were to double that cost, it would be about what we spend in a week in the War on Terror. And the GI Bill is more than a veterans' benefit. It is also an effective tool to stimulate the economy and to improve military readiness.

The GI Bill helped rebuild this country's economy after World War II. A 1988 Congressional study proved that every dollar spent on educational benefits under the original GI Bill added $7 to the national economy in terms of productivity, consumer spending and tax revenue.

Many of our Nation's leaders got their start thanks to the GI Bill, including Presidents Gerald Ford, George H.W. Bush, and Senators Bob Dole, George McGovern, and Pat Moynihan. The GI Bill also educated 14 Nobel Prize winners and two dozen Pulitzer Prize winners, including authors Joseph Heller, Norman Mailer, and Frank McCourt.

Veterans of Iraq and Afghanistan, however, receive only a fraction of the support offered to the Greatest Generation. For many, including my good friend Sergeant Todd Bowers, the burden of student loans and mounting debt can simply become too great.

When Sergeant Bowers was activated for his second deployment to Iraq, he was forced to withdraw from his classes at George Washington University, racking up an extra semester's debt without receiving credit for his coursework. While he was deployed to Iraq, Bowers was wounded when a sniper's round penetrated his rifle scope and sent fragments into the left side of his face. He was awarded the Purple Heart and Navy Commendation medal with "V" device for Valor. But when Bowers returned home, he was not greeted as a hero by his university and credit lenders. His student loans had been sent to collection, and his credit rating was ruined. Struggling to keep up with payments, Bowers was eventually forced to leave school.

The GI Bill is also an important recruitment tool. For years, the military has been lowering recruitment standards and increasing bonuses. We now spend more than $4 billion annually on recruitment, but we're still struggling to meet recruiting goals. The GI Bill is the military's single most effective recruitment tool; the number one reason civilians join the military is to get money for college. A new GI Bill, one that put college within reach of a new generation of veterans, would be a tremendous boon to recruitment and would help rebuild our military after years of war.

Above all, a World War II-style GI Bill would thank this generation of combat veterans for their service and their sacrifice. As President Roosevelt said in his signing statement to the original GI Bill: "[The GI Bill] gives emphatic notice to the men and women in our armed forces that the American people do not intend to let them down."

For all of these reasons, IAVA is calling for a new GI Bill to be funded in this year's budget.

Thank you for your time.

Prepared Statement of Paul Sullivan
Executive Director, Veterans for Common Sense

I would like to thank Chairman Filner and Members of the Committee for inviting Veterans for Common Sense to testify about the Department of Veterans Affairs' budget request for fiscal year 2009. VCS especially thanks this Committee for the dozens of hearings you held last year, and for the prompt passage of the "Dignity for Wounded Warriors Act," a bill strongly supported by our VCS members.

As Associate Supreme Court Justice Thurgood Marshall said, "Justice too long delayed is justice denied." With that quote in mind, VCS believes VA's 2009 budget request falls far short because it does not adequately seek to address what we believe should be VA's four highest budget priorities:

1. Zero tolerance for homelessness. VA's budget does not provide enough funding to reduce the number of homeless from 200,000 to as close to zero as possible.
2. Zero tolerance for VA turning away suicidal patients.
3. Zero tolerance for turning away Afghanistan and Iraq war veterans from free and prompt VA healthcare within 5 years of their discharge from active duty.
4. Zero tolerance for VA claim delays and claim errors.

VCS believes VA suffers from a capacity crisis, and that our veterans are unduly denied prompt access to VA services. Our veterans earned and need prompt ***and*** high-quality medical care as well as prompt ***and*** accurate claim decisions. VCS is outraged that government lawyers argued against the new law mandating 5 years of free VA medical care for our Iraq and Afghanistan war veterans.

VCS is concerned about three statements VA made about VA's 2007 budget:

VA Statement #1: Former VA Secretary Jim Nicholson said: "The President's 2008 budget request provides the resources necessary to ensure that servicemembers' transition from active-duty military status to civilian life continues to be as smooth and seamless as possible."

Reality: VA's 2008 budget failed to meet this goal. The Walter Reed scandal broke a few days after VA's comments, revealing the military and VA were woefully underfunded and unprepared for unanticipated patients. We thank this Congress for ignoring the Administration's chronic underfunding and increasing VA's 2008 budget.

VA Statement #2: Current VA Under Secretary for Health Mike Kussman said: "With the resources requested for medical care in 2008, the Department will be able to continue our exceptional performance dealing with access to healthcare—96 percent of primary care appointments will be scheduled within 30 days of patients' desired date. . . ."

Reality: While VA's Kussman claimed only 4 percent of patients waited more than 30 days to see a doctor, VA's Inspector General reported that 25 percent waited more than 30 days. This is six times more than VA's claim. In Charleston, South Carolina, the *Charlottesville Observer* reported that 93 percent of Iraq and Afghanistan war veterans waited more than 30 days for medical care for serious conditions such as TBI.

VA Statement #3: Former VA Secretary Nicholson said: "We expect to improve the timeliness of processing these claims to 145 days in 2008. . . . In addition, we anticipate that our pending inventory of disability claims will fall to about 330,000 by the end of 2008. . . ." In VA's press release dated February 4, 2008, VA once again promised to cut the backlog to 300,000 claims and process claims in an average of 145 days.

Reality: While VA would lead Congress to believe that VBA can improve, the pending inventory of rating-related claims is 400,000, and veterans wait an average of 183 days.

Important Facts: VCS used the Freedom of Information Act to obtain documents providing incontrovertible evidence that VA's capacity crisis requires more funding.

- VA expects to treat 5.8 million patients this year, yet VA's IG reported 25 percent, or nearly 1.5 million veterans, will wait more than 1 month to see a VA doctor.
- VA regional offices are still working on 650,000 claims of all types, yet 26 percent, or 169,000 veterans, have already waited more than 6 months.

Here are salient facts regarding Iraq and Afghanistan war veterans:

- DoD already reports 68,000 non-fatal battlefield casualties from the two wars, and VA expects to treat 333,000 veteran patients during 2009.
- VA hospitals already treated 264,000 unanticipated patients, yet 33 percent, or 87,000 veterans, wait more than 1 month to see a VA doctor.
- VA's budget proposal spends more than $7,100 per veteran on medical care, yet VA budgets only $3,900, for Iraq and Afghanistan veterans, or 55% of the cost.
- VA regional offices received 245,000 unanticipated disability claims, yet 16 percent, or 39,000 veterans, are still waiting, on average 6 months, for a VA claim decision.
- DoD reported 20 percent, or potentially as many as 320,000, of our new war veterans are at risk for traumatic brain injury, or TBI.
- A recent West Virginia survey identified 36 percent, or potentially as many as 600,000, of our veterans as having post traumatic stress disorder, or PTSD.
- Veterans who served in the National Guard and Reserves are nearly three times as likely to have their claim denied than veterans from regular active duty (14% v. 5%).
- VA diagnosed 56,246 veterans with PTSD, yet approved only 61 percent of the claims, or 34,138, for PTSD.

VA's failure to submit a budget to increase capacity and rectify other systemic problems needlessly increased suffering among our veterans. According to published reports, the number of broken homes, unemployed veterans, drug and alcohol abuse, suicides, and homelessness all rose—problems expected to worsen without immediate VA action.

As the Rev. Martin Luther King, Jr. said, "Injustice anywhere is a threat to justice everywhere." Our veterans earned and deserve better from our government. The Administration's VA budget request is dead on arrival because it does not deliver justice for our veterans in a complete and timely manner.

Additional VA Budget Suggestions

VCS believes that VA should follow the role model of General Omar Bradley, VA's Administrator after World War II. He said, "We are dealing with veterans, not procedures—with their problems, not ours." With that in mind, VCS solicited suggestions from our members, and they were incorporated in the following additional VA budget suggestions.

VCS believes that VA's failures are caused by this Administration's myopia at saving money and its inability to evolve. VA should not be able to hide behind its failures to follow the law for decades as an excuse not to begin a massive reform program to eliminate homelessness among veterans, guarantee prompt and high-quality medical care, and process disability claims accurately within 1 month.

VCS remains especially concerned that VA's inflexible leaders continue to be unable to provide justice to our Nation's veterans, especially during war when the needs of our veterans are most acute. Here are some items that would bring justice to our veterans.

- **Patient Backlog.** There is no Administration request for mandatory full funding for all priority groups, thereby excluding millions of uninsured veterans from VA hospitals and clinics. Currently there is an unlimited military budget for bullets and bombs for our military. Logically, there must also be mandatory full funding of VA's budget for hospital beds and benefits for our veterans. In addition, VA needs to stay open longer each weekday and consider being open on weekends in order to increase capacity and thus meet the increase in demand.
- **New Patients.** The VA did not request additional funding to provide the 5 years of mandatory free healthcare for our returning Iraq and Afghanistan war veterans recently signed into law. Similarly, there is no VA funding request to provide PTSD and TBI screening for all 1.6 million servicemembers deployed to the war zone. In January 2008, a U.S. District Court ruled that our class action lawsuit against VA will move forward. The Court ruled the 2 years of free medical care is a spending mandate and rejected VA's view that spending on healthcare for Iraq and Afghanistan war veterans was discretionary. Congress should codify this ruling with mandatory full funding so no future veterans wait for VA care.
- **Polytrauma.** In 2007, VA planned more than 20 polytrauma centers. VCS believes every VA medical center should be capable of treating polytrauma patients in order to meet the growing demand that more than 6 years of ongoing warfare requires. All VA medical centers should have this ability so veterans

can be treated near their homes where family members and friends can provide comfort and support.

- **Suicide Epidemic.** VA should fund a state-of-the-art suicide data collection, reporting, and analysis office. The national office should identify local, State, and Federal data about veterans who attempted or committed suicide so VA can implement the best policies to reduce suicide among all veterans, especially recent war veterans. This should include monitoring of specific cohorts of veterans by period of war, gender, race, number of deployments, length of deployments, and use of VA healthcare.
- **Claims Backlog.** In order to expedite claims and reduce the backlog, the VA budget submitted by the President should have sought new rules designed to create a presumption for a concussive blast and/or a psychological stressor so that VA can more accurately and quickly adjudicate claims for TBI and PTSD. Congress should mandate automatically approving all VA claims within 30 days, for a period of up to 1 year for deployed veterans' claims. VCS supports this bold recommendation initially made by Harvard University Professor Linda Bilmes.
- **Disability Claims.** VA should make sure that VA employees stationed at military facilities are authorized to assist with both military and VA healthcare and claims paperwork, thus ending the turf war preventing VA employees from assisting soon-to-be veterans. While VA recently signed a contract to review adding "quality of life" to the list of items considered when determining the amount of compensation payments, VA has not sought additional authority to pay such benefits.
- **Long-Term Planning.** While there is increased funding for information technology, there does not appear to be any funding for increased staffing for data collection, reports, and analysis. These are necessary so that VA does not repeat prior mistakes when VA requested insufficient funding. Congress should enact H.R. 1354, introduced by Rep. James Moran and Rep. Ray LaHood, which directs VA to define the war zones, collect data, and prepare cost and benefit use reports about the Iraq and Afghanistan wars. VCS also supports a longitudinal study of Iraq and Afghanistan war veterans that starts now. The Congress and the public must be fully and regularly informed about the human and financial costs of the two wars.
- **Overhauling VA.** VA does not appear to request money for a desperately needed agencywide overhaul, as recommended by the Veterans Disability Benefits Commission. VCS believes that our veterans and VA employees will continue to suffer as long as VA fails to plan for mandatory full funding and to plan to significantly expand timely access to VA healthcare and claims. One component would be to implement 38 USC Section 5106, and thus require the military to automatically provide VA full military and medical records on all servicemembers. Another component would be to automatically enroll all servicemembers into VA the first day the new servicemember enters the military.
- **Education Benefits.** Transition and readjustment assistance in the form of educational benefits are a meager fraction of what they were when compared to the Post-World War II GI Bill. That is why VCS strongly supports S. 22, introduced by Senator Jim Webb, "The Post-9/11 Veterans Educational Assistance Act of 2007," that substantially increases payments to veterans.
- **Personality Disorder Discharges.** There does not appear to be any funding so VA can review the applications for healthcare and disability benefits denied by VA on the basis of a personality disorder discharge given by the military.
- **Ending Stigma.** There is no funding to reduce the stigma against people with mental health conditions. Military studies confirm this stigma hinders many of our war veterans from seeking mental healthcare.
- **Ending Employment Discrimination.** Similarly, there is no funding for public service announcements to combat illegal job discrimination against veterans.
- **Vet Centers.** Congress should enact legislation expanding VA's highly successful Vet Centers so they can provide mental health services to active duty servicemembers, either at existing facilities or at new offices on military bases. This expanded service might first be targeted at military installations that have shortages of mental healthcare providers and bases expecting large redeployments from the war zones. Congress should allow families to participate in the readjustment counseling process at all Vet Centers.
- **Executive Bonuses.** Congress should allow only modest bonuses for VA executives, and these should be approved outside the agency's normal chain of command. Furthermore, VCS strongly supports performance-based incentives and bonuses for VA's rank-and-file employees for ideas and actions made to improve the delivery of healthcare and benefits to veterans.

- **Gulf War Veterans.** Years of denial of the problem of chronically ill Gulf War veterans is a tragic stain on the record of the U.S. Government in caring for our veterans. VCS strongly supports research to identify treatments for the 175,000 veterans of the 1991 Gulf War that VA estimates remain chronically ill, especially the $75 million for VA's program at the University of Texas Southwestern Medical School. Another project that deserves close Committee attention and support is actually funded by the military: VCS supports adding $30 million to the Department of Defense budget for competitive research in the Congressionally Directed Medical Research Program since the military has historically provided the majority of funding for this research, but refuses to put it in its budget.
- **Vietnam War Veterans.** VCS continues to support research and treatments for Vietnam War veterans poisoned by dioxin contained in Agent Orange. VCS also supports outreach to veterans with diabetes, prostate cancer, and other war-related medical conditions so they are aware of new VA healthcare and disability benefits for those conditions. VA must be prohibited from expending funds to block claims by "Blue Water" veterans for VA healthcare and benefits related to agent orange.
- **TSGLI.** VA's Traumatic Servicemembers' Group Life Insurance program office should hire additional staff to analyze significant discrepancies in the outcomes of TSGLI claims. According to VA, only half of the TSGLI claims were approved (2,075 approved out of 3,979 applications, or 52%). Furthermore, Active Duty veterans were 65 percent more likely to have their TSGLI approved than National Guard and Reserve veterans (66% v. 40%). Currently, TSGLI is available only to servicemembers deployed to the Iraq and Afghanistan war zones. VCS believes Congress should expand TSGLI staffing and make TSGLI benefits available to servicemembers involved in training-related accidents, regardless of their location.
- **Travel Reimbursement.** VCS believes people in our country should be treated equally, and veterans should receive the full 70 cents per mile reimbursement for travel, the same amount that Representatives and Senators receive, and not the 28 cents approved by Congress that includes a deductible that increased from $6 to $15.
- **Due Process.** VCS believes all veterans should be able to retain an attorney at the initial stages of a VA healthcare or disability benefit application in order to expedite and improve the process as well as to save VA money developing the claim; as it stands a veteran must wait until the initial VA determination is made and the veteran filed a Notice of Disagreement. VCS wishes to strongly emphasize the need for competent, unbiased, non-government legal advice for veterans and family members when a veteran has a serious injury (such as TBI or PTSD), as the most serious cases of VA healthcare and claims negligence and difficulties often involve veterans with these conditions.
- **Outreach.** VCS supports lifting the current ban on VA advertising and outreach, as described in the July 2002 memo authored by the former VA official Laura Miller. VCS believes VA should broadcast public service announcements describing VA services, especially for members of the National Guard and Reserve, who are using VA services less than their active duty peers. VCS believes Congress should fund VA training and outreach to universities so law students are encouraged to learn about laws designed to assist veterans, plus ongoing education to remain current on changes in the laws. If the military can spend billions recruiting new soldiers, then VA should be able to spend some money making sure veterans and their families know what they earned and making sure they can quickly receive it.

VCS respectfully requests the following documents be entered into the hearing record:

- "*VA Facility Specific OIF/OEF Veterans Coded with Potential PTSD*," Aug. 27, 2007.
- "*VA Benefits Activity: Veterans Deployed to the Global War on Terror*," Nov. 14, 2007.
- VA "*Analysis of Healthcare Utilization Among U.S. Global War on Terror Veterans*," Oct. 2007.
- DoD "*Contingency Tracking System Deployment File for Operations Enduring Freedom & Iraqi Freedom*," Oct. 31, 2007.
- VCS "*VA Fact Sheet*," Feb. 4, 2008 and VCS "*DoD Fact Sheet*," Jan. 12, 2008.
- "*The Elusive 'Seamless Transition'*," *Proceedings*, February 2008.

VA Facility Specific OIF/OEF Veterans Coded with Potential PTSD Through 3rd Qt FY 2007

I. Background

The Government Accountability Office (GAO) has requested VA to enumerate the total number of OIF/OEF veterans who were diagnosed with PTSD by VISN and VAMC using VA inpatient and outpatient records. GAO also asked for this information to be aggregated with Vet Center utilization data. VHA prepared an initial report in October 2004 for the healthcare utilization during FY 2004. This eleventh report covers the VA healthcare data from FY 2002 through 3rd Qt FY 2007.

II. Data Sources

OIF/OEF veteran roster

Since October 2003, the Department of Defense (DoD) Defense Manpower Data Center (DMDC) has sent the Department of Veterans Affairs (VA) Environmental Epidemiology Service (EES) a periodically updated personnel roster of troops who participated in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) who had separated from active duty and become eligible for VA benefits. The roster was originally prepared based on the pay records of individuals but in more recent months it was based on a combination of pay records and operational records provided by each branch of service. Based on the latest DMDC file received on July 27, 2007, there are a total of 751,273 unique OEF/OIF veterans (excluding 3,638 who died in theater), who have been separated as of May 2007 from active duty following the deployment. For each veteran, his/her demographic (SSN, name, DOB, gender, education, etc.) and military service specific data (branch, rank, unit component, deployment dates, etc.) were included in the record.

VHA healthcare utilization records

The roster was checked against VA's inpatient (PTF) and outpatient (OPC) electronic patient records available through June 30, 2007 to determine those who had sought treatment in VA facilities as well as the ICD–9 diagnostic codes used to describe the visits. Thus, the data we have was administrative data and not based on a careful review of each patient record. For the purpose of this report, we searched his/her healthcare utilization records during FY 2002, 2003, 2004, 2005, 2006 and through FY 2007 3rd Qt ending June 30, 2007 following his/her first deployment in Iraq or Afghanistan theater. For identification of a potential PTSD patient, we used ICD–9CM, 309.81.

The Vet Center counts were based on the data provided to EES on August 17, 2007 by the Readjustment Counseling Service (RCS). The RCS staff matched the same DMDC roster with Vet Center users' records through FY 2007 3rd Qt.

III. Distribution of Veterans by Diagnostic Code and Facility

- A veteran is counted only once in any facility specific category. For example, a veteran, who received healthcare from two or more medical centers within the same VISN, was counted once for that VISN. Likewise, a veteran who used services across two or more VISN facilities and a Vet Center was counted only once for the national overall total.
- The number for "Primary" indicates the total number of unique veterans whose primary reason for the inpatient or outpatient visit was for treatment or evaluation of PTSD.
- The number for "Any" indicates the total number of unique veterans coded with PTSD, whether or not the primary reasons for the inpatient or outpatient visit was for treatment or evaluation of PTSD.
- Both "Primary" and "Any" categories may include a suspected diagnosis.

IV. Summary

Recognizing the limitations of DMDC deployment roster and the uncertainty of the final diagnostic data based on VHA's electronic patient records, a query of VHA healthcare utilization databases using the May 2007 DMDC separation roster yielded a total of 48,559 OEF/OIF veterans coded with PTSD at a VA medical center and 14,655 veterans who received Vet Center service for PTSD. Of these, 41,591 were seen only at a VAMC; 7,687 only at a Vet Center; and 6,968 were seen at both facilities. In summary, based on the electronic patient records available through June 30, 2007, a grand total of 56,246 OEF/OIF veterans were seen for potential PTSD at VHA facilities following their return from Iraq or Afghanistan Theater.

Han K. Kang, Dr.P.H.
August 27, 2007

Number of Unique OEF/OIF Veterans With PTSD Utilizing VA Facilities During FY 2002–3d Qt FY 2007

VISN—Facility	Inpatients		Outpatients		Total Patients [1]		Vet Centers [4]			Grand Total [5]
	Primary [2]	Any [3]	Primary [2]	Any [3]	Primary [2]	Any [3]	PTSD	Sub-PTSD	Other	
1—BEDFORD	10	36	185	204	185	210	58	5	86	256
1—BOSTON	29	84	574	672	578	691	311	25	519	834
1—MANCHESTER	—	—	168	208	168	208	144	11	475	304
1—NORTHAMPTON	30	39	181	192	182	193	92	2	1729	237
1—PROVIDENCE	16	45	332	383	333	390	129	1	785	451
1—TOGUS	3	18	275	319	275	321	265	87	595	475
1—WEST HAVEN	6	18	513	559	513	561	234	22	856	663
1—WHITE RIVER JCT	11	18	223	276	224	279	142	724	560	374
VISN 1	99	236	2332	2662	2334	2684	1375	877	5605	3386
2—UPSTATE N.Y. HCS	47	96	1205	1330	1209	1335	290	32	2782	1502
VISN 2	47	96	1205	1330	1209	1335	290	32	2782	1502
3—BRONX	15	28	233	265	235	271	39	8	98	294
3—EAST ORANGE	13	30	533	583	533	586	317	30	2105	799
3—MONTROSE VA, HUDSON HCS NY	13	22	183	201	184	203	15	—	115	216
3—N.Y. HARBOR HCS	13	36	590	671	593	676	267	7	819	837
3—NORTHPORT	9	29	240	278	240	279	38	10	125	291
VISN 3	59	136	1709	1916	1715	1926	676	55	3262	2328
4—BUTLER	—	—	85	97	85	97	—	—	—	97
4—CLARKSBURG	7	16	227	249	227	250	83	—	819	296
4—COATESVILLE	10	18	170	183	173	188	—	—	—	188
4—ERIE	—	—	142	166	142	166	89	18	127	209
4—JAMES E VAN ZANDT VAMC	—	3	154	185	154	185	—	—	—	185
4—LEBANON	15	23	297	327	297	329	123	42	362	392
4—PHILADELPHIA	20	33	569	674	569	675	124	1	274	736
4—PITTSBURGH—UNIV DR	27	48	174	226	184	248	187	346	760	391

4—WILKES BARRE	8	22	221	258	222	262	158	60	1082	384
4—WILMINGTON	—	1	128	144	128	144	199	17	589	272
VISN 4	84	155	2029	2348	2032	2363	963	484	4013	2926
5—BALTIMORE	9	35	336	387	336	392	119	4	371	456
5—MARTINSBURG	14	23	368	395	368	395	96	1	26	436
5—WASHINGTON	12	28	516	572	518	579	208	30	926	688
VISN 5	35	80	1185	1311	1187	1320	423	35	1323	1531
6—ASHEVILLE–OTEEN	17	21	143	180	145	183	—	—	—	183
6—BECKLEY	—	4	166	177	166	177	123	2	112	236
6—DURHAM	25	44	429	465	432	472	210	21	2943	583
6—FAYETTEVILLE NC	14	39	650	760	654	768	85	—	9293	810
6—HAMPTON	9	17	379	422	380	424	48	49	2129	450
6—RICHMOND	14	42	381	423	384	440	93	7	643	503
6—SALEM	14	25	169	198	173	205	26	3	3	214
6—SALISBURY	29	42	538	621	540	626	77	131	1545	673
VISN 6	121	225	2758	3115	2771	3150	662	213	16668	3474
7—ATLANTA	29	49	554	614	556	620	159	21	1004	743
7—AUGUSTA	21	74	365	449	366	467	—	—	—	467
7—BIRMINGHAM	—	21	405	489	405	494	97	8	1675	571
7—CHARLESTON	11	18	333	404	336	409	189	26	3660	523
7—COLUMBIA SC	9	21	567	623	569	626	226	3	1457	768
7—DUBLIN	—	4	200	236	200	237	—	—	—	237
7—MONTGOMERY	45	64	694	771	706	785	—	—	—	785
7—TUSCALOOSA	15	28	433	451	436	455	—	—	—	455
VISN 7	126	264	3441	3901	3453	3934	671	58	7796	4340
8—BAY PINES	11	36	355	396	355	403	105	11	994	457
8—MIAMI	9	30	432	486	432	489	479	20	1450	858
8—N FL/S GA HCS	18	50	729	847	730	853	178	83	2116	955

Number of Unique OEF/OIF Veterans With PTSD Utilizing VA Facilities During FY 2002–3d Qt FY 2007—Continued

VISN—Facility	Inpatients		Outpatients		Total Patients [1]		Vet Centers [4]			Grand Total [5]
	Primary [2]	Any [3]	Primary [2]	Any [3]	Primary [2]	Any [3]	PTSD	Sub-PTSD	Other	
8—ORLANDO FL VAMC	—	—	334	386	334	386	128	23	746	457
8—SAN JUAN PR	16	57	292	428	293	432	155	112	2672	491
8—TAMPA	24	83	764	888	765	910	53	3	27	934
8—W PALM BEACH	18	31	207	227	209	230	—	—	—	230
VISN 8	95	276	2820	3312	2824	3350	1098	252	8005	3967
9—HUNTINGTON	—	3	286	307	286	308	131	15	623	369
9—LEXINGTON—LEESTOWN	21	42	273	334	279	344	48	5	317	370
9—LOUISVILLE	15	33	219	257	223	265	27	29	638	277
9—MEMPHIS	25	42	281	342	285	351	61	158	1290	378
9—MOUNTAIN HOME	14	30	315	362	316	364	82	2	179	392
9—VA MID TENN HCS NASH TN	39	85	528	633	536	655	122	270	975	728
VISN 9	111	232	1867	2194	1886	2237	471	479	4022	2458
10—CHILLICOTHE	11	23	169	195	169	199	—	—	—	199
10—CINCINNATI	10	24	256	278	258	284	57	11	846	309
10—CLEVELAND—WADE PARK	11	48	544	626	544	638	46	16	1606	655
10—COLUMBUS—IOC	—	—	205	242	205	242	123	14	156	320
10—DAYTON	15	25	186	218	189	225	44	2	39	256
VISN 10	47	118	1318	1504	1322	1526	270	43	2647	1663
11—ANN ARBOR HCS	7	19	215	252	216	256	—	—	—	256
11—BATTLE CREEK	26	36	313	354	317	360	102	—	127	426
11—DETROIT VAMC	5	23	150	215	152	220	108	16	526	294
11—ILLIANA HCS DANVILLE IL	4	21	289	348	289	350	49	9	838	372
11—INDIANAPOLIS—10TH ST	16	24	257	302	258	303	34	—	500	327
11—NORTHERN INDIANA HCS	2	8	137	178	137	179	61	16	415	223
11—SAGINAW	—	—	227	292	227	292	—	—	—	292
VISN 11	58	126	1537	1871	1542	1881	354	41	2406	2089

12—HINES	18	44	308	346	310	359	71	25	140	407
12—ILLIANA HCS DANVILLE IL	—	—	—	—	—	—	35	—	577	35
12—IRON MOUNTAIN	1	1	72	88	72	88	—	—	—	88
12—MADISON	6	24	163	199	163	207	33	30	6639	228
12—MILWAUKEE	17	45	366	431	370	441	34	12	245	464
12—NORTH CHICAGO	8	23	167	218	170	227	56	14	322	259
12—TOMAH	11	20	198	239	198	242	—	—	—	242
12—VA CHICAGO HCS	5	16	228	275	228	280	132	3	533	372
VISN 12	64	165	1442	1716	1448	1754	361	84	8456	1981
15—VA HEARTLAND—E VH MO	36	76	673	785	678	794	151	41	1978	883
15—VAMC HEARTLAND—W KANSAS MO	111	189	755	871	785	922	165	12	4047	1040
VISN 15	146	263	1418	1645	1451	1702	316	53	6025	1907
16—ALEXANDRIA	10	32	188	244	193	253	—	—	—	253
16—FAYETTEVILLE AR	16	30	239	258	241	266	—	—	—	266
16—GULF COAST HCS	13	32	560	625	565	636	530	7	1288	1021
16—HOUSTON	19	35	570	621	575	632	85	10	318	680
16—JACKSON	4	24	145	206	146	211	22	38	273	219
16—LITTLE ROCK	48	85	632	668	642	687	212	50	613	803
16—MUSKOGEE	4	12	214	241	216	244	108	22	19	321
16—OKLAHOMA CITY	15	37	360	424	363	436	63	36	328	464
16—SHREVEPORT	14	30	264	301	266	307	118	187	2052	386
16—SOUTHEAST LA HCS	3	5	357	396	357	396	71	173	12	447
VISN 16	145	314	3436	3874	3463	3945	1209	523	4903	4705
17—DALLAS	24	56	613	689	616	699	144	54	656	809
17—SAN ANTONIO	33	54	879	986	881	991	301	86	2114	1145
17—VA CENTRAL TEXAS HCS	28	37	841	1013	843	1015	264	43	1304	1198
VISN 17	85	145	2290	2639	2297	2656	709	183	4074	3086
18—AMARILLO HCS	—	2	154	178	154	179	64	64	98	216

Number of Unique OEF/OIF Veterans With PTSD Utilizing VA Facilities During FY 2002–3d Qt FY 2007—Continued

VISN—Facility	Inpatients		Outpatients		Total Patients [1]		Vet Centers [4]			Grand Total [5]
	Primary [2]	Any [3]	Primary [2]	Any [3]	Primary [2]	Any [3]	PTSD	Sub-PTSD	Other	
18—EL PASO HCS	—	—	185	204	185	204	24	1	1111	218
18—NEW MEXICO HCS	18	45	584	634	586	640	243	15	321	738
18—NORTHERN ARIZONA HCS	1	1	135	149	135	149	47	10	47	166
18—PHOENIX	30	69	847	932	852	941	103	8	942	980
18—SOUTHERN ARIZONA HCS	39	58	360	436	364	443	102	1	2475	499
18—WEST TEXAS HCS	—	2	129	151	129	151	53	3	252	175
VISN 18	86	171	2313	2588	2319	2606	636	102	5246	2877
19—CHEYENNE	—	2	129	144	129	145	107	22	575	215
19—DENVER	50	73	772	903	778	911	232	5	3266	1031
19—FORT HARRISON	2	12	328	393	328	394	234	15	674	539
19—GRAND JUNCTION	1	2	76	88	76	88	—	—	—	88
19—SALT LAKE CITY HTHCARE	27	48	482	551	485	560	198	38	2074	685
19—SHERIDAN	18	28	124	157	127	159	—	—	—	159
VISN 19	91	154	1848	2167	1856	2184	771	80	6589	2623
20—ALASKA HCS & RO	—	—	85	124	85	124	166	24	1206	242
20—BOISE	4	16	157	199	160	203	79	88	1540	265
20—PORTLAND	14	39	660	770	661	775	258	47	695	926
20—PUGET SOUND HCS	105	137	956	1061	975	1087	397	53	6662	1333
20—S. ORG REHAB WHITE CITY	—	—	67	77	67	77	37	2	82	103
20—SPOKANE	6	15	212	244	212	248	103	18	1499	298
20—VA ROSEBURG HCS	63	65	251	278	281	308	90	27	1710	355
20—WALLA WALLA	4	4	136	158	136	158	—	—	—	158
VISN 20	185	259	2427	2798	2451	2834	1130	259	13394	3505
21—CENTRAL CALIFORNIA HCS	8	16	241	285	242	290	107	2	596	335
21—HONOLULU	1	4	223	242	223	243	88	25	1853	301

21—MANILA	—	—	14	14	14	14	—	—	—	14
21—NCHC MARTINEZ	—	2	535	775	535	777	352	44	1408	966
21—PALO ALTO—PALO ALTO	28	88	501	586	508	616	125	3	1332	666
21—SAN FRANCISCO	5	20	284	315	286	325	99	13	176	381
21—SIERRA NEVADA HCS	5	16	160	175	160	177	57	3	153	202
VISN 21	43	142	1898	2300	1904	2339	828	90	5518	2742
22—GREATER LA HCS	13	38	808	930	809	938	266	24	1451	1087
22—LOMA LINDA	32	63	621	723	623	732	166	13	2827	823
22—VA LONG BEACH HCS CA	5	16	508	595	508	598	163	10	568	743
22—VA SAN DIEGO HCS CA	22	43	705	834	707	842	251	9	4673	974
22—VA SOUTHERN NEVADA HCS	6	19	281	332	282	334	78	12	541	377
VISN 22	77	174	2853	3311	2858	3334	924	68	10060	3867
23—FARGO	3	6	90	115	92	117	92	1	910	180
23—FORT MEADE	3	4	119	156	119	157	34	8	359	180
23—MINNEAPOLIS	13	61	316	378	318	400	74	61	1135	448
23—SIOUX FALLS	3	15	151	216	152	219	91	83	1589	267
23—ST CLOUD	6	14	185	205	186	209	—	—	—	209
23—VA NEB—WESTERN IA HCS	19	55	855	955	855	963	227	30	2135	1071
VISN 23	47	153	1676	1971	1681	2000	518	183	6128	2279
Unique Counts	1788	3721	41982	48148	42106	48559	14655	4194	128922	56246

1. The "total patient" counts were generated by matching a cumulative roster of 751,273 unique OEF/OIF veterans, who had been separated from active duty as of May 31, 2007, with VA inpatient (PTF) and outpatient (OPC) databases for FY 2002, 2003, 2004, 2005, 2006 and through 3rd Qt FY 2007. The DoD Defense Manpower Data Center identified and provided the identity of these veterans to the VA Environmental Epidemiology Service on July 27, 2007.
2. The number for "Primary" indicates the total number of unique veterans whose primary reason for the inpatient or outpatient visit was for treatment or evaluation of PTSD.
3. The number for "Any" indicates the total number of unique veterans with PTSD, whether or not the primary reasons for the inpatient or outpatient visit was for treatment or evaluation of PTSD.
4. The Vet Center counts were based on matching the DMDC OEF/OIF roster with Vet Center user's record through 3rd Qt FY 2007.
5. The number for "Grand Total" (n=56,246) indicates the sum of "Any Total Patients" (n=48,559) and "Vet Center PTSD" (n=14,655) after excluding known duplicates (n=6,968).

VA BENEFITS ACTIVITY
VETERANS DEPLOYED TO THE GLOBAL WAR ON TERROR
November 2007 Update

Prepared by VBA Office of Performance Analysis and Integrity
November 14, 2007

This report summarizes participation in VA benefits programs by *veterans* identified by the Department of Defense as having been deployed overseas in support of the Global War on Terror (GWOT). Information is included for the following VA programs: Compensation, Insurance, Home Loan Guaranty, Education, and Vocational Rehabilitation and Employment.

This update provides data on VA program participation for 787.196 GWOT veterans separated from military service through July 2007.

It is important to understand that because many GWOT veterans had earlier periods of service, the benefits activity identified in this report could have occurred **either prior to or subsequent to their GWOT deployment (or both).**

Chart #1 GWOT Veterans by Branch of Service

Branch of Service	Reserve Guard	Active Duty	Total
Air Force	82,236	61,906	144,142
Army	265,597	155,062	420,659
Coast Guard	327	529	856
Marine Corps	28,601	70,634	99,235
Navy	23,171	92,969	116,140
Other	4	13	17
Unknown	2,226	2,102	4,328
Total matched to VA systems	402,162	383,215	785,377
Unable to match to VA systems	927	892	1,819
Total	403,089	384,107	787,196

Note: The veteran's branch of service was obtained from VA's BIRLS system, which stores information for up to three periods of service. The branch of service associated with the most recent service date was used for the chart above.

Chart #2 Gender of GWOT Veterans

Gender	Reserve Guard	Active Duty	Total
Female	42,054	43,499	85,553
Male	356,967	336,577	693,544
Unknown	3,141	3,139	6,280
Total matched to VA systems	402,162	383,215	785,377
Unable to match to VA systems	927	892	1,819
Total	403,089	384,107	787,196

Chart #3 Age of GWOT Veterans

Age Group	Reserve Guard	Active Duty	Total
Under 20	157	280	437
20–29	135,492	247,911	383,403
30–39	119,465	74,040	193,505
40–49	105,658	51,996	157,654
50–59	35,909	7,400	43,309
60–69	4,662	277	4,939
Unknown	819	1,311	2,130
Total matched to VA systems	402,162	383,215	785,377
Unable to match to VA systems	927	892	1,819
Total	403,089	384,107	787,196

Note: Veterans' ages are calculated as the number of whole years between the date of birth in the BIRLS system. Any veteran with a missing or invalid date of birth, or where the calculated age was under 17 years or over 69 years, was placed in the "Unknown" age group.

Chart #4 Average Age of GWOT Veterans

	Reserve Guard	Active Duty
Average Age	36.0 years	30.0 years

Chart #5 Average Length of Service for GWOT Veterans Reserve

	Reserve Guard	Active Duty
Average Length of Service	3.7 years	7.7 years

Service-Connected Disability Compensation Program

VBA's computer systems do not contain any data that would allow us to attribute veterans' disabilities to a specific period of service or deployment. We are therefore only able to identify GWOT veterans who filed a disability compensation claim at some point either prior to or following their GWOT deployment. We are not able to identify which of these veterans filed a claim for disabilities incurred during their actual overseas GWOT deployment.

Many veterans file disability compensation claims for more than one condition. The table below provides information on individual GWOT veterans, not specific claimed disabilities.

Individuals included in the category "Veterans Awarded Service-Connection" are those veterans who have at least one condition that meets eligibility requirements for service connection under VA statutes and regulations. For veterans who filed a claim for more than one condition, this category contains veterans with a full grant of all conditions as well as veterans with a combination of disabilities granted and denied.

If none of a GWOT veteran's claimed conditions meet eligibility requirements under VA statutes and regulations, these individuals are included in the category "Veterans Denied Service-Connection."

Chart #6 C&P Activity Among GWOT Veterans
(Includes claims filed both prior to and following GWOT deployment)

Category	Reserves Guard	Active Duty	Total
Deployed Servicemembers	434,341	1,140,860	1,575,201
Total GWOT Veterans	403,089	384,107	787,196
Living GWOT Veterans	402,305	381,030	783,335
GWOT In-Service Deaths	784	3,077	3,861
Total GWOT Veterans with Claims Decisions	74,017	142,051	216,104
Veterans Awarded Service-Connection	63,943	134,558	198,501
Veterans Receiving Compensation	49,054	116,848	165,902
Veterans Denied Service-Connection	10,110	7,493	17,603
Veterans with Pending Claims (*as of 10–31–07*)	17,615	21,078	38,693
Veterans with Pending Reopened Claims	4,366	5,279	9,645
Pending from First-Time Claimants	13,196	15,734	28,930
Total GWOT Veterans Filing Disability Claims *	87,213	157,785	245,034

* Includes "Total GWOT Veterans with Claims Decisions" and "Pending from First-Time Claimants."

Disabilities are evaluated according to VA regulations, and the extent of the disability is expressed as a percentage from zero percent to 100 percent disabling, in increments of 10 percent. Veterans with more than one service-connected disability receive a combined disability rating.

The chart below includes GWOT veterans awarded combined service-connected disability ratings from zero percent to 100 percent, regardless of whether the veteran receives monetary compensation.

Chart #7 GWOT Veterans Awarded Service-Connection
(by Combined Degree of Disability)

Combined Degree	Reserves Guard	Active Duty	Total
0%	12,043	16,192	28,235
10%	16,351	25,495	41,846
20%	9,015	19,179	28,194
30%	7,025	19,036	26,061
40%	6,109	17,029	23,138
50%	3,292	10,200	13,492
60%	3,702	11,012	14,714
70%	2,310	6,886	9,196
80%	1,684	4,671	6,355
90%	736	1,905	2,641
100%	1,676	2,953	4,629
Total	63,943	134,558	198,501

Note: Includes corporate data. Previous reports included CPMR only.

Chart #8 Ten Most Frequent Service-Connected Disabilities for GWOT Veterans
(Both Active Duty and Reserve/Guard)

Diagnostic Code	Diagnosis Description	Count
6260	Tinnitus	64,085
5237	Lumbosacral or cervical strain	56,633
6100	Defective hearing	52,902
9411	Post Traumatic Stress Disorder	34,148
5260	Limitation of flexion of leg	30,572
5271	Limited motion of the ankle	29,200
5242	Degenerative arthritis of the spine	23,157
5299	Generalized, Elbow and Forearm, Wrist, Multiple Fingers, Hip and Thigh, Knee and Leg, Ankle, Foot, Spine, Skull, Ribs, Coccyx	21,999
7101	Hypertensive vascular disease (essential arterial hypertension)	21,931
5024	Tenosynovitis	20,582

Insurance Program Traumatic Injury Benefit

Traumatic Servicemembers' Group Life Insurance (TSGLI) is a traumatic injury protection rider under Servicemembers' Group Life Insurance (SGLI) that provides for payment to any member of the uniformed services covered by SGLI who sustains a traumatic injury that results in certain severe losses. Through October 31, 2007, 6,877 active duty servicemembers and veterans have applied for TSGLI. Of those, 3,979 were filed by GWOT veterans, and 2,142 of those received benefits.

Chart #9a GWOT Veterans Who Applied for TSGLI Benefits
(by Age)

Age Group	Reserve Guard	Active Duty	Total
Under 20	—	1	1
20–29	619	1,541	2,160
30–39	578	431	1,009
40–49	502	95	597
50–59	186	3	189
60–69	18	—	18
Unknown	—	5	5
Total	1,903	2,076	3,979

Note: The totals above reflect veterans whose claims have been approved, have been denied or are currently pending.

Chart #9b GWOT Veterans Who Received TSGLI Benefits
(by Age)

Age Group	Reserve Guard	Active Duty	Total
Under 20	—	1	1
20–29	335	990	1,325
30–39	242	272	514
40–49	135	54	189
50–59	42	—	42
60–69	1	—	1
Unknown	—	3	3
Total	755	1,320	2,075

Chart #10a GWOT Veterans Who Applied for TSGLI Benefits
(by Gender)

Gender	Reserve Guard	Active Duty	Total
Female	99	53	152
Male	1,796	2,016	3,812
Unknown	8	7	15
Total	1,903	2,076	3,979

Note: The totals above reflect veterans whose claims have been approved, have been denied or are currently pending.

Chart #10b GWOT Veterans Who Received TSGLI Benefits
(by Gender)

Gender	Reserve Guard	Active Duty	Total
Female	25	33	58
Male	741	1,336	2,077
Unknown	2	5	7
Total	768	1,374	2,142

Home Loan Guaranty Program

VA's home loan guaranty program has been helping veterans purchase homes for more than 60 years. VA guaranteed home loans are made by banks and mortgage companies to veterans, servicemembers and eligible reservists. With VA backing a portion of the loan, veterans can receive a competitive interest rate without a down payment, making it easier to buy a home.

This benefit can be used more than once if needed to (1) refinance an existing VA guaranteed loan at a lower interest rate or (2) to purchase a home that will again be used as the person's primary residence (eligible to do this normally after paying off any previous loans.)

Chart #11 Home Loan Guaranty Program Participation by GWOT Veterans

	Reserve Guard	Active Duty	Total
GWOT Veterans with VA Loan	103,419	78,003	181,422
Total Loans Made to GWOT Veterans	159,613	115,161	274,774
Dollar Amount of All Loans to GWOT Veterans	$18,111,753,284	$14,437,024,155	$32,548,777,439

Education Programs

The chart below reflects participation by GWOT veterans in VA education benefit programs since September 11, 2001. Participants may have been entitled to more than one benefit. For example, a reservist may have received Chapter 1606 benefits until he or she became eligible to receive Chapter 1607 benefits. This participant would be reported in both columns in the chart below.

Chart #12 Education Program Participation Among GWOT Veterans Since September 11, 2001

Type of Training	Chapter 30	Chapter 1606	Chapter 1607	Total
Graduate	6,509	5,867	3,292	16,711
Under Graduate	59,894	71,796	22,443	157,219
Junior College	73,355	47,657	12,111	134,166
NCD	17,213	6,920	2,426	27,027
Total	156,971	132,240	40,272	335,123

Montgomery GI Bill Active-Duty (Chapter 30) provides up to 36 months of education benefits for degree and certificate programs, flight training, apprenticeship/on-the-job training, and correspondence courses. Generally, benefits are payable for 10 years following release from active duty.

Montgomery GI Bill Selected Reserve (Chapter 1606) provides up to 36 months of education benefits to members of the reserve elements of the Army, Navy, Air Force, Marine Corps, and Coast Guard, and members of the Army National Guard, and the Air National Guard. This benefit may be used for degree and certificate programs, flight training, apprenticeship/on-the-job training, and correspondence courses. Benefits generally end the day a member separates from the Selected Reserve or National Guard. For those who are activated, eligibility is extended beyond separation for a period of time equal to time served on active duty plus 4 months.

Reserve Educational Assistance Program (REAP) (Chapter 1607) provides educational assistance to members of the Reserve components called or ordered to active duty in response to a war or national emergency as declared by the President or Congress. This new program makes certain reservists who were activated for at least 90 days after September 11, 2001, eligible for education benefits or eligible for increased benefits.

Vocational Rehabilitation and Employment (VR&E) Program—Chanter 31

Chart #13 VR&E Activity Among GWOT Veterans
(Includes participation either prior to and following GWOT deployment)

Current Case Status	Reserve Guard	Active Duty	Total
Applicant	376	881	1,257
Employment Services	134	370	504
Evaluation and Planning	1,025	2,326	3,351
Extended Evaluation	165	355	520
Independent Living	45	58	103
Interrupted	253	679	932
Rehabilitation to Employability	1,943	5,916	7,859
Unknown	86	24	110
Current Participants	4,027	10,609	14,636
Rehabilitated	696	733	1,429
Discontinued	290	294	584
Total VR&E Participants	5,013	11,636	16,649

Applicant: A veteran's case is assigned to applicant status when the VA receives an application (VAF–1900) for services under Chapter 31.

Evaluation and Planning: Determination of feasibility of a vocational goal and/or evaluation of the veteran's ability to function independently within the veteran's family and community.

Extended Evaluation: Determine the current feasibility of the veteran with a serious employment handicap to achieve a vocational goal.

Rehabilitation to Employability: Services and training necessary for entry into employment in an identified suitable occupational objective.

Independent Living Program: Services that are needed to enable a veteran to achieve maximum independence in daily living, including home accommodations, counseling, and educational services, as determined necessary.

Employment Services: Services to assist in obtaining and/or maintaining suitable employment.

Rehabilitated: The goals of a rehabilitation/employment/independent living program have been substantially achieved.

Interrupted: Temporary suspension of the program warranted due to a veteran's individual circumstances.

Discontinued: All services and benefits are terminated.

Serious Employment Handicap: A significant impairment of a veteran's ability to prepare for, obtain, or maintain employment, as determined by a VA counselor.

Sources

DoD:

- Defense Manpower Data Center (DMDC) East, cumulative count of servicemembers deployed to OEF/OIF, from September 11, 2001 through July 2007.
- DMDC West, extract of OEF/OIF servicemembers discharged to civilian status from September 2001 through July 2007.
- The DMDC list of 787,196 deployed GWOT veterans represents 50% of the cumulative deployed GWOT servicemember population of 1,575,201 through July 2007.

VBA:

- Beneficiary Identification and Records Locator Subsystem (BIRLS), as of the end of the month October 2007.
- Compensation and Pension Master Record (CPMR), active records ("A" type) as of the end of the month October 2007.

- CPMR, terminated records ("E" type) as of the end of the month September 2007.
- Corporate records as of November 01, 2007.
- Pending *Issue* File (PI F), as of the close of business on October 31, 2007.
- Vocational Rehabilitation and Employment Service Chapter 31 file, as of the end of the month September 2007.
- Loan Guaranty data, as of November 05, 2007.
- TSGLI file, as of October 31, 2007.
- Education Service data, as of the end of September 2007.

Questions

Questions may be referred to the Office of Performance Analysis and Integrity at (202) 461–9040.

Analysis of VA Healthcare Utilization
Among U.S. Global War on Terrorism (GWOT) Veterans

Operation Enduring Freedom
Operation Iraqi Freedom

VHA Office of Public Health and Environmental Hazards
October 2007

Current DoD Roster of Recent War Veterans

- Evolving roster development by DoD Defense Manpower Data Center (DMDC)
  - In September 2003, DMDC developed an initial file of "separated" troops who had been deployed to the Iraqi and Afghan theater of operations using proxy files: Active Duty and Reserve Pay files, Combat Zone Tax Exclusion, and Imminent Danger Pay data.
  - In September 2004, DMDC revised procedures for creating periodic updates of the roster and now mainly utilizes direct reports from service branches of previously deployed OEF (Operation Enduring Freedom) and OIF (Operation Iraqi Freedom) troops.
  - DMDC is actively addressing the limitations of the current roster to improve the accuracy and completeness of future rosters.
- Latest update of roster
  - Provided to Dr. Kang, Veterans Health Administration (VHA) Environmental Epidemiology Service, on July 27, 2007.
- Qualifications of DoD's OEF/OIF deployment roster
  - Contains list of veterans who have left active duty and does not include currently serving active duty personnel.
  - Does not distinguish OEF from OIF veterans.
  - Roster only includes separated OEF/OIF veterans with out-of-theater dates through May 2007.
  - 3,638 veterans who died in-theater are not included.

Updated Roster of OEF and OIF Veterans Who Have Left Active Duty

- 751,273 OEF and OIF veterans who have left active duty and become eligible for VA healthcare since FY 2002.
  - 48% (362,237) Former Active Duty troops.
  - 52% (389,036) Reserve and National Guard.

Use of DoD List of War Veterans Who Have Left Active Duty

- This roster is used to check the VA's electronic inpatient and outpatient health records, in which the standard ICD–9 diagnostic codes are used to classify health problems, to determine which OEF/OIF veterans have accessed VA healthcare as of June 30, 2007.
- The data available for this analysis are mainly administrative information and are not based on a review of each patient record or a confirmation of each diagnosis. However, every clinical evaluation is captured in VHA's computerized patient record. The data used in this analysis are excellent for healthcare planning purposes because the ICD–9 administrative data accurately reflects the need for healthcare resources, although these data cannot be considered epidemiologic research data.

- These administrative data have to be interpreted with caution because they **only apply to OEF/OIF veterans who have accessed VHA healthcare** due to a current health question. These data do not represent all 751,273 OEF/OIF veterans who have become eligible for VA healthcare since FY 2002 or the approximately 1.5 million troops who have served in the two theaters of operation since the beginning of the conflicts in Iraq and Afghanistan.
- Because VA health data are not representative of the veterans who have not accessed VA healthcare, formal epidemiological studies will be required to answer specific questions about the overall health of recent war veterans.
- Analyses based on this updated roster are not directly comparable to prior reports because the denominator (number of OEF/OIF veterans eligible for VA healthcare) and numerator (number of veterans enrolling for VA healthcare) change with each update.
- This report presents data from VHA's healthcare facilities and does not include Vet Center data or DoD healthcare data.
- The following healthcare data are **"cumulative totals"** since FY 2002 and *do not represent data from any single year*.
- The numbers provided in this report should not be added together or subtracted to provide new data without checking on the accuracy of these statistical manipulations with VHA's Office of Public Health and Environmental Hazards.

VA Healthcare Utilization from FY 2002 to 2007 (3rd QT) Among OEF and OIF Veterans

- **Among all 751,273 separated OEF/OIF Veterans**
  - **35% (263,909)** of total separated OEF/OIF veterans have obtained VA healthcare since FY 2002 (cumulative total).
    - **96%** (253,730) of 263,909 evaluated OEF/OIF patients have been seen as outpatients only by VA and not hospitalized.
    - **4%** (10,179) of 263,909 evaluated OEF/OIF patients have been hospitalized at least once in a VA healthcare facility.

VA Healthcare Utilization for FY 2002–2007 (3rd QT) by Service Component

- **362,237 Former Active Duty Troops.**
  - **36%** (132,194) have sought VA healthcare since FY 2002 (cumulative total).
- **389,036 Reserve/National Guard Members.**
  - **34%** (131,715) have sought VA healthcare since FY 2002 (cumulative total).

Comparison of VA Healthcare Requirements

The cumulative total of 263,909 OEF/OIF veterans evaluated by VA over approximately 5 years from FY 2002 to FY 2007 (3rd QT) represents about 5% of the 5.5 million individual patients who received VHA healthcare in any 1 year (total VHA patient population of 5.5 million in 2006).

Frequency Distribution of OEF and OIF Veterans According to the VISN Providing the Treatment

Treatment Site		*OEF–OIF Veterans Treated at a VA Facility**	
		Frequency	*%*
• VISN 1	VA New England Healthcare System	12,336	4.7
• VISN 2	VA Healthcare Network Upstate New York	7,460	2.8
• VISN 3	VA New York/New Jersey Healthcare System	10,255	3.9
• VISN 4	VA Stars & Stripes Healthcare System	12,709	4.8
• VISN 5	VA Capital Healthcare System	6,981	2.7
• VISN 6	VA Mid-Atlantic Healthcare System	14,437	5.5
• VISN 7	VA Atlanta Network	18,941	7.2
• VISN 8	VA Sunshine Healthcare Network	22,107	8.4
• VISN 9	VA Mid-South Healthcare Network	15,527	5.9
• VISN 10	VA Healthcare System of Ohio	7,310	2.8

Frequency Distribution of OEF and OIF Veterans According to the VISN Providing the Treatment—Continued

Treatment Site		*OEF–OIF Veterans Treated at a VA Facility**	
		Frequency	*%*
• VISN 11	Veterans in Partnership Healthcare Network	9,462	3.6
• VISN 12	VA Great Lakes Healthcare System	16,031	6.1
• VISN 15	VA Heartland Network	9,310	3.5
• VISN 16	South Central VA Healthcare Network	22,950	8.7
• VISN 17	VA Heart of Texas Healthcare Network	16,181	6.1
• VISN 18	VA Southwest Healthcare Network	13,586	5.2
• VISN 19	VA Rocky Mountain Network	11,176	4.2
• VISN 20	VA Northwest Network	15,249	5.8
• VISN 21	VA Sierra Pacific Network	12,050	4.6
• VISN 22	VA Desert Pacific Healthcare Network	21,559	8.2
• VISN 23	VA Midwest Healthcare Network	14,903	5.7

*Veterans can be treated in multiple VISNs. A veteran was counted only once in any single VISN but can be counted in multiple VISN categories. The total number of OEF–OIF veterans who received treatment (n = 263,909) was used to calculate the percentage treated in any one VISN.

Demographic Characteristics of OEF and OIF Veterans Utilizing VA Healthcare

		Percent OEF/OIF Veterans (n = 263,909)
Sex	**Male**	**88**
	Female	**12**
Age Group	**<20**	**5**
	20–29	**52**
	30–39	**23**
	≥40	**20**
Branch	**Air Force**	**12**
	Army	**65**
	Marine	**12**
	Navy	**11**
Unit Type	**Active**	**50**
	Reserve/Guard	**50**
Rank	**Enlisted**	**92**
	Officer	**8**

Diagnostic Data

- Veterans of recent military conflicts have presented to VHA with a wide range of possible medical and psychological conditions.
- Health problems have encompassed more than 8,000 discrete ICD–9 diagnostic codes.
- The three most common possible health problems of war veterans were musculoskeletal ailments (principally joint and back disorders), mental disorders, and "Symptoms, Signs and Ill-Defined Conditions."
- As in other outpatient populations, the ICD–9 diagnostic category, "Symptoms, Signs and Ill-Defined Conditions," was commonly reported. It is important to understand that this is not a diagnosis of a mystery syndrome or unusual illness. This ICD–9 code includes symptoms and clinical finding that are not coded elsewhere in the ICD–9. It is a diverse, catch-all category that is commonly used for the diagnosis of outpatient populations. It encompasses more

than 160 sub-categories and primarily consists of common symptoms that do not have an immediately obvious cause during a clinic visit or isolated laboratory abnormalities that do not point to a particular disease process and may be transient.

Frequency of Possible Diagnoses Among OEF and OIF Veterans

Diagnosis (Broad ICD–9 Categories)	(n = 263,909)	
	Frequency *	Percent
Infectious and Parasitic Diseases (001–139)	28,665	10.9
Malignant Neoplasms (140–208)	2,193	0.8
Benign Neoplasms (210–239)	9,129	3.5
Diseases of Endocrine/Nutritional/Metabolic Systems (240–279)	50,968	19.3
Diseases of Blood and Blood Forming Organs (280–289)	5,086	1.9
Mental Disorders (290–319)	100,580	38.1
Diseases of Nervous System/Sense Organs (320–389)	83,273	31.6
Diseases of Circulatory System (390–459)	39,633	15
Disease of Respiratory System (460–519)	49,464	18.7
Disease of Digestive System (520–579)	81,427	30.9
Diseases of Genitourinary System (580–629)	25,561	9.7
Diseases of Skin (680–709)	38,791	14.7
Diseases of Musculoskeletal System/Connective System (710–739)	117,424	44.5
Symptoms, Signs and Ill Defined Conditions (780–799)	93,093	35.3
Injury/Poisonings (800–999)	48,736	18.5

*These are cumulative data since FY 2002, with data on hospitalizations and outpatient visits as of June 30, 2007; veterans can have multiple diagnoses with each healthcare encounter. A veteran is counted only once in any single diagnostic category but can be counted in multiple categories, so the above numbers add up to greater than 263,909.

Frequency of Possible Mental Disorders Among OEF/OIF Veterans Since 2002 *

Disease Category (ICD 290–319 code)	Total Number of GWOT Veterans **
PTSD (ICD–9CM 309.81) †	**48,559**
Nondependent Abuse of Drugs (ICD 305) ‡	**40,320**
Depressive Disorders (311)	**32,815**
Neurotic Disorders (300)	**25,746**
Affective Psychoses (296)	**18,069**
Alcohol Dependence Syndrome (303)	**8,062**
Sexual Deviations and Disorders (302)	**4,550**
Special Symptoms, Not Elsewhere Classified (307)	**4,581**
Drug Dependence (304)	**3,613**
Acute Reaction to Stress (308)	**3,130**

**Note*—These are cumulative data since FY 2002. ICD diagnoses used in these analyses are obtained from computerized administrative data. Although diagnoses are made by trained healthcare providers, up to one-third of coded diagnoses may not be confirmed when initially coded because the diagnosis is "rule-out" or provisional, pending further evaluation.

**A total of 100,580 unique patients received a diagnosis of a possible mental disorder. A veteran may have more than one mental disorder diagnosis and each diagnosis is entered separately in this table; therefore, the total number above will be higher than 100,580.

†This row of data does not include information on PTSD from VA's Vet Centers and does not include veterans not enrolled for VHA healthcare. Also, this row of data does not include veterans who did not have a diagnosis of PTSD (ICD 309.81) but had a diagnosis of adjustment reaction (ICD–9 309).

‡81% of these veterans (32,700) had a diagnosis of tobacco use disorder (ICD–9 305.1).

Summary

- Recent OEF and OIF veterans are presenting to VA with a wide range of possible medical and psychological conditions.
- Recommendations cannot be provided for particular testing or evaluation—veterans should be assessed individually to identify all outstanding health problems.
- Thirty-five percent of separated OEF/OIF veterans have received healthcare from VA since 2002 compared to 35% in the last quarterly update. Although the percentage of war veterans seen by VA remained the same in this quarter, the percentage of OEF/OIF veterans receiving healthcare from VA and the percentage with any type of diagnosis will tend to increase over time as these veterans continue to enroll for VA healthcare and to develop new health problems, as true for other cohorts of military veterans.
- Because the 263,909 OEF and OIF veterans who have accessed VA healthcare were not randomly selected and represent just 18% of the approximately 1.5 million recent OEF/OIF veterans, they do not constitute a representative sample of all OEF/OIF veterans.
- Reported diagnostic data are only applicable to the 263,909 VA patients—a population actively seeking healthcare—and not to all OEF/OIF veterans.

  For example, the fact that about 38% of VHA patients' encounters were coded as related to a possible mental disorder does not indicate that approximately 1/3 of all recent war veterans are suffering from a mental health problem. Only well-designed epidemiological studies can evaluate the overall health of OEF/OIF war veterans.
- High rates of VA healthcare utilization by recent OEF/OIF veterans reflect the fact that these combat veterans have ready access to VA healthcare, which is free of charge for 2 years following separation for any health problem possibly related to wartime service.

  Also, an extensive outreach effort has been developed by VA to inform these veterans of their benefits, including the mailing of a personal letter from the VA Secretary to war veterans identified by DoD when they separate from active duty and become eligible for VA benefits.
- When a combat veteran's 2-year healthcare eligibility passes, the veteran will be moved to their correct priority group and charged all co-payments as applicable. If their financial circumstances place them in Priority Group 8, their enrollment in VA will be continued, regardless of the date of their original VA application.

Follow-Up

VA will continue to monitor the healthcare utilization of recent Global War on Terrorism veterans using updated deployment lists provided by DoD to ensure that VA tailors its healthcare and disability programs to meet the needs of this newest generation of OEF/OIF war veterans.

Contingency Tracking System (CTS) Deployment File for Operation Enduring Freedom & Iraqi Freedom

As of: October 31, 2007

	Total Deployment Events	Number of Members with Only One Deployment [1]	Number of Members with More Than One Deployment [2]	Total Number of Members Ever Deployed	Number of Members Currently Deployed
Army Active Duty	747,160	309,604	184,861	494,465	138,185
Army National Guard	234,214	164,358	31,694	196,052	23,864
Army Reserve	137,415	88,651	21,513	110,164	12,143
Army Total [3]	**1,118,789**	**562,613**	**238,068**	**800,681**	**174,192**
Navy Active Duty	417,409	178,716	98,210	276,926	35,894
Navy Reserve	38,984	21,258	6,198	27,456	4,244
Navy Total [4]	**456,393**	**199,974**	**104,408**	**304,382**	**40,138**
Air Force Active Duty	401,918	134,669	99,415	234,084	23,612
Air National Guard	116,638	29,142	28,952	58,094	3,079
Air Force Reserve	82,788	16,585	16,260	32,845	1,690
Air Force Total [5]	**601,344**	**180,396**	**144,627**	**325,023**	**28,381**
Marine Corps Active Duty	271,164	104,786	73,547	178,333	27,953
Marine Corps Reserve	34,372	26,712	3,686	30,398	4,439
Marine Corps Total [6]	**305,536**	**131,498**	**77,233**	**208,731**	**32,392**
DoD Active Duty Total	**1,837,651**	**727,775**	**456,033**	**1,183,808**	**225,644**

DoD National Guard Total	**350,852**	**193,500**	**60,646**	**254,146**	**26,943**
DoD Reserve Total	**293,559**	**153,206**	**47,657**	**200,863**	**22,516**
DoD Total	**2,482,062**	**1,074,481**	**564,336**	**1,638,817**	**275,103**
Coast Guard Active Duty	3,463	2,439	423	2,862	274
Coast Guard Reserve	232	205	10	215	3
Coast Guard Total[7]	**3,695**	**2,644**	**433**	**3,077**	**277**
Active Duty Total	**1,841,114**	**730,214**	**456,456**	**1,186,670**	**225,918**
National Guard Total	**350,852**	**193,500**	**60,646**	**254,146**	**26,943**
Reserve Total	**293,791**	**153,411**	**47,667**	**201,078**	**22,519**
Total	**2,485,757**	**1,077,125**	**564,769**	**1,641,894**	**275,380**

[1] Two or more deployment events with overlapping participation dates are considered a single deployment.

[2] For purposes of counting "deployments" by member, location is not considered. Breaks between deployments or "dwell times" of less than 21 days are considered to be a single deployment in CTS. This is done in order to account for legitimate breaks in a deployment such as R&R or emergency leave.

[3] *Army Source:* Joint Personnel Theater Database (JPTR), Deployed Theater Accountability System (DTAS) & Defense Finance and Accounting Service (DFAS) submissions for members earning Combat Zone Tax Exclusion (CZTE) or Imminent Danger Pay (IDP).

[4] *Navy Source:* Individual Tempo (ITEMPO) & DFAS submissions for members earning CZTE or IDP.

[5] *Air Force Source:* Deliberate Crisis Action Planning & Execution Segment (DCAPES) & DFAS submissions for members earning CZTE or IDP.

[6] *Marine Corps Source:* Marine Corps Total Force System (MCTFS) Crisis File & DTAS.

[7] *Coast Guard Source:* DFAS submissions for members earning CZTE or IDP.

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VA Fact Sheet: Impact of Iraq and Afghanistan Wars

- **Department of Defense Deployments, as of Oct. 31, 2007:**
  - Cumulative U.S. servicemembers deployed: **1,641,894**
    - Still remaining in the military: **854,698** (52%)
    - Veterans eligible for VA healthcare and benefits: **787,196** (48%)
- **Veterans Health Administration (VHA), as of Dec. 21, 2007:**
  - Patients treated: **263,909** (34% of veterans)
  - Diagnosed with a mental health condition: **100,580** (38% of patients)
  - Diagnosed with PTSD: **56,246** (21% of patients)
  - Counseled at Vet Centers: **242,000** (31% of veterans)
- **Veterans Benefits Administration (VBA), as of Nov. 14, 2007:**
  - Filed a disability claim: **245,034** (31% of veterans)
  - Still waiting for an answer: **38,693** (16% of claims filed)
  - Approved for a PTSD claim: **34,138** (65% of VHA patients)
  - Average wait time for BVA to process a claim: **More than 6 months**
- **Comparison of Active Duty with National Guard and Reserve:**
  - Veterans who served on Active Duty: **384,107** (49%)
  - Veterans activated for Guard/Reserve: **403,089** (51%)
  - Active Duty veterans with claims filed: **157,785** (41%)
  - Guard/Reserve veterans with claims filed: **87,213** (22%)
  - Active Duty veterans with claims rejected by VBA: **7, 493** (5%)
  - Guard/Reserve veterans with claims rejected by VBA: **10,110** (14%)
- **40 Year Estimate of War Costs by Harvard University, Jan. 2007:**
  - New veteran patients: **700,000**
  - New veteran claims: **700,000**
  - Financial cost to U.S. taxpayers: **$350 billion to $700 billion**

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DoD Fact Sheet: Casualties From Iraq and Afghanistan Wars

DoD Reports 72,043 Battlefield Casualties Among 1.6 Million Deployed Since 2001

Casualty Category	Afghanistan War (OEF)	Iraq War (OIF)	Total of Both Wars
Dates	Oct. 7, 2001–Jan. 5, 2008	Mar. 23, 2003–Jan. 5, 2008	Through Jan. 5, 2008
Total Deaths	471	3,901	4,371
Total Wounded, Injured, and Ill	8,264	59,407	67,671
Total War Casualties	8,735	63,308	72,043

Deployment to War Zones	Dates	Servicemembers
Cumulative Number Deployed	Sep. 2001–Oct. 31, 2007	1,641,894
Deployed Twice or More	Sep. 2001–Oct. 31, 2007	564,769

Source: Department of Defense
Afghanistan War (OEF): http://siadapp.dmds.osd.mil/personnel/CASUALTY/WOTSUM.pdf
Irag War (OIF): http://siadappdmdc.osd.mil/personnel/CASUALTY/OIF–Total.pdf

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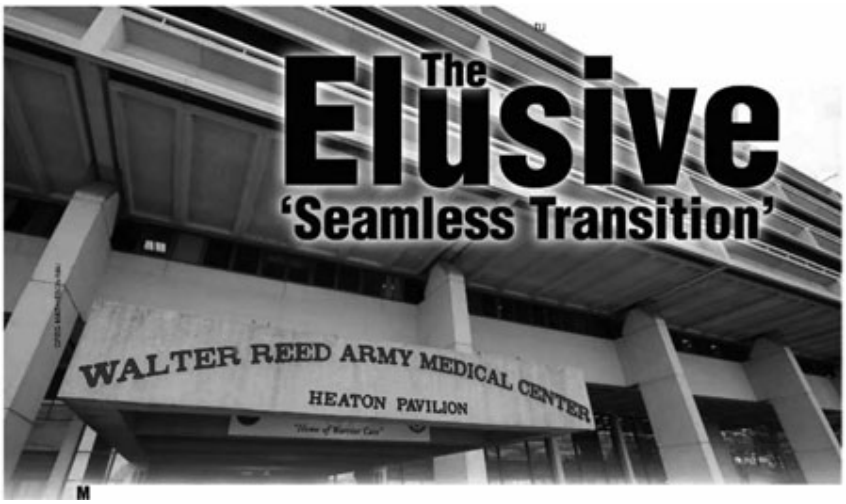
The Elusive 'Seamless Transition'



Many wounded servicemembers discharged after serving in Iraq or Afghanistan must cope with confusing—and often conflicting—systems. In moving from 000 medical care and disability benefits to those provided by the VA. For some veterans, it can be a nightmare.

By Art Pine*

In a perfect world, it would be a seamless transition. Severely wounded troops returning from Iraq and Afghanistan and discharged from the service would be able to get medical care and disability compensation payments—and a full range of benefits—from the Department of Veterans Affairs immediately. Red tape would be minimal. Counselors would help servicemember's cope with the paperwork and arrange for appointments. The veterans' military medical records would be waiting at VA facilities when they got there. Help for families would be readily available. Ideally, the entire transition would take no more than a month.

Instead, over the past 4 years, many returning Soldiers and Marines—a good number having lost arms or legs or suffered from traumatic brain injury (TBI) or post traumatic stress disorder (PTSD)—have run into a bureaucratic nightmare. Confusing regulations have mandated separate physical examinations by the Department of Defense (DoD) and the VA, often with differing outcomes involving a servicemember's disability rating. The waiting time for VA compensation checks and other benefits frequently has ranged from 6 months to 2 years—and appeals can prolong the process even more. The VA's own rulings have sometimes been inaccurate or inconsistent. And veterans, some of them unable to battle the bureaucratic dragons, have often come out the losers.

Not surprisingly, the "seamless transition" problem, as it has come to be known, has exploded into a major controversy. A series of articles in the *Washington Post* a year ago, which highlighted the problems facing outpatients at Walter Reed Army Medical Center in Washington, has spawned several high-level investigations—including an independent review ordered by Defense Secretary Robert M. Gates and the separate Dole-Shalala report, written by a bipartisan commission—to look into the problem and make recommendations. Congress just passed legislation designed to fix some of the glitches.

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Under pressure from all sides, DoD and the VA have begun working together to correct some of the problems. Over the past few months, the two Departments have hired more counselors and ombudsmen to guide sick and wounded veterans through the transition process. They have established a pilot program that would provide for a single physical examination that would serve both the military and the VA. And they have placed VA–DoD "recovery coordinators" at major military installations to improve cooperation between the Departments.

But some veterans' groups are skeptical that such efforts will solve the problem anytime soon. Paul Sullivan, a former VA official who now serves as executive director of Veterans for Common Sense, a Washington-based advocacy group that has focused on the seamless transition problem, argues that while the situation "is getting better," it will take years—even decades—for the glitches to be fixed.

"The veterans don't have that kind of time," Sullivan says. "They should not have to wait."

A Major Overhaul Needed

Sullivan, a Gulf War veteran with 15 years' experience in dealing with the VA, advocates a major overhaul of the Department to significantly simplify its regulations and procedures, greatly enlarge its staff and make veterans' benefits a full-fledged entitlement program—much like Social Security—that isn't vulnerable to political whims. He also wants the VA to upgrade the qualifications of the counselors who help veterans apply for benefits, many of whom are retired senior enlisted personnel without legal training or college degrees.

The congressional watchdog agency, the Government Accountability Office (GAO), also has called repeatedly for a major overhaul of VA procedures for determining disability compensation.

By any standard, overhauling the current system wouldn't be cheap. Although no one seems to have firm figures on how much it would take to erase the problems, estimates range to tens of billions of dollars over the next few years. "You have a systemic problem that can only be solved by simplifying the system," says Linda Bilmes, a Harvard University government expert who did a study on the seamless transition problem last year. "It's inevitably going to take a long time to resolve."

Although the waiting time for VA medical care often is long, by far the lion's share of the complaints about the transition stem from the extended length of time it takes to obtain VA compensation benefits. On the whole, returning troops seem satisfied with the military medical care they receive, which is considered of high quality. And the separate VA healthcare system is readily available to newly discharged combat veterans, and is top-notch to boot. "I don't think I ever got a complaint about the VA's medical care," says John F. Sommer Jr., national executive director of the American Legion, reflecting an upsurge in the Department's performance over the past decade. "There's little problem with the quality of healthcare once people get into the system."

The frustrations stem not just from the VA, but also from the whole gamut of procedures and delays, starting with the military's own medical discharge procedures. The combination has created a bureaucratic obstacle course—and, often, a financial hardship for Iraq and Afghanistan veterans who try to make the shift. "The problem is that veterans have to navigate among four separate systems—military medicine, military disability pensions, VA healthcare, and VA disability compensation benefits," says Sullivan of Veterans for Common Sense. "It's terribly confusing for almost everybody."

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The Nuts and Bolts

Here's how the system works.

Under longstanding regulations, seriously wounded troops are returned to one of a handful of military hospitals for medical treatment and recovery—primarily Walter Reed Army Medical Center in Washington, the National Naval Medical Center at Bethesda, Maryland, and Brooke Army Medical Center in San Antonio. After surgery or other treatment, they're put into rehabilitation programs for a while and then kept on as outpatients. Eventually, the military services' own physicians decide they've essentially done all they can for the medium-term, and it's time to decide whether the servicemember should remain in the military or be discharged or retired.

When that time comes, physicians on a medical evaluation board, or MEB, from the individual's service review the case and decide whether they think the servicemember involved is fit for duty. If he (or she) is deemed fit, he's kept on active-duty and transferred back to a "Warrior Transition Unit" that helps manage his rehabilitation schedule and prepares him for another duty assignment. If he's not deemed fit, the board recommends that he be separated from the service. For those who are considered unfit, the next step is to decide whether the servicemember should be "medically retired" or merely discharged. Physicians on a physical evaluation board, or PEB, decide how disabled the servicemember has been made by the single specific injury that made him unfit for duty—a loss of limb or a serious head wound, for example. If it's 30 percent or more, the servicemember is offered retirement status, with a lifetime package that includes a pension, medical treatment for himself and his family, commissary privileges, and an array of other benefits.

Those given disability ratings of zero to 20 percent are not offered retirement but instead are discharged, and given a lump-sum severance payment. DoD often informally advises these servicemembers to apply to the VA for medical care and compensation, where they have a prospect of receiving a higher disability for a servicemember who is suffering from mild traumatic brain injury or from PTSD, the process is especially daunting, Beck says. It's hard enough to navigate the system when your mental faculties are in place, but having a mental disability that makes it difficult for you to concentrate, for instance, makes following the process almost impossible, she says. Family members rarely have the expertise or familiarity with the system to be of much help. As a result, some veterans end up cash-strapped for months until the cash payments begin to flow. Others fall through the cracks entirely.

Not Always Easy

But doing that isn't always easy. Although veterans of Iraq and Afghanistan are entitled to temporary VA medical care without conditions, they must undergo a separate physical exam to decide how much, if anything, they'll receive in compensation and benefits from the VA's Veterans Benefits Administration. They have to fill out significant amounts of paperwork. They must submit their complete medical records from the military, which often are incomplete or even illegible. And they are responsible for keeping their appointments with physicians, clinics, and bureaucrats, no matter what their physical or mental condition.

Bewildering for many veterans is that the VA's own medical examination uses different criteria for assigning a disability rating than do the military's physical examination boards, and each of the four services has its own individual standards. DoD's physical evaluation is concerned only with the single specific injury (such as the loss of a limb) that has made the servicemember unfit for duty. By contrast, the VA examination looks at all the veteran's physical and mental ailments to determine the extent to which all of his service-connected impairments have limited his capacity to function in the civilian workforce and thus what his lifetime compensation payments ought to be. So while the PEB might score a Soldier or Marine at 20 percent, the VA could assign a score of 80 percent. To add to the problem, the just-discharged veteran faces an often-dizzying array of potential problems.

The VA uses an electronic recordkeeping system, but until recently DoD medical records were largely kept on paper. Thus information can't be transferred between the two Departments automatically. In most cases, newly discharged servicemembers must carry their paper records to the VA by hand. If the records aren't complete, it's often difficult for an individual veteran to obtain the missing portions. If he overlooks a report—or doesn't know that it exists—he may never find out about the omission.

The menu of VA and other government benefits including education grants and Social Security disability payments—is so large and complex that even experienced veterans' advocacy groups have trouble coping with it. The application form alone that veterans must fill out to obtain VA benefits is 26 pages long; the program descriptions and regulations fill a book half an inch thick; and the manual that staffers use to compile disability ratings is 2 inches thick.

Time-Consuming Process

The process of making appointments with physicians, lab technicians, counselors, and bureaucrats is time-consuming and requires frequent followup by the veteran, particularly for those with multiple impairments, which involve several specialists and rehabilitation clinics. Dealing with the bureaucracy also is a problem. Veterans' organizations say their constituents too often receive letters that are contradictory or in error. It often takes hours of work and attention to straighten things out.

"It's like being on the phone with your health insurance company all day, every day," says Meredith Beck, national policy director for the Wounded Warrior Project, an advocacy group based in Jacksonville, Florida, that has focused on the seamless transition problem.

For a servicemember who is suffering from mild traumatic brain injury or from PTSD, the process is especially daunting, Beck says. It's hard enough to navigate the system when your mental faculties are in place, but having a mental disability that makes it difficult for you to concentrate, for instance, makes following the process almost impossible, she says. Family members rarely have the expertise or familiarity with the system to be of much help. As a result, some veterans end up cash-strapped for months until the cash payments begin to flow. Others fall through the cracks entirely.

NEW SECRETARY Retired Army Lieutenant General James Peake, a physician, was sworn in as Secretary of Veterans Affairs on 20 December 2007. Here he takes his first tour of the new rehabilitation facilities at Walter Reed Army Hospital and talks to Marine Lance Corporal Josh Bliell. Officials of both the VA and the various services are seeking to simplify and accelerate the transition of wounded troops from one organization to the other.

Both the GAO and veterans groups say the system isn't equipped to handle claims involving TBI, PTSD, and other mental problems efficiently. Critics say there's such a stigma attached to mental illnesses in the military that many returning soldiers won't report them.

What Went Wrong

The roots of the whole seamless transition problem go well back into bureaucratic history. The DoD and VA procedures that have created it have been in force for decades—some dating back to the end of World War II. But the volume of returning veterans wasn't sufficient to clog the system then, and even during the Vietnam War the problem didn't come to public attention. Many seriously wounded Soldiers and Marines simply died on the battlefield, and the ones who did come home and were discharged, rather than retired, were sent to VA hospitals, where they were treated as inpatients.

The post-9/11 attack on Afghanistan and invasion of Iraq (in 2001 and 2003, respectively) changed all that dramatically. To begin with, the conflicts have gone on far longer than most top policymakers anticipated. In both wars, expectations were for a quick military victory, followed by a handover of power to the countries' own governments. A lengthy occupation, opposed by insurgents using IEDs, car bombs, and suicide bombers—and, eventually, extended and repeat deployments—weren't even on the drawing boards. Top U.S. generals and senior Bush Administration officials spoke of a quick campaign of "shock and awe" in Iraq, followed by a prompt withdrawal of American troops.

At the same time, improvements in military medicine have enabled a far greater share of seriously wounded troops to survive and return home for treatment. Better body armor protects more U.S. warfighters against explosions and bullets. Today's highly skilled medics can treat battlefield injuries more successfully, using new techniques such as one-handed tourniquets and clotting bandages. And rapid evacuation by helicopter is a matter of course. Today, only 10 percent of those wounded in battle ultimately die, compared to 30 percent in Vietnam. At the same time, the proportion of those losing arms or legs has doubled to 6 percent, from 3 percent before.

To add to the strain on stateside facilities, the combination of near-miracle medical technology and heightened pressures for cost cutting has changed the way American medicine treats such cases—and perversely contributes to the seamless transition problem. Where previous generations of wounded veterans had been treated almost entirely in hospitals, now they're released to go home and return for medical attention solely as outpatients.

Finally, the long occupation and the frequency of injuries from car bombs, IEDs, and suicide bombers have brought a sharp increase in cases of TBI and PTSD that the military had little experience in recognizing and treating in previous conflicts. (Those who suffered from PTSD during the Vietnam War were discharged and sent to VA hospitals.) It often compounds the physical wounds that the troops who served in Iraq and Afghanistan bring home.

The rival and often lethargic DoD and VA bureaucracies showed little real enthusiasm for cooperating with one another to help fix the problems. And no one at the top—anywhere in government—was pushing for a major overhaul.

Overwhelming the System

The combination of factors quickly overwhelmed both the military and the VA—and seriously exacerbated the glitches in the transition process. Before 2001, the year that the United States attacked Afghanistan, the number of pending claims for disability compensation stood at 69,000, and only a third of them had been in process for more than 6 months. By Fiscal Year 2007, which ended 30 September, the number had soared to 392,000 pending claims, and the VA was taking an average of 181 days to process them. For servicemembers who choose to appeal the VA's initial decision, the average time taken to resolve the case topped 650 days.

"It's too long, no doubt about it—much longer than I would like," concedes retired Navy Vice Admiral Daniel L. Cooper, the VA Under Secretary who heads the Department's Veterans Benefits Administration, the VA branch that deals with compensation and benefits. He says the Department hopes to bring processing time down in coming months.

By early 2004, the potential magnitude of the seamless transition problem was clearly apparent. Veterans' groups were reporting increasing numbers of serious problems. The GAO was issuing reports pointing out significant failures in the system. And lawmakers were regularly expressing outrage about cases involving their constituents.

Once the war in Iraq began, in March 2003, there were other pressures that made tackling the seamless transition problem elusive. With the conflict already proving more difficult than Washington had anticipated, the Bush Administration was reluctant to spotlight the greater-than-expected casualties. At the same time, the Federal Office of Management and Budget, faced with mushrooming domestic spending and a push for a smaller military, was leaning on departments and agencies to hold down nonmilitary spending. The VA sharply underestimated its own needs in FY 2006 and 2007, and had to seek billions of dollars in supplemental appropriations. The rival and often lethargic DoD and VA bureaucracies showed little real enthusiasm for cooperating with one another to help fix the problems. And no one at the top—anywhere in government—was really pushing for a major overhaul.

Slow Start

As might be expected, the government's reaction—in the VA, DoD, the White House, and Congress—wasn't instantaneous. In August 2003, then-VA Secretary Anthony Principi formally recognized the problem and put together a "Seamless Transition Task Force" to tackle it within the Department. The group eventually issued a report, but little was done by the time Principi left at the end of 2004.

What changed the equation was the February 2007 *Washington Post* series on Walter Reed, written by Dana Priest and Anne Hull. The articles became best known for exposing the dilapidated, mold-infested temporary housing units in the medical center's Building 18, in which severely wounded servicemembers and their families were living, but the most telling part of the series described the bureaucratic run-around they had received from hospital personnel who had been tasked with arranging for outpatient rehabilitation care, military disability ratings, and VA benefits.

"The *Post* series was about Walter Reed, but it described the same kinds of symptoms that exist in the seamless transition problem," says retired Lieutenant General Charles H. Roadman II, a former Surgeon General of the Air Force who later served on an independent DoD-appointed commission charged with investigating conditions at Walter Reed.

Walter Reed "brought the problem into the national consciousness" and led to a speedup in efforts to deal with the problem, says Paul Rieckhoft, executive director and founder of Iraq and Afghanistan Veterans of America, a New York-based advocacy group that has focused on the seamless transition problem.

The horror stories are legion. Newspapers all over the country have been running articles about returning Soldiers and Marines who have experienced serious difficulties in obtaining medical care and compensation benefits, which often leave them in a major financial bind, and seriously depressed.

Federal officials contend that some of the difficulties nationally may have been exaggerated. Although the United States has sent 1.6 million combat troops to Iraq and Afghanistan since hostilities began, there have been 66,000 cases over that period in which servicemembers have been wounded, injured, or taken ill on the battlefield. The total number of Iraq and Afghanistan veterans who have lost a limb is about 730—much lower than popular perceptions suggest. Indeed, there's a serious dispute over how big the seamless transition problem is. The VA's Vice Admiral Cooper estimates that after eliminating those wounded and severely ill Iraq and Afghanistan veterans who are granted medical retirements—and thus receive pensions from the military—the number adversely affected by the lack of a seamless transition to the VA amounts to fewer than 2,000 a year.

But Sullivan of Veterans for Common Sense argues that that definition is too narrow—and misleading. "It's true that there are about 2,000 servicemembers a year who are in the 'very seriously wounded' category," he says, "but the VA is now treating some 264,000 veterans of the two conflicts," and even those who qualify for military medical care may apply for VA disability compensation payments, which particularly benefit those in lower ranks. "The VA didn't prepare for this massive influx of claims," he says. "It's trying to narrow the definition so they can say there's no problem."

Critics question whether what is being done is really enough. Retired Air Force Major General Charles H. Roadman II cautions that the pilot projects, if successful, must be expanded rapidly, without the usual bureaucratic delays. 'There's a tendency to "pilot" things to death,' he notes.

COMMAND INTEREST Defense Secretary Robert M. Gates and Admiral Edmund Giambastiani, then Vice Chairman of the Joint Chiefs of Staff, meets with wounded troops at Walter Reed Army Medical Center in February 2007 to discuss problems at the hospital expanded to include severe difficulties encountered by servicemembers moving from the military medical system to VA healthcare.

Taking It Seriously

In the wake of the *Washington Post* series, all sides have begun taking the problem more seriously. The Bush Administration has ordered three separate investigations of the system by bipartisan commissions that have released reports this year—a special Independent Review Group named by Defense Secretary Gates, which looked into the situation at Walter Reed and Bethesda; the President's Commission on Care for America's Returning Wounded Warriors, known popularly as the Dole-Shalala Commission; and the Veterans' Disability Benefits Commission set up by Congress with members appointed by the President.

Together, they have recommended a number of steps designed to ease the strain on the system: DoD and the VA should work together to streamline procedures for determining disability compensation, collaborate on providing more assistance to help returning veterans cope with the transition, bolster support for families, work toward making their electronic recordkeeping systems compatible with one another, and do more to identify and treat post traumatic stress disorder and mild traumatic brain injury.

Congress has stepped into the fray, passing legislation, called the Wounded Warriors Act, last December designed to write some of the Commissions' recommendations into law. They range from streamlining and standardizing the procedures for calculating disability compensation and benefits to requiring DoD and the VA to develop joint policies on managing servicemembers' healthcare, including developing fully interoperable electronic health records. The law also mandates the development of a comprehensive DoD–VA policy to deal with TBI and PTSD. And it extends to 5 years the period for which newly discharged combat veterans can receive free medical care from the VA. Under previous law, the limit was 2 years.

The VA and DoD also have begun working together to fix the process on their own. Secretaries of the two Departments have been meeting every Tuesday as part of a special joint Senior Oversight Group to hammer out proposals for streamlining their procedures and providing more help to severely wounded or ill veterans. In November, the two Departments announced a pilot project in the Washington, DC, area that will experiment with a single medical examination that can be used both by the military services and by the VA. Physicians from the VA will perform examinations that embrace the services' own standards, and military boards will use the data to determine whether a servicemember is fit for duty and whether he should be discharged or retired. The VA hopes to cut in half the time it takes to go through the physical examination process.

The Army and Marine Corps have established Warrior Transition units for returning troops, in which a team of physicians, nurses, and case managers watches over each servicemember's care and helps him with the recovery process. The DoD and VA have set up early application Benefits Delivery at Discharge programs under which soon-to-be-discharged troops can begin applying for VA benefits 2 to 6 months before their discharge, enabling them to start receiving benefits within a month after their separation. They've hired special coordinators and ombudsmen to help smooth the bureaucratic process for newly separated veterans.

"We are taking this very, very seriously," says retired Navy Rear Admiral Patrick W. Dunne, the VA's assistant secretary for policy and planning, in an assurance that's repeated frequently by officials in DoD and the VA alike.

And authorities are about to launch a feasibility study on how to make the DoD and VA computer systems interoperable so that medical records can easily be transferred from one Department to the other. A big problem in the past has been bureaucratic inertia, but the two systems also have serious structural differences that make it difficult to integrate them. After some initial improvements, VA and DoD physicians can read each other's records, look at x-rays and peruse reports, but they can't enter information of their own or search for a specific result or entry. Both agencies agree that more must be done.

Uncertain Outcome

It's difficult to judge whether what's already on the books or in policymakers' sights will be sufficient to solve the problem. Stephen L. Jones, the principal deputy assistant secretary of defense for healthcare and a former Capitol Hill staffer, asserts that there still is enough impetus from last year's political brouhaha over the transition issue to keep the momentum going for the foreseeable future. "I hope that some of the system's critics are noticing the improvement already," he says.

But critics question whether what is being done is really enough. Roadman, the former Air Force Surgeon General, for one, cautions that the pilot projects, if successful, must be expanded rapidly, without the usual bureaucratic delays. "There's a tendency to 'pilot' things to death," he notes. There also is the risk that the momentum may be interrupted by political events—the lame-duck year of the current Administration, the 2008 election, and the months of organizational efforts in any new Administration.

"My fear is that something big will happen to distract Congress and the public from focusing on the problem," says Beck of the Wounded Warrior Project. "This is a difficult situation. It's not as clearly fixable as the mold on the wall of Building 18 at Walter Reed."

How quickly and how well the current plethora of steps—many of them substantial by any measure—will bring the disability benefits system closer to seamless transition for veterans returning from Iraq and Afghanistan still isn't clear. Much will depend on whether all the players involved can maintain the momentum between now and the time the new Administration is in place. The VA has a new secretary, retired Army Lieutenant General James B. Peake, a physician and decorated Vietnam War veteran, who will play a key role between now and then.

Bureaucratic Nightmares: A Sampler

The Gunny's Run-Around

When Marine Corps Gunnery Sergeant Tai Cleveland was injured during his deployment for Operation Iraqi Freedom 4 years ago, it wasn't supposed to be all that serious. "At your age, everybody has back pain," a military physician told him.

Thrown by a comrade during a hand-to-hand combat training exercise in August 2003, Cleveland landed on his back wearing a full field pack and armor, striking his head in the process. Doctors prescribed Motrin and Valium, but the pain only worsened, and the Gunny suffered chronic headaches. He began walking with a limp.

Shipped back to the States, Cleveland was sent to Walter Reed Army Medical Center in Washington, D.C., where an MRI revealed that he had several fractured vertebrae, previously undetected. By November 2004, he could hardly walk. Surgeons performed a spinal fusion, but the bracing rod became undone and lodged in his spinal canal, so they had to perform the operation again. Even so, "You're going to walk again," doctors assured him.

But the Gunny's condition worsened rapidly. The back pain and headaches persisted, and Cleveland became paralyzed from the waist down. As his wife, Robin, tells it, he also had begun to experience emotional difficulties—frequent loss of memory and flashes of anger at ordinary happenings or smells. And he began blaming everyone he saw. After 2 years as an inpatient at Walter Reed and confinement to a wheelchair, the Marine Corps began pressuring him to take retirement.

"Everything was setting him off'," Mrs. Cleveland recalls.

He finally was separated from the Marines in January of last year, with a pension—based on rank and time-in-service—that was well below what he had expected.

The disappointments continued when Tai Cleveland applied for VA benefits, his wife says. VA officials wouldn't approve any compensation payments for months because they said he wasn't really retired and couldn't qualify for benefits. The Department sent its letters and notices to the wrong mailing address, and the Clevelands never received them. VA physicians in Richmond seemed not to take the case seriously, Mrs. Cleveland says. (One physician told the Gunny, "There's nothing wrong with your arms. I'll have you back to work in 2 weeks or so."). And while the VA finally assigned Gunny Cleveland an 80 percent temporary disability rating, by December of last year he still hadn't received his final disability determination, which presumably will fully take into account his TBI and other impairments.

Meanwhile, Mrs. Cleveland says, the toll on the entire family has been enormous. Even apart from the strains you'd expect when a father comes home in the Gunny's condition, the financial and personal hardships were enormous. Mrs. Cleveland, an accountant who ran her own business in Alexandria, Virginia, had to shut down her firm to care for her husband, now 42, and take him back and forth to medical appointments—losing $45,000 worth of income that had been earmarked to help pay college tuition for two of her children. The Clevelands depleted their savings. And they eventually had to ask a service-related charity for help. "Tai took the brunt of it, but the family took the collateral damage," Mrs. Cleveland says.

The Strung Out Corporal

In July 2005, Marine Corporal Kevin Blanchard returned from Iraq on a gurney.

A combat engineer, he'd been hit by a roadside bomb and taken to a nearby field hospital. Filled with shrapnel, and with his left leg amputated below the knee, he was flown back to Washington for treatment. During a year at the National Naval Medical Center in Bethesda and Walter Reed Army Medical Center, he underwent surgery 30 times, along with treatment for mild traumatic brain injury, and spent weeks on end in rehabilitation. He was finally medically retired in July 2006. In line with standard procedures, he received a relatively small pension based on only his most critical ailment—loss of his leg—and on his rank and time-in-service.

It took yet another year for Corporal Blanchard, now 25, to get his full disability compensation benefits from the VA, which would reflect his full array of service-connected ailments and would be linked to his limited ability to work in the civilian world without regard to his rank and years of service.

"I didn't receive any response to my VA application for 2 full months," he says. "Then I called my VA case manager, and it took another 3 months to get an appointment" for initial processing. The various stages of the processing procedure were "spaced out over 4 more months," he says, with a temporary lower-level payment until the full 100 percent disability was approved. In the meantime, Corporal Blanchard says, he drew down the savings he'd managed to put away while he was still on active duty.

"They should have been able to do something [to expedite his claim] right there at the hospital [Bethesda or Walter Reed]," he says.

The Confused Marine

Marine Corporal Ruben Ramirez knew he wasn't himself when he left Iraq in 2004 for his next duty station in Japan, but he brushed it off as inconsequential. It was only when he got back to the United States in May 2005 that he realized just how sick he'd been. Plagued by nightmares, anxiety attacks, and frequent thoughts of suicide, he would lock himself in his room and struggle with bouts of severe depression.

After leaving the service in mid-2005, Mr. Ramirez went to the VA for a checkup, and came out with a diagnosis that jolted him—severe post traumatic stress disorder, liver damage, bilateral hearing loss, and tinnitus (permanent ringing in the ears). After some time in a VA psychiatric center, he applied for medical care and compensation payments. Unable to work, he was hoping that a Federal check each month would help pay the bills.

But 2 years later the VA denied his entire claim for disability compensation payments, Mr. Ramirez said—contending that he had contracted these ailments before he joined the Corps in 2001, and leaving him without any disability benefits at all. They also sent him a bill for part of his physical exam. He says he can't afford to get private care and isn't eligible for military medical care. He's on the last of his medicine now. (Ironically, the Social Security Administration, using the same military medical records, later awarded him a modest disability pension, a small fraction of what VA might have approved.)

"I don't understand," he says. "I know I didn't have these problems before I joined the Corps, or I never would have been able to sign up in the first place. Their own doctor said they were real. You don't get PTSD without going to Iraq or some other war zone. We saw enough there to make it stay with you for a good long time."

Prepared Statement of Cheryl Beversdorf, RN, MHS, MA
President and Chief Executive Officer,
National Coalition for Homeless Veterans

The National Coalition for Homeless Veterans (NCHV) appreciates the opportunity to submit testimony to the House Veterans Affairs Committee regarding the U.S. Department of Veterans Affairs (VA) budget request for Fiscal Year 2009.

Established in 1990, NCHV is a nonprofit organization with the mission of ending homelessness among veterans by shaping public policy, promoting collaboration, and building the capacity of service providers. NCHV is the ***only*** national organization wholly dedicated to helping end homelessness among veterans.

The majority of NCHV members, which includes nearly 280 organizations in 48 States, the District of Columbia, Puerto Rico and Guam, provide the full continuum of care to homeless veterans and their families, including emergency shelter, food and clothing, primary healthcare, addiction and mental health services, employment supports, educational assistance, legal aid and transitional housing.

In 2007, VA reported that about 196,000 veterans are homeless on a given night and 400,000 veterans experience homelessness at some time during the year. The VA reports its homeless veteran programs serve 100,000 veterans annually, and NCHV member community-based organizations (CBOs) serve another 150,000.

VA officials report that the partnership between the VA and community-based organizations has substantially reduced the number of homeless veterans each night by more than 25 percent since 2003—a commendable record of achievement that must be continued if this Nation is to provide the supportive services and housing options necessary to prevent homelessness among the newest generation of combat veterans from Operations Iraqi Freedom and Enduring Freedom (OIF/OEF).

FY 2009 VA Budget—Homeless Veteran Programs

Congress has established a number of programs within VA to address homelessness among veterans. The primary goal for these programs is to return homeless

veterans to self-sufficiency and stable independent living. The major homeless veterans programs administered by the VA include the Homeless Providers Grant and Per Diem (GPD) program, which includes transitional housing, supportive services centers, special needs grants, GPD program liaisons, and Stand Down support; the HUD–Veterans Affairs Supported Housing (HUD–VASH) program; the Multifamily Transitional Housing Loan Guarantee Program; and the Compensated Work Therapy Transitional Residence program. Homeless veterans also receive primary medical care, mental health and substance abuse services at VA medical centers and community-based outpatient clinics (CBOCs) through the Health Care for Homeless Veterans (HCHV) program.

The landmark Homeless Veterans Comprehensive Assistance Act of 2001 (P.L. 107–95) established new program authorities and reauthorized longstanding homeless programs within the VA. While the authorization law set explicit funding levels for many of the VA homeless programs and authorities, actual annual spending levels are set by the VA Secretary via allocation of funds from the VA medical services account, which are appropriated by Congress.

VA homeless veteran programs function not only as a safety net for homeless veterans unable or hesitant to access emergency shelter, transitional housing or supportive services organized for the general population, they also function as a safety valve when other VA programs fail to reach veterans at a high risk of homelessness, such as veterans with chronic mental illnesses, addictions and extreme economic hardships.

Our testimony will focus on these homeless veteran assistance initiatives, most of which owe their effectiveness and successes to the leadership of this Committee. We have testified many times about the need for transitional housing and services for veterans in crisis, and celebrate the reduction in homelessness among these deserving men and women during the last 5 years. As we continue that legacy, we must also provide supports that will prevent homelessness among OIF/OEF veterans returning from war.

Homeless Provider Grant and Per Diem Program

The Homeless Provider Grant and Per Diem Program (GPD) is the Nation's largest VA program to help address the needs of homeless veterans and supports the development of transitional, community-based housing and the delivery of supportive services. The program's goals are to help homeless veterans achieve residential stability, increase their skill levels and income, and achieve greater self-determination. The GPD program provides competitive grants to community-based, faith-based and public organizations to offer transitional housing and service centers for homeless veterans. The GPD program is an essential component of the VA's continuum of care for homeless veterans, assuring the availability of social services, employment supports and direct treatment or referral to medical treatment. The program also funds GPD liaisons who provide program oversight, inspections and outcomes reporting essential to the success and efficiency of grant recipients.

In September 2007 the General Accountability Office (GAO) presented testimony before the Subcommittee on Health of this Committee regarding homeless veterans programs, and reported that an additional 11,100 transitional housing beds are needed to meet the demand presented by current VA estimates of the number of homeless veterans in need of assistance. This need does not yet include the increased requests for services expected from OIF/OEF veterans over the next 3 to 5 years.

The Consolidated Appropriations Act of 2008, which became Public Law 110–161 on December 26, 2007, provided for $130 million, the fully authorized level, to be expended for the GPD program. Based on GAO's findings and VA's projected needs for additional GPD beds, NCHV has concerns about the $138 million authorization for FY2009 and believes a $200 million authorization is needed. An increase in the funding level for the next several years would help ensure and expedite VA's program expansion targets. It would provide critical funding for service, or drop-in, centers—the primary portal that links veterans in need with the people who can help them. It would guarantee continued declines in veteran homelessness, and provide for scaling back the funding as warranted by the VA's annual Community Homelessness Assessment, Local Education and Networking Group (CHALENG) reports. The GPD program has evolved into a homelessness prevention network as much as a proven intervention care and treatment collaborative partner with the VA.

Special Needs Grants

The VA provides grants to VA healthcare facilities and existing GPD recipients to assist them in serving homeless veterans with special needs including women, women who have care of dependent children, chronically mentally ill, frail elderly

and terminally ill veterans. Initiated in FY 2004, VA has provided special needs funding to 29 organizations totaling $15.7 million. The VA Advisory Committee on Homeless Veterans 2007 report states the need and complexity of issues involving women veterans who become homeless are increasingly unexpected. Recognizing women veterans are one of the fastest growing homeless populations, the Committee recommended future notices of funding availability target women veteran programs including special needs grant offerings. P.L. 109–461 authorizes appropriations of $7 million for FY 2007 through FY 2011 for special needs grants. The increased risks of homelessness among each of these populations warrants funding for special needs grants above the currently authorized level. Additional funding for the Grant and Per Diem Program would address this need.

HUD–VASH

The joint HUD–VA Supported Housing Program (HUD–VASH) provides permanent housing and ongoing treatment services to harder-to-serve homeless veterans with chronic mental health, emotional and substance abuse issues. NCHV was pleased that P.L. 110–161 included $75 million to be used for 7,500 Section 8 vouchers for homeless and disabled programs. Under this program, VA must provide funding for supportive services to veterans receiving rental vouchers. The FY2009 VA budget must reflect a significant increase in funding these services.

We believe the $7.8 million in the FY2009 VA budget proposal was agreed upon before the dramatic increase in HUD–VASH vouchers became law. Based on historical data that shows each housing voucher requires approximately $5,700 in supportive services—such as case management, personal development and health services, transportation, etc.—we estimate approximately $45 million will be needed to adequately serve 7,500 or more clients in HUD–VASH housing units. Rigorous evaluation of this program indicates this approach significantly reduces the incidence of homelessness among veterans challenged by chronic mental and emotional conditions, substance abuse disorders and other disabilities.

Multifamily Transitional Housing Loan Guarantee Program

This initiative authorizes VA to guarantee 15 loans with an aggregate value of $100 million for construction, renovation of existing property, and refinancing of existing loans to develop transitional housing projects for homeless veterans and their families. First authorized in 1998, only two projects have survived beyond the initial planning stages—in Chicago and San Diego—and only St. Leo's in Chicago has been developed.

While we believe this program seemed promising in its original design and intent, the real-life difficulties in long-term coalition building, planning and economic hardships developers have encountered to date strongly suggest a much more practical and streamlined program should be developed to address the critical supportive housing needs of homeless veterans and those at serious risk of homelessness due to chronic health problems and poverty.

A congressionally mandated analysis of 2000 U.S. Census data in FY2006 revealed approximately 1.5 million veterans are living below the Federal poverty level. The GAO and VA's own reports indicate an immediate need for more than 11,000 additional transitional housing beds for homeless veterans. And combat veterans from and—now in the fourth year of their repatriation—are requesting assistance in increasing numbers at VA and community-based service providers. The need for increased service capacity is immediate, and many community-based providers have successfully developed additional transitional and longer term residential opportunities for their clients. We believe the resources earmarked for the Multifamily Transitional Housing Loan Guarantee Program might be better allocated to support projects that can be developed and brought online more swiftly.

Compensated Work Therapy/Transitional Residence (CWT/TR) Program

In VA's Compensated Work Therapy/Transitional Residence (CWT/TR) Program, disadvantaged, at-risk, and homeless veterans live in CWT/TR community-based supervised group homes while working for pay in VA's Compensated Work Therapy Program (also known as Veterans Industries). Veterans in the CWT/TR program work about 33 hours per week, with approximate earnings of $732 per month, and pay an average of $186 per month toward maintenance and up-keep of the residence. The average length of stay is about 174 days. VA contracts with private industry and the public sector for work done by these veterans, who learn new job skills, relearn successful work habits, and regain a sense of self-esteem and self-worth. We are pleased to see the additional funding provided for in the FY2009 proposed budget.

Mental Health Programs

Virtually every community-based organization that provides assistance to veterans in crisis depends on the VA for access to comprehensive health services, and without exception their clients receive mental health screenings, counseling and necessary treatment as a matter of course. These services are well documented, and case managers report this information to the VA as prescribed in their grant reports. Followup services—counseling, substance abuse treatments, outpatient therapies, medication histories and family support initiatives—are also monitored closely and reported in client case files.

Despite significant challenges and budgetary strains, the VA has quadrupled the capacity of community-based service providers to serve veterans in crisis since 2002, a noteworthy and commendable expansion that includes, at its very core, access to mental health services and suicide prevention. The development of the VA Mental Health Strategic Plan from 2003 through November 2004, and its implementation over the last 3 years with additional funding this Committee fought for, has increased the number of clinical psychologists and other mental health professionals at VA medical centers, community-based outpatient clinics (CBOCs) and VA Readjustment Counseling Centers (Vet Centers). We believe the VA budget proposal would facilitate further implementation of the Mental Health Strategic Plan.

We strongly recommend, however, that more attention be directed to simplifying and expanding access to *community* mental health clinics for OIF/OEF veterans in communities not well served by VA facilities. Current regulations allow a veteran to apply for authorization to access services at non-VA facilities, but the process is often frustrating and problematic, particularly for a veteran in crisis. Protocols should be developed to allow the VA and community clinics to process a veteran's request for assistance directly and immediately without requiring the patient to first apply at a VA medical facility. In the interest of maximizing the immediate benefit of mental health supports and minimizing the risk of harmful and even suicidal responses by a veteran to debilitating pressures—perceived or real—this initiative should be universal and well publicized.

Conclusion

The National Coalition for Homeless Veterans thanks this Committee for its service to it's veterans in crisis. It has been a long and difficult campaign, but hundreds of thousands of lives have been restored and thousands of lives have been saved. We are honored to work alongside the Congress, the Administration, our Federal partners, and the service provider network that has transformed policy into hope and redemption for these deserving men and women. What we have learned in the last 20 years is the greatest promise we can offer the new generation of combat veterans coming home from and—we are prepared to honor your service, help heal your wounds, and ensure you enjoy the blessings of the freedom you have preserved.

Prepared Statement of Rick Jones
Legislative Director, National Association for Uniformed Services

Chairman Filner, Ranking Member Buyer, and Members of the Committee:

On behalf of the National Association for Uniformed Services (NAUS), I am pleased to present testimony to you concerning the Department of Veterans Affairs (VA) budget request for fiscal year 2009.

First we would like to thank you, Mr. Chairman, and the Members of this Committee for your hard work in adding substantial funding to the FY 2008 VA Budget including a $3.7 billion discretionary amount for the President, who requested those funds for the VA in January. This funding was sorely needed to take care of not only the troops returning from combat overseas, but also for those who have been in the VA healthcare system for many years.

The National Association for Uniformed Services celebrates its 40th year in representing all ranks, branches and components of uniformed services personnel, their spouses and survivors. NAUS membership includes all personnel of the active, retired, Reserve and National Guard, disabled veterans, veterans community and their families. We support our troops, remember our veterans and honor their service.

As you approach issues this year, NAUS highly commends the recommendations of the Veterans' Disability Benefits Commission (VDBC) and the President's Commission on Care for America's Returning Wounded Warriors (the so-called Dole/Shalala Commission). The VDBC focused on all veterans, while the scope of the Dole/Shalala Commission concentrated on combat-injured troops. NAUS is pleased that its President, retired Army Major General Bill Matz, actively served on the Veterans' Disability Benefits Commission.

The final report of the Veterans' Disability Benefits Commission has received glowing praise from most veterans service organizations, and we highly endorse those recommendations. We firmly believe that the recommendations of the Veterans Disability Benefits Commission should be used by the Committee as a road map to improvements in the Nation's recognition of the service given by our honored veterans.

The National Association for Uniformed Services strongly urges the Committee to give close study to the recommendations from the Veterans' Disability Benefits and, where appropriate, merge them with those of the Dole/Shalala Commission.

We also urge you to work with your colleagues on the Senate Veterans' Affairs Committee to establish an Executive Oversight Committee, as recommended by the VDBC, to track and ensure that there is sufficient and substantial followup and implementation of the recommendations made by both Commissions.

Funding for the Department of Veterans Affairs (VA) Healthcare

The National Association for Uniformed Services firmly believes that the veterans healthcare system is an irreplaceable national investment, critical to the Nation and its veterans. The provision of quality, timely care is considered one of the most important benefits afforded veterans. And our citizens have benefited from the advances made in medical care through VA research and through VA innovations as well, such as the electronic medical record.

The National Association for Uniformed Services endorses *The Independent Budget* recommendation for a medical care budget of $42.8 billion, an increase of $3.7 billion more than this year's operating budget and approximately $1.6 billion more than the Administration's request.

We ask that Members of the Committee give the same effort in fighting for our veterans that our veterans did in fighting for us. It is the right thing to do for the men and women who have given so much in service to our country.

In this regard, Mr. Chairman, the National Association for Uniformed Services appreciates your work in the bipartisan push to better fund veterans healthcare and benefits in the current fiscal year. Rejecting the fees and new charges for veterans and spending more on care for those returning from the battles in Iraq and Afghanistan is warmly welcomed. It will help veterans receive the kind of care they deserve for the sacrifices they made.

Never again should a situation occur in the VA health system as happened at James A. Haley VA Medical Center in Tampa and Bay Pines VA Medical Center in St. Petersburg last year.

The National Association for Uniformed Services is informed that the Haley Medical Center was on "divert" status for critical patients 27 percent of the time between Jan. 1, 2006, and Oct. 1, 2007, or the equivalent of about 170 days. VA figures reviewed by the *St. Petersburg Times* showed the hospital had diverted all patients, regardless of condition, 16 percent of the time over this period.

Since 2000, Bay Pines Medical Center diverted patients far more frequently than any other hospital in Pinellas County. In 2006, records show it diverted veterans during 1,150 hours about 48 days, or 13 percent of the time.

VA medical center officials stated they were looking after the welfare of their patients by diverting them to facilities that had the space and facilities to care for them.

The National Association for Uniformed Services believes that no VA medical facility should have to refuse to admit patients due to lack of resources. We understand that personnel issues and lack of qualified doctors and nurses could influence admissions, but these are conditions that should only occur very seldom and for only very short periods of time. Our veterans deserve to know that the medical center and related facilities nearest to them will be open, staffed and ready when needed.

NAUS strongly supports lifting the ban on veterans classified as Priority 8

The National Association for Uniformed Services strongly supports lifting the ban on veterans classified as Priority 8. Continuation of denial of access to VA healthcare for these veterans, only devalues the service of those who seek care. Restoration of Priority 8 access could be started by enrolling those veterans who can identify private or public healthcare insurance. This would also allow the VA to identify sources and bill for reimbursement for care received by these veterans.

Current policy enrolls all veterans returning from Iraq and Afghanistan at Priority 6 level initially, for a period of up to 5 years after they return from combat. If they request treatment, they are assessed and given any appropriate disability levels. However, once enrolled in the VA healthcare system they are not disenrolled and may only qualify for a Priority 7 or 8 level once their illness or injury is treated. We don't disagree with this decision but question why veterans from prior conflicts or periods of service before the OEF/OIF period are not afforded the same consideration.

Veterans of WWII, Korean War, Vietnam War and other periods, many of whom are older and infirm, are not being afforded similar opportunity for timely access to the VA healthcare system. They deserve equal consideration.

NAUS strongly opposes user fees

One legislative proposal contained in the VA budget request would establish a series of enrollment fees based on the income of certain veterans classified as Priority 7 and Priority 8 veterans. The VA budget request also proposes to increase co-pays for medications for those same Priority 7 and Priority 8 veterans to $15 from $8 for a 30-day supply. The National Association for Uniformed Services believes that to charge any veteran enrolled in the VA healthcare system more than a fair amount is not what we, as a Nation, should do. This diminishes the service these men and women gave to the country.

Disability Claims Backlog

For many years the backlog of claims for benefits has grown larger despite the best efforts of the Veterans Benefits Administration (VBA). An increase in the numbers of claims by veterans of earlier conflicts asking for increases in compensation as their disabilities worsen and the initial number claims from veterans of the OEF/OIF conflicts are a major factor in the growth of the backlog.

A decision several years ago to divert part of the VBA budget earmarked for computer hardware and software upgrades to hire more full time employees was only partly successful. In the long run, it possibly hurt processing time more by not replacing older computers with newer versions designed to handle the volume of claims being received.

Funding in the currently operating fiscal year 2008 VA appropriation provides VBA the resources necessary to hire an additional 3,100 full-time claims processors by the end of the current fiscal year. There remains, however, an enormous backlog of claims yet to be attended. At the close of January, VBA had more than 650,000 compensation and pension claims pending decision. More than 26 percent of those claims have been pending in the VBA system for more than 180 days.

At the recent briefing on the 2009 VA Budget, VA Under Secretary for Benefits, Adm. Daniel Cooper, expressed confidence that recent and continuing hiring and training efforts will allow the VBA to significantly reduce the workload and go a long way in their efforts to cut the average processing time for claims to 145 days for FY 2009. We hope that the Under Secretary is correct in his estimates.

The monetary benefits are essential to the lives of veterans and their families. Decisions which sometimes take years to resolve, have resulted in financial hardships for many including loss of homes and declarations of bankruptcy. We must speed up the decision process so not one more veteran has to suffer for lack of funds they deserve.

Restructuring the Current Disability System

The Veterans' Disability Benefits Commission and the Presidents Commission on Care of Returning Wounded Warriors both recommended that the disability and compensation systems for DoD and VA should be restructured.

Under the proposed change, DoD would maintain the authority to determine fitness to serve. For those found unfit for duty, VA would then determine the extent of disability and initiate the disability compensation and benefits programs, eliminating the needless redundancy.

This would be a more streamlined system that better supports the needs of those transitioning between active duty and veteran status. It would reduce the current complexities of processing claims and help veterans seeking disability compensation gain their awards in a more timely fashion. Since it is a principal mission of the Department, VA is in the best position to simplify the disability determination and compensation process.

MGIB Improvements

When the original GI Bill of Rights was passed at the close of World War II, it expressed our Nation's gratitude for the "Greatest Generation's" fight against tyranny, and it formed the foundation of the prosperity that flourished following the war's end.

Our military and its missions have changed a great deal since then and the current Montgomery GI Bill, as supportive as it is, needs to be improved to reflect the tremendous contributions of our servicemembers.

The National Association for Uniformed Services believes the SR–MGIB program should be removed from the darkness of DoD management, where it has been neglected, to the light of VA jurisdiction, where the general program has been given the serious attention it deserves.

The MGIB serves well the all-volunteer force by improving the way servicemen are recruited and retained. By making these much-needed improvements, we can help the program continue to meet its intended purpose for years to come.

"Seamless Transition" Between the DoD and VA

Efforts in 2007 have seen significant progress in the major stumbling block of electronically transferring DoD medical records to the VA. We urge both sides to continue to work together and continue this excellent progress. Soon we may be able to take the term "seamless transition" out of our vocabulary, at least as it relates to healthcare.

Another part of this transition was recognized by both the Veterans' Disability Benefits Commission and the Dole/Shalala Commission when they both recommended that the DoD, specifically each service, make the determinations for fitness for service and that the VA be the sole determining agency for the percentage of disability.

A test program has been in operation in the Washington, D.C., area since November 2007. Although no official reports have been made in regards to how the test is progressing, several anecdotal reports from various servicemembers indicate they are pleased with the results. The National Association for Uniformed Services believes that an expansion of this program to the entire DoD and VA should be made a high priority.

Prescription Drug Assistance

Mr. Chairman, we are disappointed that little consideration has been given to those veterans who have been prohibited from enrollment in VA's healthcare system under a decision made by the Secretary on Jan. 17, 2003.

The National Association for Uniformed Services urges the Committee to review this policy and provide a measure of relief to allow Medicare-eligible veterans to gain access to VA's prescription drug program.

As a result of the VA decision to restrict new enrollments, a great number of veterans, including Medicare-eligible veterans, are denied access to VA. The National Association for Uniformed Services recognizes that VA fills and distributes more than 100 million prescriptions annually to 5 million veteran-patients. As a high-volume purchaser of prescriptions, VA is able to secure a significant discount on medication purchases.

Enrolled veterans can obtain prescriptions, paying $8.00 for each 30-day supply. However, veterans not enrolled for care before Jan. 2003 are denied an earned benefit that similarly situated enrolled veterans are able to use.

NAUS, again, asks the Committee to consider legislation that would allow Medicare-eligible veterans to gain a measure of relief and get a break on prescription drug pricing.

We recommend the Committee authorize Medicare-eligible veterans, currently banned from the system and paying retail prices or using the newly established Part D program, access to the same discount provided VA in their purchase of prescriptions.

This issue is a win-win situation. Providing the discount would not cost the government a cent. Medicare-eligible patients would pay the same price VA pays. And these veterans would see value returned in the benefit each earned through military service.

Medical and Prosthetic Research

At the recent VA budget roll-out, Veterans Service Organizations questioned why the medical research budget recommended reducing funding levels below those of fiscal year 2007. The response focused on the fact that 2008 increases in VA research resulted from supplemental funding, not regular funding. It was also stated that recommendation, despite being lower than previous levels, was sufficient to cover VA research needs.

The National Association for Uniformed Services finds it incredulous that supplemental funding increases of $2 million in 2007 and $54 million for 2008 have answered the research matters at VA. With little known about traumatic brain injury, PTSD and various other combat-related conditions, reductions in research is not a wise decision. This reduction is especially ill-advised as our troops remain in combat, and will probably do so for the foreseeable future, and more of our brave servicemen and women will likely be affected by TBI and PTSD.

One need only to visit Ward 57 at Walter Reed Hospital or the VA prosthetics ward at the Washington VA Medical Center to see the result of cutting-edge research and development in prosthetics. The VA has long led the Nation in prosthetics development. The National Association for Uniformed Services urges the Committee to increase the budget for medical and prosthetic research.

Medicare Subvention

The National Association for Uniformed Services supports legislation to authorize Medicare reimbursement for healthcare services provided to Medicare eligible veterans in VA facilities. Medicare subvention will benefit veterans, taxpayers and VA.

Medicare subvention is a "Win-Win" situation for all. VA would receive additional, non-appropriated funding. Medicare eligible veterans would receive world-class medical treatment in a system that our government has provided for their care. And taxpayers would see the costs of Medicare-provided care reduced, because medical services can be provided by the VA at lower costs than in the private sector.

In addition, direct billing between VA and the Centers for Medicare and Medicaid Services (CMS) would reduce opportunities for fraud, waste and abuse of the Medicare system.

We urge Members of the Committee to consider legislation to enable Medicare subvention.

Construction

The budget request for 2009 for all Construction, both major and minor projects, has been reduced by $855 million. We question the wisdom of reductions in this account.

In 2004 the VA completed a long study called Capital Asset Realignment for Enhanced Services (CARES). In it the VA laid out a well-researched plan to close some assets, build new ones and move some others. The plan stated good reasons for doing this. One of which is that the many major building assets are outdated and cost too much to maintain.

With good progress currently being made in the building and acquisition of new facilities, now is not the time for VA to reduce funding for these purposes. We urge Members of the Committee to re-examine these cuts and if warranted, which we believe will be the case, restore the funding to a sufficient level necessary to upgrade VA facilities and assets.

VA Nursing Home Construction, Grants for State Extended Care Facilities

The National Association for Uniformed Services urges Members of the Committee to recognize the growing long-term care needs of America's veterans.

VA is a nationally recognized leader in providing quality nursing home care. One of the settings for nursing home expenditures is in State veterans' nursing homes. As America's aging veterans population grows older, affordable State nursing homes remain an attractive pathway for veterans' nursing care close to home.

The National Association for Uniformed Services strongly supports additional funding for the State veterans' nursing home program. It is important that we do so because despite projections of decline in the overall veterans population, from 24.3 million to 20 million over the present decade, it is projected simultaneously that the number of those aged 75 and older will increase from 4 million to 4.5 million and the number of those over 85 will more than double, from about 640,000 currently to nearly 1.3 million in 2012.

VA reports that a number of State nursing home facilities, already planned and approved for construction, are hung up because current year funding falls short of needs. In the current year, the Priority 1 backlog stands at 92 validated construction projects, submitted by 23 States. In addition, it is our understanding that funding for nursing home construction in smaller States, like Utah, fall behind the schedule of funding for larger States due to VA decision methodology.

With VA paying about one-third the cost of care in State veterans' nursing homes, the shortfall of funding in the State program needs to be addressed. To continue reductions to this program is the wrong way to go in planning for the care needs of an aging veterans population.

As one of our members said, "The Nation's old warriors are getting a double whammy. The Congress and Administration team up to speak for veterans' nursing homes then refuse to "walk the talk" by withholding the funding required to make nursing homes happen, especially in States smaller than New York. Conclusion: they speak with forked tongue."

The Administration request for $85 million will fund fewer than 25 of the 92 projects ready for construction. VA is unable to support the proposed new State veterans homes without a NAUS-endorsed increase of $115 million above the Administration request.

Merchant Mariner Belated Thank You

On behalf of the nationwide membership of the National Association for Uniformed Services (NAUS), we thank Members of the Committee for its favorable actions on H.R. 23, "The Belated Thank You to the Merchant Mariners of World War II Act."

NAUS commends your strength of leadership in recognition of heroic service put forth during World War II by the thousands of young men who volunteered for service in the United States Merchant Marine. These forgotten heroes have struggled for more than six decades for acceptance among their military brethren and the public. And it is unthinkable that these brave men should be given a cold shoulder by the Nation they proudly served.

Mr. Chairman, the National Association for Uniformed Services believes that it is now time for the United States to recognize properly these individuals for their exceptional contribution and strength of effort. They helped preserve the freedoms we enjoy today.

On behalf of a grateful Nation, we urge you to extend these benefits to those once young men who went to sea as crewmembers of the Merchant Marine during World War II. Your action in taking up this bill and ensuring its passage by the entire House is much appreciated by NAUS and the surviving Merchant Mariners of that era.

There are not many of them left. They have aged with their country. But age does not disguise the heroic contribution those now almost-ancient mariners gave to help secure the American victory in World War II. They certainly deserve recognition and a very belated "thank you" from a grateful Nation. We now ask your colleagues in the Senate take action soon and produce a similar outcome as this Committee initiated.

Appreciation for Opportunity to Testify

As a staunch advocate for veterans, the National Association for Uniformed Services recognizes that these brave men and women did not fail us in their service to country. They did all our country asked and more. Our responsibility is clear. We must uphold our promises and provide the benefits they ***earned*** through honorable military service.

Mr. Chairman, you and your Committee Members are making progress. We thank you for your efforts and look forward to working with you to ensure that we continue to protect, strengthen, and improve veterans benefits and services.

Again, the National Association for Uniformed Services deeply appreciates the opportunity to review the previous actions of Congress and look ahead to the upcoming year.

Statement of Friends of VA Medical Care and Health Research

President's FY 2009 Budget Proposal for the VA Medical and Prosthetic Research Program

FY 2008 Appropriation	FY 2009 President's Proposal	FY 2009 FOVA Recommendation
$480	$442	$555

On behalf of the Friends of VA Medical Care and Health Research (FOVA)—the diverse coalition representing more than 80 national academic, medical, and scientific societies; voluntary health and patient advocacy groups; and veteran-focused organizations—thank you for your continued support of the Department of Veterans Affairs (VA) Medical and Prosthetic Research Program. We are deeply concerned about the President's proposed fiscal year (FY) 2009 budget for the VA research program. A time of war is not the time to cut research on the grievous injuries being suffered by veterans of the Afghanistan and Iraq wars.

FOVA Recommendations: For FY 2009, FOVA recommends an appropriation of $555 million for VA medical and prosthetics research and an additional $45 million for necessary research facilities upgrades appropriated via the VA minor construction account.

Prior Year Support: FOVA thanks the Committee for its strong support of VA research as evidenced by your FY 2008 views and estimates with regard to the VA Medical and Prosthetic Research Program. The Committee's recommendation—$480 million—was a $69 million increase over the previous fiscal year and the President's FY 2008 proposal. Your support for the program undoubtedly encouraged both chambers to adopt your recommendation as the program's final appropriation. FOVA encourages you to develop a views and estimates statement for FY 2009 that reflects this same commitment to medical research for the benefit of veterans, and ultimately, all Americans.

VA Research Improves Veterans' Lives: The VA Medical and Prosthetic Research Program is one of the Nation's premier research endeavors, attracting high-caliber clinicians to deliver care and conduct research in VA healthcare facilities. The VA research program is patient-oriented and focused entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population. Recent successes to which VA has contributed include the implantable cardiac pacemaker, a new vaccine for shingles, and state-of-the-art prosthetics, including a new bionic ankle.

President's Budget Request Falls Short: Considering the proven success of the VA research program, FOVA is disappointed with the President's proposal of $442 million for VA research in FY 2009. The proposal fails to maintain funding at the level appropriated in FY 2008. If enacted, the proposed $38 million (8%) cut will lead to significant programmatic reductions and will impede research advances in diseases and injuries that impact the veteran population. According to the President's proposal, VA will have to cut funding for research in central nervous system injury by 20%; acute and traumatic injury, military occupations and environmental exposure, and substance abuse by 18%; and mental illness by 15%. The cuts are counter to the Committee's report language calling for "additional research in the areas of mental health—especially the causes, prevention, mitigation, and treatment of post traumatic stress disorder (PTSD) . . . the full spectrum of traumatic brain injury; [and] substance abuse." The President's budget request assumes the cut in the VA R&D account will be made up by large increases in Federal funding from other agencies, nonprofits, and private industry which we are skeptical will materialize.

Research Advances Require Sustained Investment: While FOVA appreciates the significant increase in funding approved last year, a one-time investment in research will not lead to the medical advances required to improve the lives of the Nation's veterans. VA research grants are awarded on a 3- to 5-year cycle; funding must be maintained over the grant cycle to sustain the investigator's research. Cuts in funding require VA to cut award levels for ongoing projects, thus diminishing productivity and output. In addition, funding fluctuation may limit the number of investigators willing to enter—and remain in—the VA system. The VA research program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators to the VA healthcare system, who in turn provide first-class healthcare to our Nation's veterans. FOVA encourages the Committee to consider the long-term needs of veterans and VA investigators when promoting future funding allocations for the program. The coalition encourages Congress to support planned growth for the VA research budget over the course of the next 3 years to continue the upward trajectory of the program in an orderly fashion.

Thank you for considering our views.

Statement of Hon. Jeff Miller
a Representative in Congress from the State of Florida

Thank you, Mr. Chairman, for holding this hearing to discuss the fiscal year 2009 funding for the Department of Veterans Affairs.

I am committed to our responsibility to ensure that the budget we adopt will continue to meet both the complex needs of our new generation of younger veterans as well as maintain and improve the quality of services for our older veterans.

I would first like to congratulate Secretary Peake for his recent confirmation as VA Secretary and thank him for his appearance before us today. You have an important task before you, and the Members of this Committee look forward to working with you in responding to the emergent challenges in taking care of our veterans.

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

It is satisfying to see that after this Committee uncovered weaknesses in the process VA used to develop its healthcare budget in 2005, the budget request for subsequent fiscal years has become more transparent. The Department proposes nearly $39 billion for VA healthcare—the largest amount ever requested by any Administration.

However, I would be remiss in not expressing my concern about the inclusion of legislative proposals to establish enrollment fees and increases in pharmacy co-payments for certain veterans without service-connected conditions similar to requests that Congress has rejected year after year.

Having chaired the Subcommittee on Disabilities and Memorial Affairs in the past, I am encouraged that the budget includes planning to reduce compensation processing time and improve accuracy.

In the State of Florida, the VA patient workload is among the highest in the Nation and the demand for VA healthcare continues to grow, especially in Okaloosa County, the center of my Congressional District.

When they released their report several years ago, the Capital Asset Realignment for Enhanced Services (CARES) Commission identified this Florida Panhandle region as underserved for inpatient care. In fact, it is the only market area in the VISN, VISN 16, without a medical center.

The absence of a VA inpatient facility continues to be one of the biggest concerns of veterans who live in this area. Currently, many of these veterans have to drive to Mississippi to receive inpatient care.

Bringing a full service VA hospital to the first district is something I have fought for since I first came to Washington and will continue to do. I look forward to working with the Department in support of VA's overall capital construction program to address the issue of providing timely access to inpatient healthcare for veterans living in and around Northwest Florida.

Collectively, we share the same goal of providing exceptional service to those who have served in our Armed Forces and sacrificed so much for our freedom.

I hope that this hearing will point the way toward close cooperation among all of us as advocates of our Nation's veterans to respond to their constantly evolving needs and those of their families.

Statement of Hon. Harry E. Mitchell
a Representative in Congress from the State of Arizona

Thank you, Mr. Chairman.

I appreciate you holding a hearing to discuss the President's Budget Proposal for FY–09.

Since this Congress convened last January we have made veterans' affairs a top priority. Unfortunately, this budget undermines all of our hard work.

Last year, we passed a VA appropriations bill which made the single-largest investment in veterans' healthcare in the 77-year history of the agency.

We passed the Joshua Omvig Suicide Prevention Act.

And we passed important Wounded Warrior Legislation, which would not have been possible without your leadership and the work of this Committee.

These are all important first steps . . . but years of neglect and lack of oversight at the VA has left much more to be done.

A year ago *The Washington Post* broke their investigative story about the poor quality of care at Walter Reed Army Medical Center. As Chairman of the Oversight and Investigations Subcommittee, I was especially upset and appalled.

Our Nation's veterans have served honorably to protect us and our country. We have an obligation to treat them the dignity and respect they have earned.

The first line of defense against waste, fraud, and abuse is the independent and nonpartisan Office of Inspector General. The IG is one of the best ways of ensuring accountability at the VA during a time of war.

Unfortunately, the President proposes we reduce the IG's budget to $77 million for FY 2009, a 5 percent decrease from last year. It is absolutely irresponsible to make deep cuts to the VA's watchdog when hundreds of thousands of veterans need the VA to make improvements.

The Oversight and Investigations Subcommittee will hear from VA officials next week to find out how we can afford this cut at a time when we need serious accountability.

I am also stunned by the President's irresponsible proposal to slash the Medical and Prosthetic Research budget to $442 million for FY 2009, an 8 percent cut, and the proposed reduction in veterans' rehabilitation research by more than 7 percent.

I simply can't believe the President wants to deny our war-wounded veterans the option of having cutting-edge prosthetics.

Our wounded warriors have unique injuries and require unique prosthetics. It is our responsibility to make sure they have the tools they need to lead healthy and productive lives following their injuries.

Last year, we were able to look past the President's irresponsible VA proposals and win strong bipartisan support for appropriate funding levels. I know we can do the same this year.

I am looking forward to hearing from our witnesses today, and I yield back.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC.
March 7, 2008

Honorable James B. Peake, M.D.
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing on "The Department of Veterans Affairs Budget Request for Fiscal Year 2009" on February 7, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 18, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Questions for the Record

The Honorable Bob Filner, Chairman
House Veterans' Affairs Committee
February 7, 2008
The Department of Veterans Affairs Budget Request for Fiscal Year 2009

Question 1(a): The VA research program has proven to be incredibly successful, even with its modest budget in comparison to other research entities. Evidence of VA research success includes the discovery of a shingles vaccine in 2005, exemplary discoveries in prosthetics, and the implementation of a clinical trial of psychotherapy to treat post traumatic stress disorder. However, VA researchers face the fact that the amount of funding they can receive for a grant award is capped at $125,000 per year for a period of 3 to 4 years. In comparison, National Institutes of Health researchers receive on average up to $360,000 per year for a period of 5 years. Even with differences in salary support included in these numbers, the discrepancy between the grant allocations is significant. Can you give the Committee your reasoning to hold the research cap at $125,000 year-to-year, despite the obvious inflationary factors of the cost of labor, supplies, equipment, reagents, drugs, procedures, etc.

Response: The Department has maintained the pre-clinical research funding cap at $125,000 per year in order to maintain the diversity in breadth of the investigator base. Where appropriate, we will increase funding individual research projects with the resources provided in the President's budget submission.

In addition, a large number of projects have received budget supplements of up to $25,000 with the appropriations provided in fiscal year (FY) 2007 and FY 2008.

Question 1(b): Considering VA researchers' productivity in spite of their limited resources, do you believe VA researchers would be more productive if the VA research funding cap was increased?

Response: The Department of Veterans Affairs (VA) researchers use all funds provided in an extremely effective manner. Where appropriate, the Department is able to increase funding for individual research projects with the resources provided in the President's budget submission and those increases will result in continued high productivity.

Question 2(a): VA has implemented the Capital Asset Realignment for Enhanced Services (CARES) program to prepare the Department for meeting the healthcare needs of veterans in modern healthcare facilities. CARES documented a $300–400 million need for construction and upgrading VA research infrastructure, particularly its research laboratories. Yet we understand that VA expects your Research Infrastructure Evaluation and Improvement Project, directed at reviewing the overall function and performance capabilities of research space and infrastructure, to take another 3 years to complete. Can you provide us with additional information on the research facility needs of the program and a preliminary estimate for research infrastructure costs?

Response: As part of VA's research infrastructure evaluation and improvement project, a detailed questionnaire regarding current research space allocation and condition was disseminated to all field sites to gather preliminary information. Preliminary results showed a need for research infrastructure corrections across the system. To better document and prioritize issues identified in the preliminary assessment, a comprehensive evaluation instrument designed to ensure a thorough and consistent systemwide review of research space was developed and tested at three pilot sites.

In 2007, VA selected a contractor to complete the research facility site visit infrastructure reviews. Since September 2007, 15 site visits have been conducted at locations across the country. In a 3-year span, approximately 70 site visits will be completed. Because the research infrastructure evaluation and improvement project is still underway, a cost estimate is not yet available.

Question 2(b): During the next 3 years as the Research Infrastructure Evaluation and Improvement Project proceeds, what are your plans to improve research space and facilities?

Response: Over the next 3 years, VA plans to thoroughly assess a large number of sites to identify any deficiencies in research infrastructure and create an amelioration plan and prioritization list, accordingly. An added benefit of the site visit infrastructure reviews is the opportunity to provide a de-brief to facility management, highlighting deficiencies and needs at each location, encouraging some more timely corrective actions.

Question 2(c): What research infrastructure projects have the Research Infrastructure Evaluation and Improvement Project identified to date, and what are the prospective costs of those projects?

Response: Because the research infrastructure evaluation and improvement project is still underway, a list of research facility projects and costs is not yet available.

Question 3(a): Your budget says you intend to cut some programs that this Committee believes are very high VA research priorities, including studies in traumatic brain injury, polytrauma, mental health (with emphasis on PTSD), burns, amputations and eye injuries from Iraq and Afghanistan. As indicated in your budget request, how were these particular research studies targeted for reduction, specifically studies of central nervous system injury to be reduced by 20%; studies of acute and traumatic injury, military occupations and environmental exposure and substance abuse, reduced by 18%; and studies in mental illness, reduced by 15%?

Response: VA's strong commitment to research on mental illnesses, including post traumatic stress disorder (PTSD), and substance abuse, and injuries to the brain, spinal cord, and extremities has been reflected in constant growth in the number of projects and funding over the last few years. As a result of the supplemental appropriation in FY 2007 and the emergency appropriation in FY 2008, there have been considerable investments in expensive equipment such as high-resolution magnetic resonance imagers that will be used to enhance VA research in these areas. Over the next few years these investments will pay off in better understanding and treatments of these disorders, but the very large increases were "one-time" expenses that have effectively met the immediate needs for enhancing the strong ongoing research programs.

Question 3(b): Is your decision to cut these projects consistent with your public statements to highlight the needs of OIF/OEF veterans, in both your healthcare and research programs? How so?

Response: Healthcare Programs. VA uses an actuarial model to forecast patient demand and associated resources needs for healthcare. Actuarial modeling is the most rational way to project the resource needs of a healthcare system like the Veterans Health Administration (VHA). The estimates in the FY 2009 President's submission represent the best possible estimates based on the information available at that time. VA estimates it will require $1 billion in FY 2008 to treat 293,345 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) unique patients and nearly $1.3 billion in FY 2009 to treat 333,275 OEF/OIF unique patients. Based on our experience in FY 2007 and for FY 2008 to date the 14-percent increase (39,930) in workload and 20-percent increase ($216 million) in funding appear realistic.

Research Programs. The FY 2009 budget request for medical and prosthetic research includes $252 million for research directed at the full range of health issues of OEF/OIF veterans, including traumatic brain injury (TBI) and other neurotrauma, PTSD and other post-deployment mental health, prosthetics and amputation healthcare, polytrauma, and other health issues. In addition, the quality and effectiveness of the investigators carrying out this research is reflected by their success in drawing funding for veterans research from other Federal agencies and from the private sector. For example, these non-VA sources contributed on the order of 100 million dollars for mental health and substance abuse research in FY 2007. Due in part to VA capital investment and vigorous VA efforts to develop Federal and private partnerships to develop new treatments for PTSD, we expect non-VA funding to grow substantially in the next few years.

Question 4: In recent years, the government has invested a lot more in Federal research, especially biomedical research at NIH, NSF, CDC and also at DoD. But VA's research program investments have lagged and shown only very modest growth over the past 10 years. This year, the Administration would actually reduce the program by $38 million over the FY 2008 funded level, and would hope that NIH and other funders would step up and fill the void. VA touts its research and researchers as world-leading. Normally, organizations, whether in the private or public sectors, are rewarded when they do well. Given that the VA research program is remarkably productive and necessary to both current and future veterans, how can you justify cutting your investment in VA research and allowing your research facilities and laboratories to continue deteriorating?

Response: VA remains committed to increasing the impact of its research program. We have carefully prioritized our research projects to ensure they continue to address the needs of both current and future veterans. The FY 2009 budget request includes $252 million for research directed at the full range of health issues of OEF/OIF veterans, including TBI and other neurotrauma, PTSD and other post-deployment mental health, prosthetics and amputation healthcare, polytrauma, and other health issues. Additional research funding priorities covered by the FY 2009 budget request include aging and geriatrics, chronic diseases and health promotion, personalized medicine, women's health, and long-term care. VA researchers also continue to successfully compete for and receive funding from other Federal and non-Federal research sponsors that provide additional resources for VA's research program.

Question 5(a): The VA's FY 2009 budget submission includes proposals that would institute a tiered annual enrollment fee, increase pharmaceutical co-payments, and eliminate the VA's current practice of offsetting third-party billings of first-party debt. The VA's budget estimates that these proposals would provide receipts of $379 million in FY 2009, $464 million in FY 2010, and $2.3 billion over 5 years and $5.2 billion over 10 years. Please provide the Committee with the estimated number of enrollees and unique patients, by year, for the period of FY 2009 to FY 2019 that VA estimates will choose not to enroll and choose not to seek VA healthcare.

Response: The tiered enrollment fee for Priority 7 and 8 enrollees would be $250 for veterans with family incomes between $50,000 and $74,999; $500 for veterans with family incomes between $75,000 and $99,999; and $750 for veterans with family incomes equal to or greater than $100,000 beginning in FY 2010.

Approximately 1 percent of Priority 7 enrollees have incomes greater than $50,000 and VA estimates that few, if any, will be assessed the enrollment fee. VA estimates approximately one-half of the estimated 1.7 million Priority 8 veterans will not be subject to the tiered enrollment fee (income less than $50,000). Of the 852,000 Priority 8 veterans assessed the tiered enrollment fee; VA estimates that 440,000 will choose not to pay the enrollment fee.

Priority 8 enrollees who do not currently use the VA healthcare system (46 percent did not use VA in 2007) and low users of VA healthcare services are expected to choose not to pay the enrollment fee. This information is based on the results of the 2007 VHA survey of enrollees, which found that 92 percent of Priority 8 enrollees have some type of public or private healthcare coverage other than VA. However, Priority 8 enrollees who are not insured are likely to pay the enrollment fee and remain in the VA healthcare system.

As shown in the table below, VA estimates approximately 444,000 enrollees, or 144,000 patients, would choose not to pay the annual enrollment fee in 2010.

Impact of Tiered Annual Enrollment Fee and Increased Pharmacy Co-pay, FY 2009–18										
	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Unique Enrollees	0	444,085	437,635	452,752	446,032	439,050	432,281	425,914	420,499	414,589
Unique Patients	0	143,808	141,431	146,422	143,605	140,910	138,411	136,112	134,086	131,845

Question 5(b): Since healthcare dollars are "discretionary," by what mechanism would these receipts be considered "mandatory" and what is the policy rationale for deeming these receipts mandatory spending?

Response: The Administration made a policy decision that classified these veterans' fees as mandatory receipts in order to ensure that the appropriation funding for veterans healthcare was not adversely impacted should Congress not enact the fees. If the fees were proposed as discretionary, then the scoring rules of development of the President's budget would have required direct appropriation offset in the amount of the anticipated collections. To avoid this potential of veteran healthcare funding shortfall in the President's budget request, the fees were proposed as mandatory fees with deposit to the Treasury.

Question 6: The VA's FY 2009 budget request provides nearly $8 million in response to the Dole/Shalala report. With the recent enactment of Wounded Warrior provisions in the National Defense Authorization Act, what additional resources will you need in FY 2009, above and beyond the $8 million you have slated for meeting the recommendations of the Dole/Shalala report, to comply with the appropriate provisions of this law?

Response: VA and the Department of Defense (DoD) are working together to implement the provisions of Dole-Shalala Commission and the most recently passed National Defense Authorization Act (NDAA). VA has awarded a $3.2 million contract to Economic Systems, Inc. of Falls Church, Virginia to perform a 6-month study to develop options for a new quality of life benefit and a new long-term transition benefit for participants in VA's vocational rehabilitation & employment program (Chapter 31). The findings from this study are intended to inform the Department's decisionmaking process regarding key components of recommendation two of the Dole-Shalala Commission to completely restructure the disability and compensation systems. Until all implementation plans are complete we will not be able to fully estimate costs.

Question 7: Your FY 2009 budget submission estimates a total increase of 90,000 unique patients, which includes an estimated increase of OEF/OIF veterans of 40,000. This increase includes an estimated increase of 2,621 Priorities 7 and 8 veterans. In light of your historical experience in estimating workload increases from year-to-year, how confident are you that your estimated overall increase of 1.6 percent is accurate? How confident are you that you will only see an additional .2-percent increase in Priority 7 and 8 veterans?

Response: The annual patient projections that are generated by the VA enrollee healthcare projection model are a function of the projected enrolled population and the mix and intensity of workload for those enrollees as projected by the model. The patient projections are then adjusted to account for those veterans who seek only non-modeled services such as vet centers.

The following chart presents the accuracy of the model supporting the 2004 through 2007 VA healthcare budgets. The projections were adjusted to reflect policies that were not implemented, such as enrollment fees and pharmacy co-payment increases.

The differences between the projections and what actually happened have become closer over the years. A significant reason is that initially there was limited enrollment trend data in the years just after eligibility reform available to inform the model. For example, when the model that supported the 2004 budget was developed,

VHA only had actual enrollment data from 1999 to 2001 to inform the analysis, and the data showed significant variability.

In addition, components of the model methodology and data sources are continually updated. For example, the model supporting the 2004 budget relied on projections for the veteran population (VetPop) that were based on the 1990 Census. VetPop has since been updated with data from the 2000 Census, and the updated VetPop has been incorporated into later models.

The 2007 enrollment projections and actuals reflect an improved methodology for identifying enrollee deaths. This reduced both the projected and actual number of enrollees for 2007 as compared to earlier years.

Accuracy of Actuarial Model Projections						
	VETERAN ENROLLEES			VETERAN PATIENTS [1]		
Fiscal Year	Actuarial Projections [2]	FY Actuals	Percent Difference	Actuarial Projections [2]	EFY Actuals	Percent Difference
2004	7,130,921	7,419,851	−3.9%	4,796,105	4,622,155	3.8%
2005	7,860,389	7,655,562	2.7%	4,835,534	4,768,304	1.4%
2006	7,941,971	7,872,438	0.9%	4,885,820	4,845,062	0.8%
2007 [3]	7,618,345	7,833,446	−2.7%	4,834,305	4,872,030	−0.8%

[1] Includes veteran patients who used services projected by the model. Does not include veteran patients who only used dental, readjustment counseling, LTC, or foreign medical program services.
[2] Adjusted to reflect policies not implemented, such as enrollment fees and rx co-payment increases.
[3] The FY 2007 enrollment projections and actuals reflect an enhanced methodology to identify enrollee deaths, which reduced both the projected and actual enrollment numbers.

VA believes the 0.2 percent estimated increase in Priority 7 and 8 veteran patients is a reasonable estimate. Approximately 75 percent of the Priority 7 and 8 patient populations are in Priority 8. The Priority 7 patient population is growing slowly because of the relatively small size of the non-enrolled Priority 7 veteran population. In addition, the Priority 8 population is reduced each year because of mortality; therefore the actual growth in the combined Priority 7 and 8 populations over time is slowing.

Question 8: The VA's FY 2009 budget proposes spending $3.9 billion on mental health, a $319 million increase over FY 2008. This increase includes a 44-percent increase in spending for the Mental Health Initiative, a 12-percent increase in VA Domiciliary care, and 4-percent increases for Inpatient Hospital care, Psychiatric Residential Rehabilitation treatment, and Outpatient care. Do you feel confident the increases in areas other than your Mental Health Initiative are sufficient to meet the ever-growing demand on mental healthcare services faced by the VA?

Response: The proposed $319 million increase in mental health spending represents the sum of a $161 million increase in the *Mental Health Initiative* and a $158 million increase in mental health spending through the veterans equitable resource allocation (VERA), all in medical care funding. Together the funding will be adequate both to address the needs of returning veterans and to enhance services for veterans of all eras.

To put the projected increases in funding in perspective, we calculate that it is sufficient to support the recruitment and hiring of over 3,200 new mental health staff members. This is an extraordinary number of new positions for any health system, especially in light of VA's already filling of more than 3,800 new mental health staff positions over the past 2½ years.

Question 9: The VA has requested a 44-percent increase in funding for the *Mental Health Initiative*. In November 2006, the GAO reported that VA failed to fully allocate the resources that had been pledged for the *Mental Health Initiative* in FY 2005 and FY 2006. Have the resources provided in the past for this initiative been fully allocated? In your opinion, what innovative care and treatment capabilities have been developed through the *Mental Health Initiative* that would not have been realized through simply providing increases in other mental health programs?

Response: Funding allocated for the *Mental Health Initiative* is projected to increase from $370 million in 2008 to $531 million in 2009, an increase of $161 million or 43.5 percent. As noted in the question, the Government Accountability Office (GAO) raised concerns about under-execution of these funds in FY 2006. However,

in FY 2007, $306 million was allocated for the *Mental Health Initiative* and $325 million was actually spent, an excess of over 6 percent and a measure of VA's commitment to provide access to high quality mental health services.

The *Mental Health Initiative* has supported the implementation of the VHA *Comprehensive Mental Health Strategic Plan*. In this, it has supported major enhancements for mental health services. Specific initiatives have included:

- Enhancing access through major increases in staffing.
- Increases mental health services available in community-based outpatient clinics (CBOC).
- Developing services for patients with serious mental illness in rural areas.
- Expanding program for homeless veterans.
- Promoting the integration of mental health with primary care.
- Increasing mental health services for older adults across care settings.
- Transforming specialty mental health services to emphasize rehabilitation and recovery.
- Establishing mental health services to address the specific needs of returning veterans.
- Implementing a comprehensive strategy for suicide prevention.

Question 10: In December, this Committee held a hearing on "Stopping Suicides: Mental Health Challenges within the U.S. Department of Veterans Affairs." In light of the alarming increase in the suicide rate among veterans, is the VA doing anything differently today regarding this issue than you were doing 6 months ago? How do you think the VA can better address this painful issue—does it include more resources, more data collection, novel approaches to providing care and services?

Response: VA's information on suicide rates depends upon gathering information on veterans' causes of death from medical examiners in communities throughout America as processed by the States and the Federal Center for Disease Control and Prevention (CDC). This is a rigorous process that takes time. The data that are available from CDC goes through the end of 2005.

Studies on returning veterans have demonstrated that the rates of suicide among those who served in OEF/OIF is not significantly greater than those for age, sex, and race matched individuals from the general U.S. population. Studies on veterans who received care from VHA demonstrated rates of suicide that are somewhat higher than those for age and sex matched individuals from the community. However, there has been no significant increase in rates between 2001 and 2005. Moreover, the observed elevation in rates can be probably best attributed to greater mental and physical illness as well as disability in the VA population.

VA is rapidly implementing its program for suicide prevention by enhancing mental health services and by supplementing its mental health programs with initiatives that target suicide more directly. It was approximately 1 year ago that VA began to hire suicide prevention coordinators in each of its medical centers, and somewhat over 6 months ago that it partnered with the Substance Abuse and Mental Health Services Administration to develop hotline services specifically for veterans. Both of these programs have continued to grow over the past 6 months. One recent advance has been the implementation of a program in which the suicide prevention coordinators have been identifying veterans who survive suicide attempts and others at high risk so their monitoring and care can be enhanced. VA's suicide prevention programs continue to advance. Some enhancements will be based on established evidence, while others will require new research and intervention development.

One of the most important strategies for suicide prevention must be destigmatizing mental illness and promoting its treatment. This can be best accomplished by delivering the message that access to high quality mental health services is available to veterans through the VA, and that the treatments provided are effective.

Question 11: On July 31, 2007, the VA submitted a "White Paper on the VA Disability Claims Processing Workforce." The report listed a total of 3,100 new hires funded through the FY 2007 appropriation (400), the FY 2007 supplemental (800), and the FY 2008 House Appropriations recommended level (1,900). The VA projected an end-of-year staffing level for Compensation and Pension of 9,068 FTE (direct) and 10,998 FTE (direct) for FY 2008. The VA's FY 2009 budget submission provides a 2007 level of 8,353 FTE (direct) and estimates an FY 2008 level of 10,304 FTE. The VA's estimate for FY 2009 is 10,998, the same level the VA projected in July for the end of FY 2008. The VA's budget request for FY 2009 estimates an additional 694 direct FTE (for a total of 10,998) over the FY 2008 current level

(10,304). Why is the VA now estimating the same FTE levels for FY 2009 as you projected, back in July, for the end of FY 2008?

Response: The table below illustrates the Veterans Benefits Administration's (VBA) 2008 and 2009 budget for compensation and pension (C&P) direct personnel as of September 30 of each year. The onboard full time employees (FTE) are the actual staffing levels. Cumulative FTE levels translate the onboard FTE's annual employment period into its equivalent fraction of the year, which explains why the cumulative and onboard FTE levels differ when FTE are employed for less than a full year. VBA will continue to hire throughout the fiscal year to meet the 2008 end-of-year goal of 10,998 onboard direct C&P FTE.

	FY 2008	**FY 2009**
On-Board FTE	10,998	10,998
Cumulative FTE	10,304	10,998

Question 12: If Congress has already provided the resources to bring this staffing level up to the level you now project for FY 2009, haven't we already paid for this increased level, and shouldn't the resources you propose in FY 2009 to reach this level result in a greater number of claims processors by the end of FY 2009?

Response: FY 2008 VBA funding supports 14,857 FTE. Inasmuch as one FTE equals one employee for a full year and we are in an upward hiring trend, we will end the year with 15,570 employees onboard. About 1,900 of those will be onboard less than a full year and therefore will not equate to a full FTE for FY 2008. In FY 2009, VBA plans to maintain the onboard FTE at a constant level of 15,570 throughout the year and anticipates the 2009 cumulative FTE will equal the on-board FTE, since no additional hires are projected for FY 2009.

Question 13: How much, overall, do you estimate that it would require over the next 5 years in Major Construction funding for the VA to fully meet the CARES recommendations?

Response: The Department estimates that it will, at a minimum, require maintaining a funding stream consistent with what has been recently authorized and appropriated (over the past 5 years) to continue effectively implementing the major medical facility construction requirements needed to provide improved and efficient healthcare delivery services to veterans. All future capital needs are evaluated, along with other VA needs on annual basis, and all funding decisions are reflected in the President's budget submission.

As reflected in the FY 2009 VA budget submission there are currently 40 ongoing VA major medical facility projects. Including the President's 2009 budget request, VA will have received more than $5.5 billion to date in major and minor construction for projects and other related to CARES since FY 2004. As also shown in the budget submission, the future funding needs for these existing ongoing projects is currently $2.3 billon. Along with the existing projects, a number of potential major medical facility projects are also listed in the VA budget submission. The list of potential projects are updated each year as part of the annual VA capital investment process, and projects may be added or deleted from this list.

Question 14(a): The VA's FY 2009 budget requests $83 million for facility activations. The VA states that this level will enable the VA to open 51 CBOCs. Last year, VA requested $21 million and currently plans on opening 64 CBOCs. In light of the estimate of opening fewer CBOCs in 2009, is the VA requesting fewer resources for activations in FY 2009 than it is spending in FY 2008?

Response: The $83 million for facility activations is for the non-recurring startup costs related to major construction projects, not to open new CBOCs. The only increased funding requested for new CBOCs is for the estimated new workload that will be created which is estimated at approximately $300,000 per CBOCs in the first year and approximately $35,000 in the second year. This equates to $19,008,000 in FY 2008 (64 new CBOCs x $297,000 = $19,008,000). The estimate for FY 2009 is also $19,008,000 (which is divided $9,504,000 in medical services and $9,504,000 in medical facilities).

The FY 2009 computation is as follows:

51 new CBOCs × $300,000 =	$15,300,000
64 CBOCs year 2 × $35,000 =	$2,240,000
Estimate for other one-time costs and inflation	$1,468,000
Total	**$19,008,000**

Question 14(b): Please provide details on which facilities the VA plans on activating in 2008 and which facilities it plans on activating in 2009?

Response: There are 64 CBOCs planned for activation in 2008. CBOC activation sites for 2009 has not been decided, we are reviewing the 2009 recommendations.

2008 CBOC Activations

VISN	CBOC	VISN	CBOC	VISN	CBOC
4	Dover	9	Berea	16	Stillwater
4	Monongalia	9	Grayson County	16	Branson
5	Andrews AFB	9	Hamblen	16	Eglin AFB
6	Charlottesville	9	Hawkins	16	Pine Bluff
6	Hickory	9	Hazard	18	Miami/Globe
6	Hamlet	9	Madison	18	SE Tucson Urban
6	Franklin	9	Bolivar	18	Thunderbird
6	Lynchburg	9	Carroll County	19	Cut Bank
		9	Dyer County	19	Lewistown
7	Aiken	9	Harriman (Roane County)	19	West Valley
7	Childersburg	9	Hopkinsville (Christian County)	20	North Idaho
7	Spartanburg	9	Jellico (Campbell County)	20	NW Washington
7	Stockbridge	9	McMinnville (Warren County)	20	West Metro Portland
		9	Philips County	20	South Puget Sound
8	Camden	9	Pigeon Forge Clinic	22	Orange County
8	Jackson	9	Scott County	23	Bellevue
8	Putnam			23	Carroll
		10	Parma	23	Cedar Rapids
15	Daviess			23	Holdrege
15	Hutchinson	11	Alpena County	23	Marshalltown
15	Jefferson City	11	Charleston	23	Shenandoah
15	Knox	11	Clare County	23	Wagner
15	Graves Co KY	11	Elkhart County	23	Watertown

Question 14(c): Please provide the Committee with the average cost to activate a CBOC and the costs that the VA estimates for activations for a major medical facility.

Response: In FY 2007, the average cost to activate a CBOC, including the cost of staff, was $4.4 million. These costs including the cost to activate are included in the budget requests of each of the three separate appropriations but there is no separate identification of either the operating or activation costs of CBOCs.

The FY 2009 included $83 million for facility activations which was for the non-recurring startup costs related to major construction projects. This is based on an estimated 10 percent of the project cost for non-recurring activation costs which are requested in the year these startup costs must be obligated.

Question 15: The VA's budget request for Medical Facilities estimates $9.5 million in obligations for CBOCs. Please provide the Committee with the average cost for a CBOC. Also, please provide a list of obligations for CBOCs and the number of CBOCs (consistent with the data found on pages 1d–4 and 1D–6 of the FY 2009 submission) over the last 5 years and any estimates regarding obligations planned for CBOCs from FY 2009 to FY 2013.

Response: The $9.5 million in the medical facilities appropriation for CBOCs in FY 2009 is computed as shown below. There is also $9.5 million in the medical services appropriation. The only increased funding requested for new CBOCs is for the estimated new workload that will be created which is estimated at approximately $300,000 per CBOCs in the first year and approximately $35,000 in the second year. This equates to $19,008,000 in FY 2008 (64 new CBOCs × $297,000 = $19,008,000). The estimate for FY 2009 is also $19,008,000 (which is divided $9,504,000 in medical services and $9,504,000 in medical facilities).

The FY 2009 computation is as follows:

51 new CBOCs × $300,000 =	$15,300,000
64 CBOCs year 2 × $35,000 =	$2,240,000
Estimate for other one-time costs and inflation	$1,468,000
Total	**$19,008,000**

Below are the total annual decision support system (DSS) costs for CBOCs and the average per CBOC: For example in FY 2007, if one divides the total cost by the average cost, the number of CBOCs is 663 which is less than the 731 reported in the budget. The reason for this is that some CBOC are in multiple locations under one contract but are only counted once for cost purposes and are counted as multiple CBOCs for facility count purposes. Two examples of this are: Veterans Integrated Service Network (VISN) 9 St. Charles has 10 CBOC locations under a single station number for cost purposes and VISN 6 Danville has nine CBOC locations but only a single station number for cost purposes. There are a total of 28 locations that are counted once for cost purposes, but actually have multiple CBOCs ranging from 2 to 10.

	Total Cost (SB)	**Average Cost ($M)**
FY 2003	$2.086	$3.311
FY 2004	$2.352	$3.647
FY 2005	$2.541	$3.885
FY 2006	$2.713	$4.181
FY 2007	$2.935	$4.426
Estimates		
FY 2008	$3.182	$4.426
FY 2009	$3.421	$4.501

Estimates for FY 2010 and beyond will not be available until the submission of the FY 2010 President's Budget.

Question 16: VA Office of Rural Health—$1 million and 1 FTE: is this sufficient? Studies indicate that over 40 percent of veterans returning from OEF/OIF come from rural communities. Rural communities have supplied a disproportionate share of veterans due to large contingents of National Guard and Reserve servicemembers. Over a year ago, Congress mandated the creation of the Office of Rural Health. Your FY 2009 budget requests $1 million and 1 FTE for 2009. Given the scope of the office—to conduct studies and develop policies and programs to meet the health needs of the rural veteran population, a population already presenting challenges in the provision of healthcare—do you believe that one FTE is sufficient to carry out the responsibilities of this office?

Response: The Office of Rural Health (ORH) is currently staffed with a director and a health systems specialist which meets our current demands. We will increase staff as needed. To complement current ORH staff, ORH leverages expertise from a range of other VHA offices, VISN rural health consultants in the field, and is directly supported by the Assistant Deputy Under Secretary for Health for Policy and Planning, which provides the staff resources of the Office of Strategic Planning and Analysis as well as the Office of Enrollment & Forecasting. ORH also uses contracts which allow ORH to leverage rural health expertise with rural health leaders, academic institutions, and rural health organizations outside VA to assist with operational and strategic planning, coordination of research initiatives, and the development of pilot programs.

Question 17(a): The VA's FY 2009 budget request for long-term care estimates an Average Daily Census (ADC) level of 11,000 for nursing home care. The Veterans Millennium Health Care and Benefits Act (P.L. 106–117), which was enacted in 1999, requires the VA to maintain an ADC of 13,391. With the veterans' population demographically growing older, there would seem to be a concomitant increase in demand for nursing home care. Does the VA plan to submit a budget request for long-term care that meets these statutory obligations for nursing home care?

Response: VA's philosophy is to provide long-term care services in the least restrictive environment that is safe for the veteran. The increasing availability of home and community-based non-institutional extended care services both in VA and in the private sector during the decade since the Millennium Act was developed has resulted in stable or falling nursing home occupancy in both sectors even as the population has aged. VA will continue to meet the statutory requirement to provide nursing home care for all veterans with a service-connected disability rating of 70 percent or more who need such care and seek it from VA. There are no current plans to seek additional funding for nursing home care beyond that required to maintain current capacity.

Question 17(b): How much more long-term care funding would be required to meet the VA's statutory mandate to maintain an ADC of 13,391.

Response: Based on VA's FY 2009 budget request, an additional $664 million would be needed to maintain an average daily census (ADC) of 13,391 in VA nursing home care units.

Question 18: According to the "Priority List of Pending State Home Construction Grant Applications" for FY 2008, VA is facing a backlog of $553 million in Priority 1 projects. Priority 1 projects are those projects that already have State funding to start construction. In light of this increasing backlog, how can the Administration justify a proposed cut in this account of $80 million?

Response: VA anticipates that the FY 2009 funding request will be sufficient to fund all Priority Group 1, Subpriority 1 (Remedies for Life/Safety) projects for State veteran homes.

Question 19(a): Your report to the Committee, dated February 26, 2008, states that VA believes 2013 would be the first year it would be able to allow enrollment of new Priority 8 veterans. If the enrollment ban were lifted, allowing the enrollment of new Priority 8 veterans, on October 1, 2008, how many additional resources, overall and by specific appropriation account, would the VA estimate would be needed to handle the increased demand and workload?

Response: VA's strategic analysis identified significant challenges with regard to building the capacity, both in terms of infrastructure and staffing, required to reopen enrollment for Priority 8 veterans in the near term without severely disrupting VA's ability to provide timely, high quality care to eligible veterans. This analysis

demonstrated that 2013 would be the soonest that VA would be able to put in place the needed infrastructure to accommodate increases in demand. The report also noted meeting staffing requirements within this timeframe would remain a challenge due to nationwide healthcare workforce shortages. VA estimates that the treatment cost in 2013 for this policy change is $3.1 billion excluding any additional capital requirements.

Under current enrollment policy, VA's projected demand for healthcare services is expected to increase over the next several years. While enrollment growth has slowed since the suspension of enrollment in Priority 8, the volume of healthcare services required by enrollees continues to grow due to the aging of the enrolled population. VA will need to continue to build capacity in the coming years to meet this increased need for healthcare services from eligible veterans. Providing healthcare services to these new Priority 8 enrollees would require that VA develop additional capacity beyond the growth needed under the current enrollment policy. For example, VA will need to grow ambulatory services 15 percent by 2013 under the current enrollment policy and by a total of 24 percent under full enrollment (including Priority 8 veterans). Further, the growth in demand for VA healthcare services varies significantly across the VA healthcare system. For example, to meet the combined increase in demand for services under both current enrollment policy and full enrollment in 2013, some areas will have to grow ambulatory services by as much as 45 percent. Without first building the needed infrastructure and staff capacity, VA would be unable to accommodate the large increase in workload without compromising quality and timeliness of care.

Question 19(b): If the level to qualify as a Priority 7 veteran was increased to 150 percent of the Geographic Means Test beginning on October 1, 2008, how many additional veterans does the VA estimate would be allowed to enroll for VA medical care with such a change and what additional resources would be required to meet this increased demand, overall and by appropriation account, for FY 2009.

Response: VA is conducting an analysis to assess the impact on enrollment and utilization by increasing the income thresholds of the geographic means test thresholds which vary by county and number of dependents. VA will provide the results of this analysis to the Committee when the analysis is completed.

The Honorable John J. Hall, Chairman
Subcommittee on Disability Assistance and Memorial Affairs
House Veterans' Affairs Committee

Question 1: In your testimony, you said the President's Budget Request would allow for improvement in the timeliness and accuracy of claims processing. This has been VA Strategic Plan Goal Number One since at least 2003, but the backlog has only gone up since that time. Can you provide some clear, concise and measurable objectives for 2009 that will realistically result in improvements that Congress can track?

Response: VBA continues its efforts to reduce the pending claim inventory and improve claims processing timeliness. Disability compensation and pension claims receipts requiring a rating decision are projected to increase to 854,904 in 2008 and 872,002 in 2009. VBA has set aggressive performance targets to successfully address this significant increase in claims. Measurable performance objectives established for FY 2009 include 145 days, on average, to process compensation and pension rating claims, an accuracy rate of 92 percent for rating related claims, and an end-of-year inventory of approximately 300,000.

Question 2: You have listed as a major goal for 2009 to reduce the timeliness of processing a claim from 183 days to 145 days. At one point, the goal was 125 days. I recently convened a hearing in which a private employment plan reminded me that they are obligated under the ERISA law to process claims in 45 days and can do it in 3 days. How is it fair to veterans that you do not have the same goals as the private sector?

Response: There is no private sector model of claims processing (private insurance, Federal Employees' Compensation Act, etc.) that has a benefits system as complex as VA's. The following requirements set VA apart from other entities that process claims:

- VA is required to establish that the claimed disability was incurred in, aggravated by, or otherwise determined to be a result of military service, often many years after discharge from service.
- Under the Veterans' Claims Assistance Act (VCAA), VA has the duty to assist the claimant in gathering evidence needed to support their claim. Specific notification requirements must be followed.
- VA must determine the veteran's ability to earn income at a level equal to a non-disabled veteran.
- VA must determine the amount of compensation to award based on a combined disability rating evaluation, as well as process any ancillary benefits to which the veteran may be entitled.

Rightly, the laws governing VA are designed to benefit veterans. However, as a result, the system under which claims are adjudicated imposes legal requirements that create inherent delays in claims processing.

Recently, the CNA Corporation appeared before the Veterans' Disability Benefits Commission. CNA compared the VA disability compensation program to similar Federal disability programs and explored lessons learned from other programs. Some of the areas considered were claims processing, performance measurement, quality, training, staffing, costs, and processing sites. CNA concluded that, except for timeliness, VA does not appear to be under-performing in comparison with other disability programs and that recent training improvements and hiring initiatives seem promising for improving VA timeliness in the long term.

Question 3: Your projection for the volume of claims receipts is projected to reach 872,000 in 2009, which is an increase in the backlog. Isn't that counterproductive to everything you are talking about doing to improve C&P services?

Response: The disability claims workload from returning war veterans and veterans from earlier periods has continuously increased since 2000. VBA's annual rating claims receipts grew 45 percent from 2000 to 2007. In 2008 and 2009, we anticipate receipts will increase to 854,904 and 872,002 respectively. However, as rating receipts increase, VBA's national production level is also expected to increase to 878,205 in 2008 and 942,706 in 2009. The increase in staffing across the Nation has prepared VBA for this projected increase in workload. With a workforce that is sufficiently large and correctly balanced, VBA can process rating claims in a timely and efficient manner. We project that our pending rating inventory will decrease in 2008 and 2009 with a projected end-of-year inventory of approximately 300,000 in 2009.

Question 4: Neither in the budget proposal, nor in your testimony do I see how you are going to deal with the nature of the complexity of claims by using more modern tools. I recently held a hearing on using Artificial Intelligence to automate the claims processes and we heard from several very credible experts on its use in the private sector and its potential for VA, but I don't see it as a priority in the budget. Online Access and Virtual VA do not change the fact that the Regional Offices still print a paper record and manually rate claims. Where in the Budget, do you include a request for an automated decision support system?

Response: VBA, in collaboration with the Office of Information and Technology (OIT), is developing the paperless delivery of veterans benefits initiative. This initiative will employ a variety of enhanced technologies to support end-to-end claims processing. In addition to imaging and computable data, we will also incorporate enhanced electronic workflow capabilities, enterprise content and correspondence management services, and integration with our modernized payment system, VETSNET. Similarly, we are also exploring the utility of business-rules-engine software to both manage workflow and potentially to support improved decisionmaking by claims processing personnel.

To fully develop this initiative, funded through $20 million appropriated in the FY 07 supplemental, VBA will engage the services of a lead systems integrator (LSI). The LSI will work closely with VA to fully document our business and systems requirements for an end-to-end claims process supported by technology. While this process will be enhanced by the advanced technologies this is fundamentally a business transformation effort. Business process modeling and resulting improvements will be a key feature in this effort, building upon the claims processing study recently completed by IBM Global Business Systems.

In addition, the FY 2009 budget request calls for $17 million for expansion of our existing imaging and electronic file repository, Virtual VA. This funding will ensure that we are able to make demonstrable progress in our current efforts to enhance claims processing through technology as we develop the longer term plan. This

longer-term plan will move us toward a more automated decision-support system built upon a claims process that is less reliant on paper records.

Question 5: I see that C&P programs are requesting an additional $14 million or a 17 percent increase over last year. Does that include the $20 million supplemental funds VBA got last year?

Response: We assume that this question refers to the compensation (only) medical exam pilot program, page 2A–2 of the 2009 Budget Submission. The funding for contract exams in the benefits budget supports the 10 pilot sites in Atlanta, Boston, Houston, Los Angeles, Muskogee, Roanoke, Salt Lake City, San Diego, Seattle, and Winston-Salem. The $20 million in supplemental funds VBA received last year for contract exams is included in the general operating expenses (GOE) C&P request. The six sites funded by the GOE appropriation are Cleveland, Indianapolis, St. Louis, Des Moines, Lincoln, and Waco.

Question 6: You mentioned in your testimony that you are enacting some of the Dole/Shalala Commission recommendations, but those are somewhat limited. You did not mention the 113 recommendations from the Veterans' Disability Benefits Commission, which was a much more in depth study since it ran for over 2 years and not just 4 months. What is your plan to deal with those recommendations; especially with the issues they raised surrounding the VA Schedule for Rating Disabilities, Quality of Life payments and presumption?

Response: VA is in the process of evaluating all of the recommendations from the Veterans' Disability Benefits Commission and the Dole-Shalala Commission. The 113 recommendations made by the Veterans' Disability Benefits Commission fall into categories based on what organization has been assigned action: VA, DoD, Congress, some combination, or no action required. There are 36 assigned to VA alone, and they are being worked by the organization under which the activity or responsibility falls. In response to the recommendations made by both of these commissions, a contract was awarded in February 2008 to study long-term transition payments, quality-of-life payments, and earnings-loss payments. The final draft report is expected on July 28, 2008. The contract completion date is August 11, 2008. Any decisions on changes to the rating schedule, including consideration of quality-of-life issues, must await the outcome of the study. The Department is tracking progress on all of the recommendations on which we share responsibility. VA organizations are updating the status of each recommendation to reflect ongoing and completed actions.

Question 7: What about the Global War on Terror Heroes Task Force your predecessor chaired? What are you going to do with those recommendations?

Response: In April 2007, Secretary Nicholson submitted the task force on Returning Global War on Terror (GWOT) Heroes report to the President. The report contained 25 recommendations—which included 100 action items with implementation dates—to improve the delivery of Federal services to returning servicemembers. The 90 actions items with target dates on or before March 1, 2008, are completed or commenced as required.

The task force recommendations have resulted in the enhanced delivery of VA services to veterans, and VA continues to seek ways to improve. Senior leaders within VA are accountable for ensuring the remaining GWOT task force implementation actions in the areas of information technology enhancements and VA/DoD data exchange are implemented in a timely manner.

Question 8: A single DoD/VA disability evaluation process has been advocated by most of the recent Commissions and Task Forces and certainly seems to have support among the veterans' community. I understand the pilot is underway, but should conclude shortly. What are your views on taking such a step with DoD and what would be the next phase toward implementation of a single exam process?

Response: VA initiated a pilot of the single disability examination system (DES) with DoD on November 29, 2007. VA has been actively participating in regular reviews with DoD to evaluate the ongoing progress and effectiveness of the National Capital Region (NCR) DES pilot program. VA believes that data from the current workload must be analyzed and concerns addressed prior to any consideration of expanding the pilot.

Question 9: At a previous hearing, VA staff were unable to tell me what happened to the Office of Seamless Transition, which has now become a *VHA/DoD* Out-

reach Coordination Office—how has VBA been dropped from the process? How are newly disabled veterans who seem to have a difficult enough time in getting claims processed supposed to navigate the system without this level of support? Why was Congress not informed about such a major realignment and our input not included?

Response: In January 2005, the Under Secretary for Health (USH) established the Office of Seamless Transition (OST) to assist servicemembers in their transition from DoD to VA. In addition to VHA employees, OST was supported by VBA, which provided staff to help with benefits issues. Two active duty Marine Corps officers and one Army officer were also detailed to the office. The mission of OST was to ensure that every severely injured or ill servicemember returning from combat received priority consideration and world-class service within VA.

In the late summer of 2007, VHA reorganized the OST into three components: the OEF/OIF Program Office; the Care Management and Social Work Service; and the Office of OEF/OIF Outreach, recognizing that separate focuses had evolved with respect to efforts on behalf of our Nations' returning servicemembers. The USH created the OEF/OIF Program Office as a direct report. On an ongoing basis, the executive director of the office collaborates with DoD on policy and course direction related to transition of healthcare services for servicemembers as they move between DoD and VHA. The office also works with other offices in VA and VBA to specify remedies for barriers and challenges as they are identified. In response to public law, such as components of the NDAA that require VHA actions, the office facilitates the development of action plans that assure the intent of such issuances are met fully and timely, including any that require joint action with other VA or DoD offices.

In response to a need for higher-level clinical case management, VHA created the Care Management and Social Work Service within the Office of Patient Care Services (PCS) in October 2007. The new service's placement under PCS takes advantage of the synergistic alignment with the polytrauma and rehabilitation and mental health chief consultant offices, and other clinical specialties, which are deemed critical for internal coordination of veterans' care. The office's mission is to coordinate patients' healthcare and provide family support. This office has staff detailed from VBA for support on benefit issues, and from active duty military officers. The office works closely with OEF/OIF program directors and case managers at VA medical centers, VBA offices, and DoD discharge staff to ensure a smooth transition to VA services at locations nearest to the veteran's residence after their military discharge. This coordination allows enhanced identification of these veterans at their local VA facilities for continuity of medical care and processing of benefits claims.

The third component of focus is the Office of OEF/OIF Outreach, which provides a national focus on VHA's systematic efforts to identify new veterans and to provide information on services available to them. The office's military liaison coordinator assures that VHA participates in National Guard and Reserve's post deployment health reassessment (PDHRA) activities and assists in coordinating the pre- and post-deployment briefing. This office also receives lists from DoD of servicemembers who are in the physical evaluation board process, and sends this information to the local VHA office where the servicemember resides. The local VHA office sends a letter from the Secretary with information about VA. For those leaving active duty due to service connected medical problems, the outreach effort is intensified to ensure a full understanding of the VA compensation process and vocational rehabilitation and employment programs. VA briefings on healthcare services and benefits are conducted at townhall meetings and include VHA and VBA staff who assist and present to family readiness groups and to unit drill activities near the home of returning National Guard/Reservists. Current efforts are underway to reach out using a call center to those who are separated from the military and have not used VA healthcare to encourage them to consider VA as an option as they need services.

Question 10: I have heard that there has been some confusion over the clothing allowance. It used to be adjudicated and paid by VBA. Now VHA has oversight and the veteran must go to a VAMC to apply.

Response: Although VHA has assumed responsibility for the clothing allowance program, the process for application does not require the veteran to report to the VA medical center (VAMC) to apply. The veteran can fill out the form (VAF–8679) and mail it to the local VAMC prosthetics department. If he does not have a form, he can call and one will be mailed to him. VHA is also in the process of placing this form on the Web site to be downloadable and fillable. The only time a veteran may be asked to come to a VAMC is to determine if he meets the qualifications for a clothing allowance and this generally applies only to those non-static veterans whose medical condition is subject to change.

Question 11: Is this not adding another step to the process?

Response: No additional steps have been added to the process, as a matter of fact, there has been elimination of the steps when the application had to be sent from VBA to VHA for determination of non-static allowances. Now the determination is made and the processing of payment made at the same time.

Question 12: Additionally, if VBA does not inform the veteran, and I have seen decision letters that no longer inform amputees and other eligible veterans about the benefit, how do they know it even exists?

Response: With all new awards of service connection, VA Form 21–8764, *Disability Compensation Award Attachment* is included with the decision letter. The attachment includes an explanation of the clothing allowance benefit. It also instructs veterans to contact the prosthetics department at the nearest VHA facility to apply for the benefit. This information is also provided in VA's annual publication, *Federal Benefits for Veterans and Dependents*, which is available at many VA facilities and also electronically on VA's Web site.

Question 13: Furthermore, some of the OIF/OEF amputees are getting their prosthesis through TRICARE contracts and are not using VAMCs, so how are they going to get their clothing allowance?

Response: The veteran only needs to complete the application (VAF 8679) and send it to the local VA prosthetics department, who will review his rating and if service connected for the condition, the staff will establish the veteran as "static" and no further action will be required.

Question 14: I am very concerned, as I am sure we all are, about the caregivers of the severely injured servicemembers and I appreciate the pilot programs underway to assist them. But my concern is with providing them with other resources and would like to hear your opinion on creating a caregiver allowance and extending CHAMPA eligibility to them, even if they are not the veteran's dependent.

Response: VA will study this option. VA has come to appreciate the importance of support to family caregivers whose severely injured loved ones transition into VA healthcare.

Question 15: What is the current status of the Vets Center in Middletown, NY?

Response: The lease for the Middletown Vet Center (726 East Main Street, Suite 201, Middletown, NY 10940) was signed on September 28, 2007. The property is currently being built-out and the projected move-in date is April 14, 2008. The team leader, two counselors and the office manager positions have been filled and staff are providing services in temporary space donated at the Orange County Veterans' Service Office, Port Jervis, Monticello and Newburg CBOCs. The first client was provided service on December 27, 2007.

Question 16: Regarding the CARES process at the Hudson Valley VA System I believe the VA must do what is best for our veterans, not what is most beneficial for the VA bureaucracy. What is the status of the Enhanced Use Lease process for these hospitals and what principles do you believe should guide the VA in this decision?

Response: VA's guiding principles when using the enhanced use leasing program are to produce developments that provide direct benefits to veterans with much needed healthcare and services that VA does not offer, not a benefit of VA's bureaucracy. Examples are assisted living facilities, transactional and permanent housing for homeless veterans, continuous care retirement communities, low income senior housing and other in-kind considerations. These types of services are put in place with veterans' preference and priority placement as well as the conveyance of the property value as a discount to the veteran's costs when occupying the facilities.

At Montrose VA expects to facilitate the provision of those types of services and healthcare with a developer/lessee that will be selected through a full and open competition. The enhanced use leasing process will formally begin in the summer of 2008 at a public hearing to present VA's concepts to the community and stakeholders to receive input and comments. The process is expected to have 2 phases. The first phase will be immediate for the land and buildings currently available due to underutilization and vacancy. The second phase will be the remaining land and buildings that will be available after the VA's capital plan for Montrose and Castle Point is completed.

Question 17(a): What stage is the performance bonus review process in?

Response: The Department concluded its 2007 Senior Executive Service (SES) performance review process on December 7, 2007.

Question 17(b): What do you think of the level of bonuses that were paid out last year to Senior Executive Service officials at the VA?

Response: In January 2008, I reviewed the changes made to the VA SES performance review process including the level of bonuses that were paid out last year. I believe the distribution and level of bonuses paid to our SES officials was based on VA's overall performance as a Department and the individual performance of each executive who received a bonus.

Question 17(c): Do you intend to take a more active oversight role in the process than your predecessor?

Response: While serving as Acting Secretary, Deputy Secretary Gordon H. Mansfield modified various components of VA's SES performance review process. Deputy Secretary Mansfield's modifications resulted in more accountability on the part of every SES member and enhanced the credibility and integrity of VA's SES performance management system. These modifications also promote a Department-wide service delivery to our Nation's veterans and their families. I fully support the modifications he made and will continue the active oversight implemented by Deputy Secretary Mansfield.

Question 18: In 2004, Congress enacted the Veterans Health Programs Improvement Act of 2004 (P.L. 108–422). Section 201 of the Act authorizes VA to make subsidy payments to the States to assist State veterans homes in recruiting and retaining nursing personnel to reduce nursing shortages. I understand VA personnel have been developing regulations to carry out the intent of Congress, but those regulations have not been published, now nearly 4 years after passage. As required by Section 201(b) of the Act, "[t]he Secretary shall establish such interim procedures as necessary so as to ensure that payments are made to eligible States under that section commencing not later than June 1, 2005, notwithstanding that regulations under subsection (j) of that section may not have become final." What are the causes for the long delay in promulgating these regulations, and what are the Department's plans to implement these provisions of law?

Response: It was necessary for VA to define the scope of coverage for different categories of nurses and analyze the extent of nursing shortages and the efficacy of different recruitment and retention incentives. Consultation with State Veterans Home stakeholders was undertaken to be sure the final regulation would be compatible with their needs. The proposed regulation was published in the Federal Register on April 11, 2008, and is currently outstanding for a 60-day public comment period from the date of publication.

Question 19: When can State veterans homes expect to see these regulations published?

Response: The proposed regulation was published in the Federal Register on April 11, 2008, and is outstanding for a 60-day public comment period from the date of publication. Following that period, VA will respond to any public comments received and publish the regulation as quickly as possible thereafter.

Question 20: In Section 211 of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 109–461), the Department is authorized and required to provide severely disabled service-connected veterans (70% disabled or greater) with equitable access to State veterans homes, by reimbursing homes the full cost of care for these veterans, as well as for any veteran whose primary need for nursing home care is due to a service-connected disability. That Act also requires VA to furnish prescription medications to veterans in State homes to treat their service-connected disabilities, and medication for any disabilities of veterans who have service-connected disabilities rated at 50 percent or more disabling. The Department has not implemented this law, whose effective date was March 22, 2005. Currently, the VA is contracting with private sector nursing homes to deliver care to these veterans. A GAO report on VA Long Term Care (March 2006) found that the State veterans home program can provide higher quality of care to veterans at a much lower cost for services. What is the Department's plan to implement these

measures, and what are the assumed costs or savings that would result from implementation?

Response: VA must establish a new regulation in order to implement these measures. The regulation has been drafted and was placed in the concurrence process on February 14, 2008. After departmental concurrence is received, it will be reviewed by the OMB, published as a proposed rule in the Federal Register for a 60-day mandatory public comment period, revised if necessary in response to public comments, and then published as a regulation in the Federal Register.

Question 21: When can State veterans homes expect to see these authorities implemented?

Response: VA will proceed to implement these measures as quickly as possible thereafter.

Question 22: In 2006, this Committee received testimony from the President of the National Association of State Veterans Homes as follows: "States have presented over $400 million in projects that are presently pending before VA. Also, a February 2006 VA survey of States documented that $161 million will be required in life-safety projects alone over the next few years. We believe that the total backlog of all conceivable State construction projects, including increased capacity to meet rising demand in California, Texas, Florida and other States, could easily top $1 billion." Last year, Congress provided $165 million in funding for construction grants for State extended care facilities. This year, the Administration's budget submission requested only $85 million for this program. What is the current dollar total of backlogged requests for new construction or renovation under this program from State homes? Of this amount how much is requested by State homes for construction of vital life and safety repairs and upgrades and how many new bed-producing projects, with their costs, are pending in VA's construction backlog?

Response: There are 178 initial applications included in the FY 2008 State home construction grant program, with an estimated cost to VA of $971,624,000. Of these, 39 applications are for life and safety repairs ($97,198,000), 97 are for renovations of existing State veterans homes ($245,917,000) and 42 are new bed-producing projects ($628,509,000). Only 92 of the 178 initial applications have certified the commitment of State matching funds required to make them eligible for a VA grant. These 92 applications have an estimated cost to VA of $535,467,000, including $80,353,000 for 19 life safety projects, $78,949,000 for 53 renovation projects, and $376,165,000 for 20 new bed-producing projects.

Question 23: Based on the Department's contacts with the States, please estimate the number of construction project requests you expect to receive this year, with their estimated costs.

Response: The States do not consistently inform VA of its plans. VA will not know the cost or priority of new grant applications for certain until after August 15, 2008, which is the deadline for submission of applications to be considered for inclusion in the FY 2009 priority list.

Question 24: What criteria did the Department use to determine a funding level of $85 million for the State extended care grant program for Fiscal Year 2009?

Response: VA anticipates that the FY 2009 funding request will be sufficient to fund all Priority Group 1; Subpriority 1 projects (Remedies for Life/Safety).

Question 25: Congress is in receipt of numerous reports that VHA, NCA and VBA are contracting out Federal functions to contractor performance without conducting cost comparisons, which is clear violation of the OMB A–76 Circular, governmentwide competition rules that apply to the VA, as well as FY 2008 VA appropriations language that makes even clearer that the VA must comply with these competitions. VA acknowledges that 80% of the blue collar jobs contracted out is held by veterans including disabled veterans. Will you commit to ensure that your Department follows the circular and the law, in order to ensure that VA is in compliance with the law and that the interests of the taxpayer and veterans seeking Federal employment are well served?

Response: VA is committed to following the Circular and the law. In addition to OMB A–76 Circular, VA must also comply with title 38, section 8110 which states "Notwithstanding any other provision of this title or of any other law, funds appropriated for the Department under the appropriation accounts for medical care, med-

ical and prosthetic research, and medical administration and miscellaneous operating expenses may not be used for, and no employee compensated from such funds may carry out any activity in connection with, the conduct of any study comparing the cost of the provision by private contractors with the cost of the provision by the Department of commercial or industrial products and services for the Veterans Health Administration unless such funds have been specifically appropriated for the purpose." Federal positions are not being directly converted to contractor performance in contravention of the Circular or the law. VHA ensures that it complies with OMB A–76 Circular, *Performance of Commercial Activities*, title 38, section 8110 and other applicable laws. VA submits the Annual Section 305 report required by Public Law 100–262, Veterans' Health Care Eligibility Reform Act of 1996. All VHA contracting activities are required to provide an annual certification and, to report all FTE that are converted to contract performance during the given fiscal year.

Question 26: You stated at the hearing that a significant share of the IG's work was done through contractors. Please provide the Committee with an inventory of the number of contractors used by the IG over the last 5 years, the functions they performed, the dollar amount and share of the IG budget that was used to pay contractors, and when and how contractor performance has been evaluated, to determine if it is cost effectiveness to continue to contract out this work.

Response: Over the last 5 years, the Office of Inspector General (OIG) contracted for work related to the annual audits of VA's consolidated financial statements (CFS) and the Federal Information Security Management Act (FISMA) as shown in the table below. Although the majority of the CFS work was performed by contractors, until FY 2007, most of the FISMA work was performed by OIG personnel.

Before FY 2005, OIG provided narrative comments but no rating for contractor performance. For FY 2005 through FY 2007 OIG evaluated the contractor's interim performance for the following areas as required by the Office of Acquisition and Logistics, Acquisition Operations Service:

- Contractor's compliance with initial performance schedule.
- Effectiveness of contractor's schedule tracking system.
- Contractor's ability to adapt to customer initiated schedule changes.
- Contractor's ability to plan, develop, track and preserve project management documentation.
- Effectiveness of the contractor's use of teaming.
- Ability of contractor to work with the customer.

OIG will provide a final rating of (1) highly effective, (2) effective, (3) marginally effective, or (4) ineffective at the end of the contract performance period.

Fiscal Year	Contractor	Contract Amount	Share of OIG Budget (percent-rounded)	Purpose of Contract
2007	Deloitte & Touché LLP	$3,705,493	5 percent	Annual CFS audit
2007	Deloitte & Touché LLP	1,013,550	1 percent	Annual FISMA audit
2006	Deloitte & Touché LLP	$3,611,915	5 percent	Annual CFS audit
2006	Internet Security Systems, Inc.	25,000	.04 percent	Penetration testing for FISMA audit
2005*	Deloitte & Touché LLP	3,496,204	5 percent	Annual CFS audit
2005	Internet Security Systems, Inc.	25,000	.04 percent	Penetration testing for annual FISMA audit
2004	Deloitte & Touché LLP	4,302,739	7 percent	Annual CFS audit
2003	Deloitte & Touché LLP	4,190,734	7 percent	Annual CFS audit

*The OIG awarded a new contract in FY 2005 for the annual CFS audit through competition, which resulted in a lower price.

Question 27: P.L. 108–445 requires the Department to report to Congress annually for 5 years after implementation of the physicians' pay bill to determine if the law is helping with recruitment and retention of physicians. The reports during the first 2 years must also address how many VA medical dollars are still being spent on contract care rather than in-house medical staff. Congress has still not received

a single report even though the law took effect over 2 years ago. When is the Department going to comply with these reporting requirements?

Response: The annual report on physicians pay was provided to the Chairman and Ranking Members of the Senate and House Committees on Veterans' Affairs and the House Subcommittee on Health on November 16, 2007.

Question 28: P.L. 108–445 also encouraged the VA to offer its RNs alternative work schedules that are regularly available to nurses in the private sector. How many facilities have offered AWS since the law took effect over 2 years ago, and how many nurses per facility are working AWS?

Response: VA implemented two alternate schedules authorized by Public Law 108–445. The 36/40 work schedule that authorizes nurses to work three regularly scheduled 12-hour shifts within an administrative work week and be paid for a full 40-hour work week, and the 9 month/3 month work schedule that authorizes nurses to work full-time for 9 months with 3 months off-duty within a fiscal year and be paid at 75 percent of the full time rate.

The law gives the direction for establishing the two work schedules; however no facility is mandated to use them. Individual facilities may choose to offer the alternative work schedule (AWS) if they believe these schedules would benefit its posture of retaining well qualified staff as an employer of choice.

Currently there is no mechanism to centrally track the complete use of the AWS per facility and by individual because of limitations in the personnel and accounting integrated data (PAID) and enhanced time and attendance (ETA) systems. For example, nurses who are authorized to work the 36/40 AWS (36/40 AWS) whose tour of duty cross administrative work weeks presents timekeeping challenges in the ETA system. The Office of Human Resources Management, Work Life and Benefits Service is currently researching and considering solutions that can be quickly implemented to resolve these problems.

The Honorable Joe Donnelly
House Veterans' Affairs Committee

Question 1: VA has said that the budget would provide sufficient resources to virtually eliminate the time a patient has to spend waiting for an appointment to see a doctor by the end of 2009. While that is an admirable goal, is it realistic, and what are some of the steps you plan to take to ensure that will happen?

Response: The access list in March of 2008 was 28,724, a reduction of 126,977 since March 2007. (The access list is defined as all patients on the electronic wait list or those with an appointment but waiting more than 30 days beyond their desired date). VA is working diligently to ensure that patients do not have lengthy waits for clinic appointments and we expect to have the access list down to 25,000 by the end of FY 2008 and virtually eliminated by September 2009.

Question 2: VA has said that the budget would provide sufficient funds to reduce the disability claims backlog by 24 percent (to 298,000) by the end of 2009. Is this realistic, and what are some of the steps you plan to take to ensure that will happen? Also, can we go further to reduce the backlog and wait time even more, and if so, is this an issue of funding, or whether we can fundamentally change how the system works?

Response: VA has embarked on an extensive hiring and training initiative to reduce the pending inventory. The goal of reducing the claims inventory to 298,000 by the end of 2009 is realistic if claims receipts do not exceed projections.

Court cases and legislative changes can result in an unforeseen increase in claims. Current law also imposes requirements that create inherent delays in the claims process.

Question 3: Do you believe there is adequate funding in this budget for mental health, ensuring returning veterans are better screened for potential problems, and providing care for those in need? How will increased funds be used to accomplish this goal?

Response: VA's proposed budget for FY 2009 includes $3.9 billion to continue to improve access to mental health services across the country. This is an increase of $319 million, or 9 percent, above the 2008 level. These funds will help VA continue to deliver exceptional, accessible mental healthcare. Our strategy for improving ac-

cess includes increasing mental healthcare staff, over 3,800 new mental health professional and support staff have been hired since FY 2005, resulting in a total of almost 17,000 mental health staff in the VA system. In addition to growth in staff, the enhancement funding supports new care models, such as integration of mental health services into primary care sites and training of mental health staff to provide psychotherapies with particularly strong evidence bases, as research has become available to identify such treatment models. We have expanded our tele-mental health program, which allows us to reach about 20,000 additional patients with mental health conditions each year.

The budget also include funds for the *Mental Health Initiative*, which focuses on enhancing access to all mental health programs, including those for OEF/OIF veterans, increasing recovery oriented services, integrating care between mental health and primary care, and promoting a national model for suicide risk identification and prevention.

Dollars in Thousands	**2007 Actual**	**2008 Estimate**	**2009 Estimate**
Mental Health Initiative	$352,835	$370,029	$531,283

As part of its efforts to increase access to mental health services in the most appropriate setting, a portion of *Mental Health Initiative* funding is directed toward increased staffing for outpatient mental health programs in 2008 and 2009. In addition, VA is planning to increase the number of intensive outpatient substance abuse programs. This effort reflects the continued transition from inpatient care to more effective intensive outpatient care for treating substance abuse problems.

Dollars in Thousands	**2007 Actual**	**2008 Estimate**	**2009 Estimate**
Outpatient	$1,421,340	$1,523,990	$1,584,424

Mental Heath Initiative funds are being used to increase funding for suicide prevention.

Dollars in Thousands	**2007 Actual**	**Estimate 2008**	**Estimate 2009**
Suicide Prevention	$8,635	$15,472	$15,509

These funds have been used to establish a National Suicide Prevention Center of Excellence in Canandaigua, New York, which has established a national suicide hotline and a comprehensive public health education approach within VHA to increase awareness of the issue of suicide, emphasizing that suicide prevention is the responsibility of all VA employees. In addition, VHA has funded suicide prevention coordinators at each medical center to provide local awareness on preventing suicide among veterans as well as recognizing veterans at high risk for suicide, and providing appropriate care. Ongoing funds will expand the Center, provide additional training opportunities, and support and expand the roles of the facility-based suicide prevention coordinators.

Increased funding levels reflect the VA OEF/OIF enrollees' unique healthcare usage patterns, particularly for mental health services. For example OEF/OIF enrollees are expected to need more than eight times the number of post traumatic stress disorder (PTSD) residential rehabilitation days than non-OEF/OIF enrollees. OEF/OIF enrollees also have an increased need for inpatient acute psychiatric care and outpatient psychiatric and substance abuse treatment.

Question 4: When will VA lift the ban on enrolling Priority 8 vets? What is your estimate for the amount of additional resources needed in order to allow you to lift this enrollment ban?

Response: VA estimates it would require a budgetary increase of $3.1 billion, not including additional infrastructure costs, to provide healthcare services to an additional 1.4 million Priority 8 enrollees and approximately 750,000 patients in 2013, the first year VA believes it could put in place the necessary infrastructure to accommodate the increase in workload associated with reopening enrollment Priority 8 veterans.

To understand the full magnitude of the cost of re-opening enrollment such an endeavor must be viewed within a long-term strategic framework, namely the estimated 5-year cost of $16.9 billion and the 10-year cost of $39.2 billion. These estimates represent the costs of providing healthcare services to these new Priority 8 enrollees but do not include the capital costs needed to build the associated infrastructure. Further, VA's strategic analysis identified significant challenges with regard to building the capacity, both in terms of infrastructure and staffing, required to re-open enrollment for Priority 8 veterans in the near term without severely disrupting VA's ability to provide timely, quality care to eligible veterans.

Under current enrollment policy, VA's projected demand for healthcare services is expected to increase over the next several years. While enrollment growth has slowed since the suspension of enrollment in Priority 8, the volume of healthcare services required by enrollees continues to grow due to the aging of the enrolled population. VA will need to continue to build capacity in the coming years to meet this increased need for healthcare services from currently eligible veterans. Providing healthcare services to these new Priority 8 enrollees would require that VA develop additional capacity beyond the growth needed under the current enrollment policy. For example, VA will need to grow ambulatory services 15 percent by 2013 under the current enrollment policy and by a total of 24 percent under full enrollment (including Priority 8 veterans). Further, the growth in demand for VA healthcare services varies significantly across the VA healthcare system. For example, to meet the combined increase in demand for services under both current enrollment policy and full enrollment in 2013, some areas will have to grow ambulatory services by as much as 45 percent. Without first building the needed infrastructure and staff capacity, VA would be unable to accommodate the large increase in workload without compromising quality and timeliness of care.

Question 5: We know you are doing your best to ensure that OIF and OEF veterans receive the necessary medical care. What are you doing about ensuring the VA's ability to provide care for all veterans, in both urban and rural areas, in our clinics and hospitals around the country?

Response: VA monitors its ability to provide care through a series of internal and external measures with special emphasis on quality and access. VA has improved access to care for veterans in both urban and rural areas through a variety of mechanisms to include additional outpatient access points, technology, sharing agreements and purchased care.

CBOCs enhance access to all veterans. VA has opened over 570 new CBOCs since 1995. With regard to veterans residing in rural areas, VA operates or contracts for care at 100 outpatient clinics located in areas considered rural or highly rural. CBOCs offer veterans a full array of primary care, mental healthcare, and in some instances specialty care services in communities where they live and work.

VA uses the latest advances in information technology with the use of telehealth technology. Telehealth involves the use of electronic information and communications technologies to provide and support healthcare when distance separates the participants. These new information technologies help support care delivery in the home, allowing veteran patients to enjoy better health and to continue living independently. Telehealth also serves to increase access to specialty care for conditions such as cardiac disease, mental health, diabetes, post-surgical followup and rheumatology. VA is designating lead clinicians to formalize these projects into models of care that can be implemented nationally to increase access to specialty care for veterans in rural areas. This will begin with mental health, surgery, rheumatology and endocrinology. Telehealth models have been developed to link VAMCs and CBOCs. These models encompass the clinical, technology and management processes involved in providing services to remote CBOCs.

Telehealth technology has the potential to extend the reach of other established programs such as home-based primary care, mental health intensive case management and primary and ambulatory care into rural and urban areas. Extending these services outside current geographical boundaries and into rural areas reduces unnecessary hospital admission and alleviates patient travel burden.

VA is involved in many sharing agreements to maximize resources. Sharing of healthcare resources results in enhanced healthcare benefits for veterans; reduced costs and minimized duplication of resources and services.

VA provides care through the fee basis program to enhance access to care outside of VA facilities. In FY 2007, VA purchased over $2 billion in care for our Nation's veterans. VA has implemented a demonstration project (Project HERO) intended to assess VA's ability to leverage contracts on a large scale for these needed services. This project, implemented in four VISNs, requires vendors to meet these internal

VA access standards, provide facilities alternatives to care when internal resources are not available, and improve sharing of clinical documentation associated with these external services.

VA established the Office of Rural Health to meet the unique needs of veterans residing in rural areas. This office collaborates with other program offices to assess multiple care delivery models to ensure veterans in rural and remote locations have available services. This includes tools such as mobile healthcare vans, expanded use of telehealth tools and additional care coordination with home health providers.

These multiple options allow VA to be effective and efficient in providing care for all veterans, in both urban and rural areas.

Committee on Veterans' Affairs
Washington, DC.
February 27, 2008

Honorable James B. Peake, M.D.
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake,

In reference to the full Committee hearing on the Department of Veterans Affairs Budget Request for Fiscal Year 2009, held on February 7, 2008, I would appreciate a response to the questions listed below. Please respond to these questions no later than March 27, 2008.

1. With respect to the mileage deductibles for travel reimbursements, are these deductibles being collected from veterans who are traveling long distances to VA medical facilities, and if not, could you please provide documentation on when this practice stopped?
2. What is VA doing to increase the number of doctors, nurses, mental health professionals and other specialty practitioners in order to provide better access to care to our veterans?
3. Regarding the VA medical center in San Juan, Puerto Rico, why has the VA proposed large expenditures for the existing facility in San Juan, when there is a proposal to replace that facility?
4. When a security breach occurs with a physician's personal computer which has received a waiver from the Secretary, who will ultimately be held responsible for the costs of the breach?

It would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. Please restate the question in its entirety before providing the answer.

Thank you for your cooperation in this matter.

Sincerely,

Steve Buyer
Ranking Republican Member

Questions for the Record

The Honorable Steve Buyer, Ranking Republican Member
House Committee on Veterans' Affairs
February 7, 2008
Department of Veterans Affairs Budget Request for Fiscal Year 2009

Question 1: With respect to the mileage deductibles for travel reimbursements, are these deductibles being collected from veterans who are traveling long distances to VA medical facilities, and if not, could you please provide documentation on when this practice stopped?

Response: Currently, the Department of Veterans Affairs (VA) does collect deductibles from most veterans' travel reimbursements, including those who travel long distances. However, 38 U.S.C. 111 allows VA to waive the deductibles in cases of "severe financial hardship," which VA defines in regulations. Under the current regulation, 38 C.F.R. 17.144, VA may limit findings of severe hardship for situations including loss of employment, sudden illness or a disability that causes a veteran's income to fall below the maximum pension level, currently $13,092.

We are amending the regulation to reflect the new $0.285 (28.5 cents) mileage payment and the new deductible of $7.77 for each one-way trip.

Question 2: What is VA doing to increase the number of doctors, nurses, mental health professionals and other specialty practitioners in order to provide better access to care to our veterans?

Response: With involvement from the VA Healthcare Retention and Recruitment Office (HRRO), the Office of Management Support, the Office of Mental Health Services, the Office of Nursing, and the Office of Patient Care Services, VA has developed comprehensive recruitment initiatives to attract and retain healthcare professionals to the Veterans Health Administration (VHA).

Consolidated data from the 2008–2012 Veterans Integrated Service Network (VISN) Workforce Succession Strategic Plans identified 10 occupations as national priorities for recruitment and retention. The programs offered through HRRO provide assistance to 8 of these top 10 occupations: registered nurses, physicians, pharmacists, practical nurses (LPN/LVN), diagnostic radiology technologists, medical technologists, physical therapists, and medical records technicians.

The Employee Incentive Scholarship program (EISP) impacts the recruitment and retention of health professionals required throughout the agency. Over 92 percent of the scholarships went to employees; 187 scholarships were awarded to pharmacists for advanced degrees.

The Education Debt Reduction program (EDRP) provides up to $48,000 of education loan repayment for qualified student debt. It is used as both a recruitment tool by being offered in vacancy announcements of hard-to-recruit/retain occupations, and as a retention tool by spreading out loan payment reimbursements yearly over a maximum of 5 years.

VA has taken several actions at multiple levels to promote the recruitment and retention of qualified mental health professionals in VHA. The VA HRRO, the Office of Management Support, and the Office of Mental Health Services have developed a comprehensive mental health enhancement recruitment initiative that includes several new recruitment resources, including employee incentive referral initiative and recruitment brochure development, on targeted and general advertising.

Furthermore, VHA closely tracks the hiring status of newly awarded mental health enhancement positions and backfill positions designed to support the implementation of the Mental Health Strategic Plan. The hiring status of these new positions is tracked on a monthly basis through an online reporting system. These data are reviewed monthly by program staff and VHA leadership. In addition, the recently implemented mental health staffing performance monitor tracks the hiring status of newly awarded mental health positions and backfill positions against preset targets.

Rates of hiring have increased significantly, following the implementation of the new mental health recruitment resources. Since fiscal year (FY) 2005, when VA began implementing its Mental Health Strategic Plan, 3,827 (out of 4,326) newly awarded mental health enhancement positions have been hired (figures are as of the end of January 2007). The vast majority (3,355) of these newly hired staff are mental health professionals. The remaining (472) positions include support staff essential for cost-effective provision of services.

Question 3: Regarding the VA medical center in San Juan, Puerto Rico, why has the VA proposed large expenditures for the existing facility in San Juan, when there is a proposal to replace that facility?

Response: There is currently a plan in place to upgrade facilities in San Juan through a combination of a significant amount of new construction and renovation. The Congress has funded, and construction is already underway for the construction of a new bed tower of 225,000 gross square feet (GSF) that will contain 314 inpatient hospital beds. This will relocate all of the nursing units out of the existing tower and into this modern, seismically safe new building.

In addition, in FY 2008, funding was provided in the appropriation for the construction of a new administrative building of approximately 100,000 square feet to enable administrative space to vacate the hospital to permit needed expansion of

some clinical programs. The request in FY 2009 will fund the construction of new clinical space (120,000 GSF) on top of the ambulatory care center.

When the administration building and the new clinical space are completed, the existing bed tower will be demolished and the lower floors of the existing hospital will be remodeled (222,000 GSF). The opportunity to make these improvements will be much less costly than constructing a replacement hospital and will provide the modern facilities needed to serve veterans.

Question 4: When a security breach occurs with a physician's personal computer which has received a waiver from the Secretary, who will ultimately be held responsible for the costs of the breach?

Response: In cases where we grant a waiver to a physician for the use of a personal laptop, VA accepts the risk that the laptop could be compromised. Therefore, it is VA's responsibility to pay for the costs of a resulting data breach, such as credit monitoring services.

From lessons learned as a result of the major data breach experienced in 2006 and the 2007 data breach at one of its research centers, VA is aggressively addressing information/data security. A top priority of the Secretary of Veterans Affairs is for the Department to set the *Gold Standard for Data Security*. In order to achieve this priority, VA is implementing systemwide strategies that promote data security awareness among employees as well as a change in the culture and capability in all facilities and remote locations. [OMB comment: Statement from Vol. 2, p. 4–A–5 of 2009 budget submission.]

It is the intent of the VA Chief Information Officer to continue to reduce the use of other equipment where we can, especially when there is a demonstrated need to work remotely. VA plans to use government furnished equipment (GFE) in cases where staff need to work while on travel or from home.

While it would be very difficult to completely eliminate the use of other equipment, in order to reduce the associated risk, VA is implementing a new remote access solution called remote enterprise security compliance update environment (RESCUE). This will ensure that VA data are not remotely downloaded to an unencrypted laptop or desktop. RESCUE will be able to determine if a user is accessing the VA network through GFE or other equipment. If the user is signing on through a piece of other equipment, the access will be limited to a Web browser, and data cannot be saved locally or printed. The user will be able to continue to work in a restricted area.

Committee on Veterans' Affairs
Washington, DC.
March 7, 2008

Carl Blake
National Legislative Director
Paralyzed Veterans of America
801 18th Street, NW
Washington, DC 20006

Dear Carl:

In reference to our Full Committee hearing on "The Department of Veterans Affairs Budget Request for Fiscal Year 2009" on February 7, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 18, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

The Independent Budget
Washington, DC.
April 3, 2008

Honorable Bob Filner
Chairman
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Filner:

On behalf of *The Independent Budget*, we would like to thank you for the opportunity to present our views on the FY 2009 budget for the Department of Veterans Affairs (VA). Only through cooperation between the veterans' service organizations and the members of the Committee can we hope to attain an adequate level of funding to provide timely and quality healthcare and benefits services.

We have included with our letter a response to each of the questions that you presented following the hearing on February 7, 2008. Thank you very much.

Sincerely,

Raymond C. Kelley
National Legislative Director
AMVETS

Joseph A. Violante
National Legislative Director
Disabled American Veterans

Carl Blake
National Legislative Director
Paralyzed Veterans of America

Dennis Cullinan
National Legislative Director
Veterans of Foreign Wars of the United States

In the past, *The Independent Budget* has not included amounts attributable to Medical Care Collections in your budget estimates. This year, you have included collections in your baseline for FY 2008 and these amounts are included in your FY 2009 Medical Services estimate. In your testimony you again state this year that "medical care collections should be a supplement to, not a substitute for, real dollars." VA's collections estimates over the last few years have been reasonably accurate.

Question 1: Why does *The Independent Budget* believe that collections are not "real dollars"?

Response: The aforementioned quote does not imply that we do not believe that medical care collections are "real dollars." It is simply meant to reflect our belief that funding for Department of Veterans Affairs (VA) healthcare programs should be provided in full with federally appropriated dollars. Our budget recommendations this year better reflect this policy position that we have long supported. The Administration, year-after-year, chooses to include medical care collections as part of its overall funding authority for Medical Services. In the past, the VA did a very poor job of meeting collections estimates that it formulated its operating budget on. We will not deny that in recent years, the VA has done a much better job of meeting its collections estimates. However, we remain concerned about a process that is grounded in so much uncertainty, especially in light of the fact that shortages between what the VA estimated it would collect and what it actually collected have never been funded.

As such, we believe that the cost of medical care services should be provided for entirely through direct appropriations. In order for *The Independent Budget* recommendation to best reflect what we believe the total funding needs of the VA healthcare system for FY 2009 to be, we had to use the maximum appropriation amount included in P.L. 110–161 for VA medical care and add the projected medical care collections to that amount to formulate a real baseline.

Despite this fact, we realize that political considerations will not allow for the policy for which *The Independent Budget* for FY 2009 advocates as it relates to medical care collections. With this in mind, we cannot openly oppose a funding level that

approaches our bottom line recommendation for funding, even if collections are considered as a component.

Question 2: How would *The Independent Budget* recommend that this $2.5 billion in estimated collections, roughly 6 percent of the medical care appropriations request, be utilized?

Response: We believe that this money could be reinvested in various programs that are part of the Veterans Health Administration (VHA) or the entire VA. First and foremost, we believe that a large portion of the money collected can be devoted to capital investment projects. The VA has not adequately addressed the long list of projects identified by the Capital Asset Realignment for Enhanced Service (CARES) process. Moreover, as explained in the Construction section of *The Independent Budget*, the VA should be reinvesting 5 to 7 percent in its capital infrastructure each year. However, the VA currently only reinvests about 2 percent.

We also remain concerned that the VA falls well below the requirement for long-term care capacity (defined as average daily census) as mandated by P.L. 106–117, the "Millennium Health Care Act." A portion of the money achieved through medical care collections could be used to correct this deficiency. Additionally, the VA could invest this money in State Extended Care facilities which support the VA long-term care program.

We also believe this money could be used to properly staff the Office of Rural Health so that it can better fulfill its mission. *The Independent Budget* believes that this new office has not lived up to the expectations placed on it. However, the VA has not set this office up for success. It is telling that the VA plans on devoting only $1 million and one new full-time employee (FTE) to this office in FY 2009. This will bring the Office of Rural Health up to three FTE. This is wholly unacceptable, particularly given the fact that rural healthcare access might be the single biggest healthcare issue facing the VHA.

Finally, we would suggest some of the resources generated through medical care collections could be used to make the VA more competitive in the market for hiring critical staff. The VA is at a significant competitive disadvantage when trying to hire certain healthcare professionals. This is particularly true of nurses, rehabilitation specialists, and specialized care doctors.

Question 3: Since collections are reimbursements or payments for medical services rendered, shouldn't this money be utilized to offset the cost of providing healthcare?

Response: Historically, the purpose of collections has not had a direct bearing on the utilization of such funds throughout the evolution of what is now the Medical Care Collections Fund (MCCF). When the VA collection authority was initially established in 1986 to seek reimbursement from third-party health insurers, collections were meant to be utilized as a deficit reduction tool. It then evolved into a tool to offset VA's healthcare budget in 1997, and expanded to become a medical care utilization tool in 1999 by allowing VA to increase cost-sharing on veterans. In doing so however, such funds were supposed to be used to reduce medical care waiting times and to reduce the burden of cost sharing on veterans for medications and prosthetics. In 2003, MCCF was created to consolidate revenue accounts, thus increasing the total amount of collections available to further offset VA's healthcare budget.

While the purpose and utilization of collections has evolved, as mentioned previously, we continue to hold the belief that collections supplement the cost of providing healthcare. Veterans' healthcare should not be dependent upon an uncertain funding mechanism like medical care collections. However, as we also discussed, we realize that political considerations will not allow for the policy by which *The Independent Budget* for FY 2009 believes funding for VA healthcare services should be provided. In the meantime, we cannot openly oppose the use of collections to provide for medical care services so long as the total of appropriated dollars and actual collected dollars meets the funding levels that we believe are necessary to operate the VA healthcare system.

Committee on Veterans' Affairs
Washington, DC.
March 7, 2008

Kerry Baker
Associate National Legislative Director
Disabled American Veterans
807 Maine Avenue, SW
Washington, DC 20024

Dear Kerry:

In reference to our Full Committee hearing on "The Department of Veterans Affairs Budget Request for Fiscal Year 2009" on February 7, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 18, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

The Independent Budget
Washington, DC.
April 12, 2008

Honorable Bob Filner
Chairman
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Filner:

On behalf of *The Independent Budget*, I would like to thank you for the opportunity to present our views on the FY 2009 budget for the Department of Veterans Affairs (VA). Only through cooperation between the veterans service organizations and the Members of the Committee can we hope to attain an adequate level of funding to provide timely quality healthcare and benefits services.

I have included with this letter a response to the questions that you presented following the hearing on February 7, 2008. Thank you very much.

Sincerely,

Kerry Baker
Associate National Legislative Director
Disabled American Veterans

Claims Processors

The Independent Budget (IB) recommends an increase of $381 million for the General Operating Expenses account, which provides funding for the Veterans Benefits Administration. This recommendation is $286 million over the Administration's request. Your testimony states that "Congress should authorize 12,184 FTE for FY 2009." The VA estimates a total FTE number for Disability Compensation, Pension and Burial of 12,120 for FY 2009, a difference of 64 FTE below your recommended level.

Question: Providing these additional FTE would cost approximately $5 million. If we provide this additional increase of $5 million to meet your FTE target, do you still believe that we should provide the remaining $281 million of your requested increase or will you provide the Committee with an updated GOE recommendation?

Response: As an overall concept, it is important to note that we do not believe that the increase in VBA funding in the Administration's FY 2009 budget submission is enough to meet basic inflation and the annualized pay raise (2.9 percent). Our assumption for general inflation applied to VBA accounts is approximately 3.2 percent. In order for the VBA recommendation to cover the annualized pay raise and this projected inflation rate alone, it would take approximately $80 million; however, the Administration request is only $44 million over FY 2008 funding appropriated levels.

The VA also assumed a lower starting level for FTE for Comp & Pen for 2008. We cannot explain this discrepancy.

As for the budget itself, the VA requests 703 additional FTE for Comp & Pen at a cost of $48.7 million. We recommend an increase of 825 FTE for Comp & Pen at a cost of $78.3 million. The VA assumes the lowest possible cost for all new FTE. VA assumed a lower average cost per FTE for 2009 than they did in FY 2008 and FY 2007, for which we believe to be unrealistic. We do not assume that the VA will only hire new claims adjudicators at the lowest possible salary.

The largest single difference in our budget recommendation is reflected in the "Summary of Discretionary Appropriation Highlights." The VA assumes net reductions due to reimbursements and unobligated balances for Compensation & Pension (C&P) that are $145 million more than we project in our budget recommendations. The two items listed above make up the vast majority of the difference in our C&P recommendations and by extension our VBA recommendations.

We recommend 160 additional FTE for education at a cost of $14.3 million. The VA only anticipates an increase of 20 FTE at a cost of $4.3 million. The *IB* recommends an increase of 115 FTE for Vocational Rehabilitation and Employment (VR&E), at a cost of $12.5 million. The VA actually projects a decrease in FTE for VR&E in FY 2009. These two FTE elements account for approximately $23 million more in the *IB* recommendations than the Administration recommends.

The VA projects essentially no increase in obligations for Insurance. Given that its current FY 2008 estimate starts out $5 million less than our recommendation, we end up with a difference of approximately $10 million for FY 2009.

The sum of the differences listed above totals approximately $244 million. Other minor differences can be attributed to our assumed pay increase of approximately 3.0 percent. Likewise, we attribute other differences in our budget recommendation to not having the exact information available for VA's baseline amounts for FY 2008 when we begin developing our recommendations.

Based on the above, we continue to recommend the respective increase called for in *The Independent Budget*.