THE VA'S BUDGET REQUEST FOR FISCAL YEAR 2007

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

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THE VA'S BUDGET REQUEST FOR FISCAL YEAR 2007

WEDNESDAY, FEBRUARY 8, 2006

U.S. House of Representatives,
Committee on Veterans' Affairs,
Washington, D.C.

The Committee met, pursuant to call, at 10:10 a.m., in Room 334, Cannon House Office Building, Hon. Steve Buyer [Chairman of the Committee] presiding.

Present: Representatives Buyer, Stearns, Moran, Brown of South Carolina, Miller, Boozman, Brown-Waite, Turner, Evans, Filner, Snyder, Michaud, Herseth, Strickland, Berkley, and Udall.

The Chairman. Good morning. I would like to welcome everyone to our first hearing of the second year of the 109th session of Congress. The Committee on Veterans' Affairs Full Committee will come to order this day February 8, 2006. Today you will hear testimony from Secretary Jim Nicholson on the Administration's fiscal year 2007 budget request to the Department of Veterans Affairs. You will then hear testimony on the Independent Budget, provided by representatives of four veterans' services organizations which developed that document: AMVETS, Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States. We will also then hear testimony on the budget from the American Legion and Vietnam Veterans of America.

Mr. Secretary, I am glad you can be with us here today to share with this Committee the President's proposed budget for 2007. I commend you for taking both hands onto this challenge, because what was presented to you last year wasn't your budget. You went through some difficult moments, and it appears that improving the integrity of the process has borne fruit with this budget.

Mr. Secretary, you just marked your one-year anniversary as the chief steward of our nations veterans. It's been a year of challenge, and you are to be thanked for your willingness to squarely meet those challenges. A year ago I expressed my confidence that you would join Mr. Evans, this Committee and me in making the VA the best it could possibly be. You have done so. Veterans' health care is excellent by any standard. Your National Cemetery Administration and the VA's

insurance program continually rate among the nation's best-run government programs. Your leadership and that of Dr. Perlin, and many within the department, in response to the catastrophe of Hurricane Katrina, was magnificent. The VA set the standard in your response. It is our job to preserve those areas of excellence and work together in a bipartisan fashion to ensure that every service we provide meets high standards, which means to right the wrongs.

It is worth noting that the President has proposed substantial increases in the budgets of four agencies: the Departments of Defense, State, Homeland Security, agencies focused on fighting the war on terror; and the Department of Veterans Affairs, an agency focused on caring for those who are in the battle.

As Chairman of this Committee, my three top priorities remain: number one, caring for veterans who have service-connected disabilities, those with special needs, and the indigent; two, insuring the seamless transition from military service to the VA; and three, providing veterans every opportunity to live full and healthy lives.

Mr. Secretary, these priorities I noted from your statement almost mirror your own. As stated in your written testimony, "The cornerstone of VA's medical care budget is providing for the veterans who need VA the most: those with service-connected disabilities, those with lower incomes, and veterans with special health care needs." You further emphasize the importance of priority consideration for ill and injured veterans returning from combat in the global war on terror.

We have an obligation to those who bear the burdens of war and of military service, and their survivors. Our work must move us toward fulfillment of that obligation. There are some concerns in the budget that you have before us today. Mr. Secretary, last year you brought us a similar request for enrollment fees and increased co-pays. While I personally agree that it is appropriate to ask for cost sharing of these veterans, category sevens and eights, this Committee by a majority did not support them. This is around the 795 million. If the Committee does not go along with these, then we must buy that back into the budget, and that will be a challenge before us. So, the lobbying effort is going to have to intensify to convince members as to why this is the prudent thing to do.

You will hear great demagoguery in this room today with regard to increased fees, or even the creation of an enrollment fee. You have got organizations out there that almost want -- they want to create, and convince the sevens and eights that they have an entitlement by virtue of service. And so you have got a challenge ahead of you.

Your request also relies on funds generated by management efficiencies recently called into serious question by the GAOs, so I welcome your response to the GAO report. Further, the VA's projections of nearly $3 billion in collections, given the agency's track record, ap-

pear to be overly optimistic. I want to applaud you, though, on your focus on improving the revenue cycle management process.

Nowhere in the statement, Mr. Secretary, did you mention your plans to enhance management of the information technology within your department. And so I would like for you to address the CIO issue. And with a new generation of veterans looking to us for care, this is a management efficiency that we must realize without delay.

Also, nowhere did you mention enhancements to the education benefit for our veterans, especially those now returning from their service. As you know, I created the Subcommittee on economic opportunity to emphasize programs that focus on empowering veterans to take advantage of this Nation's opportunities by creating and fostering ability and self-sufficiency. Increasing the skills of veterans is a means to get good jobs, own their own homes, and support their families, as an investment in America's future. History has shown that veterans empowered to take the opportunities offered by this great country is a repayment many times over in the investment made.

That is why that I am announcing today that I will support initiatives to modernize the GI Bill. I welcome ideas and proposals such as the one made by the Partnership for Veterans' Education led by Vice Admiral Norb Ryan. The Montgomery GI Bill, as good as it is, does not reflect the realities facing today's service members, especially in the Guard and Reserve. We must modernize the GI Bill. I've directed my staff to work with Ranking Member Evans on this endeavor.

This is a complex effort, given the need to coordinate with numerous House and Senate Committees, as well as various departments and agencies within the executive branch. So Mr. Secretary, I would also call on your help in this endeavor to modernize the GI Bill, and welcome your comments.

This budget sends the right message to our men and women in uniform, that if you are hurt or wounded, the VA will be there for you. After all, budgets, systems, and programs are about service to people. I have visited with soldiers wounded in Iraq who are recovering at the VA Polytrauma Rehabilitation Center in Minneapolis. This is one of the VA's four such centers dedicated to treating patients with multiple complex traumas, which often include brain injuries.

The Committee's staff has also visited the three other polytrauma centers, and I extend my deep appreciation and tremendous satisfaction for the dedication of the employees who are doing quality work.

The quality of care these heroes receive, again, it's impressive, and we are grateful to the VA professionals because they zealously provide that care.

What was perhaps even more impressive to me was the spirit of the young warriors. They wanted to rejoin their unit. They are very optimistic about their recovery, they are proud of their service, and they have not taken counsel of their fears. We owe these men and women

and their family members, and all America's veterans, our best.

[The statement of Chairman Buyer appears on p. 69]

THE CHAIRMAN. I would now like to thank Mr. Evans for his opening statement.

MR. EVANS. Thank you, Mr. Chairman. I know that I expressed the sentiments of many on this Committee when I say that we will do all that we can to make sure VA does not experience any more budget shortfalls. Yesterday, I stated that I was baffled by the Administration's remark that this budget was a landmark budget for veterans. I am still baffled today. Although the President's budget requested increase looks good at first glance, it does not deliver the resources needed to provide veterans with the health care and benefits they need. Across the gamut of VA health care I can see actual cuts in such areas as in medical research. In other areas I have seen slight increases, over what, I believe it is not sufficient.

I have learned something already, something we learned since last year is to treat the VA health care budget with caution. I certainly hope I colleagues approach this request with skepticism, which to me seems to be warranted.

Mr. Chairman, I have a prepared statement I'd like to submit for the record. Thank you very much.

THE CHAIRMAN. Mr. Evans, your written statement will be submitted into the record. Without objection.

[The statement of Mr. Evans appears on p. 74]

THE CHAIRMAN. I will now turn to our first witness and I will share with my colleagues that we will give great latitude during your time period for questioning and statements that you may have.

Our first witness is the Secretary of Veterans Affairs, the Honorable R. James Nicholson. He's a 1961 graduate of the United States Military Academy of West Point, New York. Secretary Nicholson served eight years on active duty as a paratrooper and ranger-qualified army officer, and then 22 years in the Army reserve, retiring at the rank of colonel. While serving in Vietnam, he earned the Bronze Star, Combat Infantry Badge, the Meritorious Service Medal, Republic of Vietnam Cross for Gallantry, and two air medals. He is our former ambassador to the Holy See.

We welcome you, Mr. Secretary. The Committee looks forward to hearing your testimony, and you may begin. And please begin, opening with an introduction of the staff that you brought with you.

STATEMENT OF THE HON. R. JAMES NICHOLSON, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JONATHAN B. PERLIN, MD, PHD, MSHA, FACP, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION; DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION; WILLIAM F. TUERK, UNDER SECRETARY FOR MEMORIAL AFFAIRS, NATIONAL CEMETERY ADMINISTRATION, ROBERT J. HENKE, ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; TIM S. MCCLAIN, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; RITA A. REED, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; AND ROBERT MCFARLAND, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY, AND CIO OF THE DEPARTMENT OF VETERANS AFFAIRS

SECRETARY NICHOLSON. Thank you, Mr. Chairman, Mr. Ranking Member, members of the Committee. I do have a written statement that I would like to have entered into the record.

THE CHAIRMAN. Your written statement will be entered into the record. Hearing no objection, so ordered.

SECRETARY NICHOLSON. And I would like to introduce the team that I have with me here at the table this morning, a team of dedicated, competent experts. And to my immediate left is Dr. John Perlin, the Under Secretary for Health. Next is Admiral Dan Cooper, the Under Secretary for Benefits. He is a submariner, but seems to operate pretty well on the surface, we are finding. And on the far left is Under Secretary Bill Tuerk, the Under Secretary for Memorial Affairs.

To my immediate right is Bob Henke, Assistant Secretary for Management. To his right is Ms. Rita Reed, the Deputy Assistant Secretary for Management. And to the far right is Tim McClain, the General Counsel for the Department of Veterans Affairs.

Mr. Chairman, as Secretary, it is my great privilege and responsibility to lead the Department of Veterans Affairs. I am pleased to announce this morning a landmark Department of Veterans Affairs budget proposal of $80.6 billion for 2007 that is truly historic in its scope of services to veterans. Behind the budget figures, Mr. Chairman, is a great story. It is one of America's truly good news stories. And so before we get down to the numbers, I would like to brag a bit on my department's people and their successes. And back home, where I come from they used to say it ain't bragging if it is true.

And one of those truths, Mr. Chairman, is that our VA employees, all 225,000 of them, come to the aid of their communities and their fellow citizens, veterans and non-veterans alike, in times of disas-

ters and other national emergencies. To make my point I need only to mention the heroic efforts of VA employees during Hurricane Katrina, and Rita. Not only did our staffs evacuate several hundred patients out of our hospitals in the Gulf area to other hospitals, and not only did they do it quickly and efficiently, they did it at great personal risk and great personal sacrifice and loss.

It is also a fact that the VA knows how to protect our veterans' vital health information against these kinds of catastrophic events that swept us in the Gulf Coast. Because veterans' health care records are electronic, no matter where our New Orleans veterans were eventually relocated, their complete health records were available for uninterrupted care and treatment.

And I might add that in recognition of our accomplishments during the storm, I was recently privileged to present Senate Resolution 263 to Gulf region VA employees. That was a congressional commendation for their extraordinary efforts as a first responder to a disaster of unprecedented proportion.

Mr. Chairman, following a decade-long health care transformation, my department stands as a recognized leader of America's health care industry, and we have the credentials to prove it. The Journal of American Medical Association has applauded VA's dedication to patient safety. The Washington Monthly featured VA in an article entitled, "The Best Care Anywhere." U.S. News & World Report described the entire VA as the home of "top-notch health care," in its annual best hospitals issue. And a Rand report ranked VA performance, on 294 measures of quality, as significantly higher than any other health care system in America. Even the New York Times, just last month, in an article by Paul Krugman, no less, called the VA the model for our nation.

While these enthusiastic stories about the VA from outside are always welcome, truly welcome, the most meaningful measure of our success comes from the millions of men and women that we serve, that we care for: our patients, our veterans. They are our biggest supporters. Our veterans ranked our care a full 10 percentage points above their counterpart patients in private hospitals. Yes, for the sixth consecutive year the American Customer Satisfaction Index reports that veterans are more satisfied with their health care than any other patients in America. This speaks volumes about the competency and the compassion of our caregivers in our health care system. For us, the support of our veterans, the people who know us the best, is the highest level of praise that we can receive. That is what gives us our bragging rights.

Because of our first-rate, high quality health care, veterans are coming to us in ever greater numbers. Fully 7.6 million are currently enrolled for our care. This year, we expect to see well over 5 million of them.

Mr. Chairman, President Bush in his 2007 budget proposal for the Department of Veterans Affairs is fulfilling his promise to our veterans with a strong budget that respects their service to our country, and takes a significant step toward redeeming America's debt to our heroes. The President's total request is for $80.6 billion. This is an increase of 12.2 percent over last year's record amount. It is 8.8 billion above the fiscal year 2006 level. This budget contains the largest dollar increase in discretionary funding for VA ever requested by a president.

The resources requested for VA in the 2007 budget will strengthen even further our position as the nation's leader in delivering accessible, high-quality health care, that already sets the national benchmark for excellence.

In addition, this budget will allow the department to maintain our focus on benefits, on timely and accurate claims processing. The President's 2007 budget will also enable us to expand veterans' access to national and state veterans cemeteries. As an integral component of our fiscal year 2007 goals, we will continue to work closely with the Department of Defense to fulfill our priority that service members, transition from active duty military status to civilian life, veteran life, is smooth and as seamless as possible.

Mr. Chairman, our written statement presents a detailed description of the President's proposal for fiscal year 2007, but I would like to take a few moments to highlight some of the key component of this historic budget.

During 2007, we expect to treat 5.3 million patients, including more than 109,000 combat veterans who served in Operation Enduring Freedom, and/or Operation Iraqi Freedom.

The 3.8 million veteran patients in priorities one through six will comprise 72 percent of our total patient population in 2007. This will be an increase of 2.1 percent in the number of patients in this core group, and will represent the fourth consecutive year during which those veterans who count on us the most will increase as a percent of all patients treated.

The President's 2007 budget request reflects the largest dollar increase for VA medical care ever requested by a president, and includes our funding request for the three medical care appropriations, 27.5 billion for medical services, including 2.8 billion in collections, 3.2 billion for medical administration, and 3.6 billion for medical facilities.

The total proposed budgetary resources of 34.3 billion for the medical care program represent an increase of 11.3 percent, or 3.5 billion over the level for fiscal '06. And it is 69.1 percent higher than the funding available at the beginning of the Bush Administration.

The VA is also focused on delivering timely, accurate, and consistent benefits to veterans and their families. The volume of claims'

receipts has grown substantially during the last few years, and is now the highest that it's been in the last 15 years, as we received over 788,000 claims in 2005. This trend is expected to continue. We are projecting the receipt of over 910,000 compensation and pension claims in 2006, and more than 828,000 claims in 2007.

One of the key drivers of new claims activity is the increase in size of the active-duty military force now including reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom. This has led to a sizable growth in the number of new claims, and we expect that this pattern of growth will continue.

A natural outcome of this increasing claims workload is growth in our mandatory spending accounts, which are growing even faster than VA's discretionary accounts. We estimate that mandatory spending will increase by 14.5 percent, to over $42 billion, from an estimated fiscal year 2006 level of 36.7 billion. This growth is largely in the compensation and pension account, and reflects the combined impact of adding new veterans and beneficiaries to the rolls, increasing levels of disability ratings for veterans already on the rolls, and annual cost-of-living adjustments for all veterans' beneficiaries.

In addition, we expect to continue to receive a growing number of complex disability claims, resulting from post-traumatic stress disorder, environmental and infectious risks, traumatic brain injuries, complex combat-related injuries, and complications resulting from diabetes. Each claim now takes more time and more resources to adjudicate. We will address our ever-growing workload challenges by improving our training and productivity, by moving work among regional offices in order to maximize our resources and performance, by simplifying and clarifying benefit regulations, and by improving the consistency and quality of claims processing across our regional office system.

Mr. Chairman, our veterans are leaving this life at an ever-increasing pace. Every day now 1,800 men and women who dedicated their lives to the continuation of our democracy are being laid to rest in fields of honor. Of the 16 million World War II veterans who proudly served us, fewer than 3 and a half million now remain. And by this time next year, that number is projected to be less than 3 million. Korean War veterans are all in their seventies and eighties now, and Vietnam veterans, most of us, at least, are resisting the notion that we are next, but of course we are.

It has been said that a nation is known by the way it honors its dead. I firmly believe that America's greatness is reflected in the final tributes and perpetual care with which we respect the service of our departed veteran. Buglers play taps for more than 107,000 veterans in our national cemeteries each year, and in '07 that will increase by 5.4 percent, and will be 15.1 percent more than the number that

were interred in 2005.

The President's 2007 budget request for the VA includes 160.7 million in operations and maintenance funding for the National Cemetery Administration. This represents an increase of 11.1 million, or 74.4 percent over the amount for fiscal year 2006. We will expand access to our burial program by increasing the percent of veterans served by a burial option in a national or state veterans Cemetery within 75 miles of their residence, to 83.8 percent in '07, which is 6.7 percent over that of '05. Our plan for the biggest expansion of the national cemeteries since the Civil War is on track.

So Mr. Chairman, I started out my testimony by saying that this budget is historic, that this is a landmark proposal funding, unmatched by any previous VA budget ever. And I also said that VA's 225,000 employees are doing a terrific job of taking care of our veterans. This level of competent and compassionate care was earned by the men and the women who, through blood, sweat, and tears, served America selflessly, honorably, courageously.

Veterans don't seek the spotlight of approval, Mr. Chairman. So as the Secretary of Veterans Affairs, it is my privilege to lead our national applause in grateful thanks for every gift our veterans have given us. This proposed budget for the VA is President Bush's appreciation for our heroes.

Thank you very much, Mr. Chairman.

[The statement of R. James Nicholson appears on p. 99]

THE CHAIRMAN. Thank you, Mr. Secretary. At this time, I would like to yield to Mr. Evans. He has a question now and then he's going to have to leave the room. Mr. Evans?

MR. EVANS. Thank you, Mr. Chairman.

You once again offer up legislative proposals that have been soundly rejected by Congress. Is this just stubbornness? As a Marine, I am quite familiar with stubbornness, but do you find it impossible to request a budget in leiu of legislative proposals? Thank you Mr. Chairman

THE CHAIRMAN. I would like to ask minority counsel to repeat the question.

MINORITY COUNSEL. Mr. Evans notes that you once again offer up legislative proposals that have been soundly rejected by Congress and asks, "Is it just stubbornness?" Mr. Evans notes that as a Marine, he's familiar with stubbornness, and then asks, "Do you find it impossible to request the dollars that you actually need, in lieu of the legislative proposals?"

SECRETARY NICHOLSON. Thank you, Mr. Evans. That is an important question and was not unanticipated. I personally believe in these policy proposals. I think they are reasonable in the overall context of what we are doing in this giant health care and benefits

system, because what we are asking is for people who want to get the best health care in the world, who have no injuries, disabilities, service-connected ailments of any kind, and who are working and have work, to pay $21 a month for their health insurance, and to pay a reasonable co-payment for their pharmaceuticals. And the composite of that to this budget, as you know, is $795 million, which is a significant amount. It's in the composite of the revenue that would accrue as a result of that, and the adjustment in the number of people using the service.

What it will do, in spite of the fact that this is a huge budget, it would just help ensure our ability to do our job even better. And there are things that in spite of how well we are doing, there's more that we can do, and there are things that we can do better. And I don't see it being a hardship. It is just for categories seven and eight, and I think it is very reasonable. It is also very equitable, because if you spent 30 years in the service and retire, you go on TriCare and you have both a copayment and an enrollment fee, and it is substantially higher than this.

THE CHAIRMAN. Thank you, Mr. Evans.

I have four questions. First, Mr. Secretary, I would direct this to you and then perhaps further comment from Dr. Perlin and Mr. McClain. I am hoping that you can comment on the process that was a started down in Charleston with regard to the VA and the Medical University of South Carolina, on the issues of collaboration, and how that is possibly being leveraged, not only with regard to construction at New Orleans; now even possibly in Las Vegas, and Orlando. So I welcome your comments on that.

I also welcome your comments on regard the land acquisition issues at Denver. You had made a request to us at the end of last year. Minority had made an objection, so I would like you to help explain that to the Committee, and what your proposals are.

With regard to diabetes standardization, I am aware that in 2006, the VA Appropriations Act specifically prohibits the VA from replacing the current system by which VISNs select and contract for blood glucose testing supplies and monitoring equipment. I would like to know what the present status is, and what directives you have given to the VISN directors; and it is my understanding there are three VISN directors that are not conforming, so I would appreciate your comments.

Mr. Secretary, another question -- perhaps Admiral Cooper can help us -- is with regard to a budget reduction. On the direct compensation FTE, it actually decreases by 48 in this '07 budget. Given the number of claims that are coming in and the expected backlog, please explain.

Also, Mr. Secretary, and perhaps directed to Under Secretary Tuerk, the Committee has an interest in the National Shrine Pro-

gram, and I welcome your comments with regard to that, because I also don't see that in this budget. Mr. Secretary?

SECRETARY NICHOLSON. Thank you, Mr. Chairman. I will start, and then refer to the experts that we have.

The question of collaboration is an important one, and I strongly support collaboration wherever we can achieve it. That is, with the military, with DOD, and/or with academia. Collaboration with academia has redeemed itself. It was, you know, it was General Bradley right after the war who had my job, who insisted to President Truman that we locate these new hospitals, wherever possible, next to an existing academic medical facility. And he had the vision, and it is so valid that we could, cross-pollinate the staffs through the training, the research, the teaching that would go on, and we could further stimulate and grow our doctors, and that has worked wonderfully well to the advantage of the VA, such that we have three Nobel Prize winners out of the VA system, as doctors.

Sixty percent of the physicians in America today received training in a VA hospital. We have good physicians, and so does America. An added plus is the economies, as well as the dynamics, that inure to that, especially when we can co-locate with DOD facilities, so I am very supportive of that proposition.

And I am quite aware of these areas that you mentioned. I will probably let Dr. Perlin address the Charleston issue, having been down there. Let me just address New Orleans. We have a major study group, task force, really, going on in New Orleans, trying to decide what we should do in New Orleans. We are collaborating with the local leadership group in New Orleans, Bring New Orleans Back, with the local elected officials and the people here in Washington representing the state. We are hoping to have our task force study done by the end of February, so that we have a good notion of what we should do, based on what we know.

But the last point is not unimportant, because there are things that still are not clear, like what is going to be the population of New Orleans. What is going to be the veteran population of New Orleans. And what is going to be the status of protecting a facility, of hardening it against a recurrence like we've just been through, vis-a-vis the levees or hurricane vulnerability?

These are important questions. We want to collaborate, as we have down there for so long, with LSU, Charity, and Tulane. So, where are they going to locate? You know, the good news is that everybody's talking and everybody has, good intentions, and we know that we will replace that hospital, at some size and in some location. But I could not tell you that today.

You mentioned the land acquisition in Denver. Denver is another area that the CARES process has deemed needs a new hospital. And the existing hospital will no longer be located with the collaborative

hospital, which is the University of Colorado Health Science Center, because it has moved out to the old Fitzsimmons General Hospital campus.

And we've gone through turmoil trying to find a place to locate our new hospital out there so that we cannot only be next to the new university hospital, but the new children's hospital that is under construction. Happily, with the cooperation of some of the local elected people who had other notions about a piece of ground that was still left there, we have been able to get that under control, so to speak, and at a price that is compatible.

But it's not going to stay that way forever, because the local municipality there, Aurora, really wanted to use that piece of ground for a destination resort hotel. Since they've accommodated us, they still want to have that destination hotel. They need to acquire that ground, and they've done an assemblage, and they want our transaction to take place; i.e., buy the ground, so they have the money to go buy the other ground, to do what they really wanted to do.

And that can be done in two stages. The initial ground acquisition to tie up the deal would be $25 million. There is another office building involved that will become part of the hospital, but that does not have to be appropriated with the expedition that is needed, for us to secure the ground, to be in a position to build and collaborate like we have in the past.

I think while we are on that subject, I will hand this to Dr. Perlin to talk to you about Charleston, and then we can come back and talk about FTE and other things, after that.

Dr. Perlin. Thank you, Mr. Chairman. And Mr. Secretary, I would agree with the way you have laid this out. I particularly appreciate the support of you, Mr. Chairman, Chairman of the Health Subcommittee, Chairman Brown, for really helping us discover a template for a way of looking at the value of collaborations. Down in Charleston, we were presented with an analysis of the economic value of collaboration. It looked not only at media capital costs, but life cycle costs for operations, suggesting ways that we might partner.

As a first step in this partnership, the ability to provide not only veterans but citizens of the state of South Carolina with new technology for cancer therapy that has a precisely-aimed beam, a technology known as TomoTherapy, and angiography suites, present the very first starting block of improved sharing. For our providing some capital equipment, the return is free or significantly reduced costs for the use of this equipment, enhancing care for veterans and the community and state. So this is really a win-win.

I make this point because it really provides us nationally with a template for looking at opportunities for collaboration, ways to improve operational efficiencies, capital efficiencies, as we think about some of the challenges of ensuring the veteran get the care they need

in the out years.

So certainly, as we look at sites such as New Orleans, we place a great deal of attention not only on the long-standing relationship of affiliations, but ways in which we go forward that create synergies for all involved.

THE CHAIRMAN. John, if you can be brief so we can move to the other members' questions: the diabetes question, the FTE, and the national shrine. So if you can try to hold your comments to a minute.

SECRETARY NICHOLSON. Yes, sir. The question on information technology, again, another very important area. In spite of how well we have done in the transformation and use of modern technology for our electronic record system, which is nothing less than phenomenal -- and unprecedented; no other major health care system has yet achieved it -- we still need a major transformation inside the VA in information technology. I think all of you members know that, and we know that. The question then is, how to do it? How to force that cultural change that is going to take an organization that's big, spread out, far-flung, and to achieve the standardization that you really need so that we can have it do much better in reporting inventory control, collection processes, and talking to each other. I think we all stipulate to the need.

So then, how should we do this? We've had a major consultant come in, Gartner, and look at it, and they looked at also the history on this, which hasn't been very good, in trying to do this, and said, "You need to do the draconian step, you need to just totally change this," which would be to just move to a total centralized model. The impacts of that you have to think through, because again, we have, medical applications going on all over this country, the Philippines, Guam, and some of them are quite unique, especially in the research area.

So, do you take that prerogative of developing their own model and their own software for that application, draw that all back up into the central headquarters here in Washington, and then have an IT czar decide, or is there some hybrid of that?

I believe that we need to do the hybrid, which we call the federated system, which is that we do consolidate the budgeting. We would give far more responsibility and authority to the Assistant Secretary for IT, the Chief Information Officer, who is currently Assistant Secretary McFarland, who is brilliant and again, one of those other lucky things we have a guy like that that has come into the government, and who has the background to help us.

If you think tactically, we can still have these medical modules working on their own unique software that they may need, after getting the budget approval for that, from the centralized authority for it. If we can get that done, we will have taken quantum steps toward standardizing this organization. And then see what, how it evolves.

That is what I think we should do.

THE CHAIRMAN. All right. Now we are going to have to narrow it down to 30 seconds. Be really brief on this, I need to get to other members. The diabetes standardization, are you following what the appropriators have asked?

DR. PERLIN. Yes, we are.

THE CHAIRMAN. Thank you. With regard to the direct compensation on FTE you have a decrease, Admiral Cooper, in the budget, in the face of growing claims.

MR. COOPER. Mr. Chairman, we developed the budget 18 months ago. At that time we considered certain planning factors. In fact, we got a fairly large increase in FTE for 2006. That increase was predicated partially on the fact that we anticipated the legislation that called for special outreach in states with the lowest average compensation payments per veteran. We factored that in. We figured there will be 98,000 more claims coming in because of that outreach. We expected to start that outreach close to the start of fiscal year 2006. Therefore, we would have fewer total incoming claims, as we headed into 2007. We have not started that project yet, but we are in a hiring process now.

The fact is, for VBA in general, we got an increase. We apportioned that out to the several programs. If I need to, I will reapportion within those numbers. So across VBA we recieved a slight increase of about 173. So, in the planning process 18 months ago, it looked logical to reduce slightly in 2007. I will reorient as the budget is approved.

THE CHAIRMAN. Secretary Tuerk?

MR. TUERK. Thank you, Mr. Chairman. I appreciate your bringing the National Cemetery Administration, and particularly, our National Shrine Commitment into focus. Apart from keeping our cemeteries open, and developing 11 new cemeteries to serve the needs of veterans, advancing the National Shrine Commitment is my highest priority.

This budget is good news with respect to the National Shrine Commitment program. This year, the budget for the National Shrine Commitment is increased by 40 percent, from approximately $20 million to $28 million. Perhaps of equal significance, funding for the gravesite renovation projects, for the raising, realigning, the cleaning of headstones, and for turf maintenance, is scheduled to increase at an even higher rate, by 65 percent.

Clearly we are headed in the right direction. We are on a growth curve. When we get this funding, it is my belief and my hope, that we will be nearly halfway down the list in the National Shrine Commitment projects. So I am quite pleased with this proposal.

THE CHAIRMAN. Okay. Thank you very much. Mr. Filner?

MR. FILNER. Thank you, Mr. Chairman. Let me first say for the record something that we Democrats communicated with you, Mr.

Chairman, in writing: that while Congress on the floor of the House is moving to greater transparency in our processes, you are taking us and this Committee backwards. To stop the joint sessions with the Senate, inviting the members of the VSOs really makes the process less transparent. Regardless of the timing of those meetings, we had thousands of veterans able to see what was going on here, able to connect up with their own members of the Committees, and see what we do. I, again, would urge you to reconsider that decision to stop a long, long tradition of having VSOs and their members come in for their own sessions.

Mr. Secretary, you called this is a, "landmark, historic budget, biggest increase ever by a President." I am sure the President said to you, "You are doing a heck of a job, Jimmy." And I think that is a good comment on this budget.

I think you could have sent a video from last year's appearance, because the same costs for veterans are being proposed as last year. We have proposals that have been soundly rejected by the Congress which are in your budget; steep increases in co-payments for the prescription drugs; enrollment fees; another underestimation of returning soldiers from Iraq and Afghanistan; continuing to drive priority eights out of VA health care; an unrealistic figure for third-party collections and inflation; management efficiencies which seems to be a category so flexible that you add that to whatever perceived shortfall is and one, that the GAO recently said was undocumented in the past budgets.

So, your real budget is way below what you are claiming here as historic and landmark. Not only are you on the surface $1.7 billion below what the Independent Budget will show us in the next panel, including the priority eights, your legislative proposals probably won't get passed. And so that is another $1.3 billion out. Your management efficiencies of close to a billion may not materialize. You overestimate collections. So I count you are almost $4 billion short of where we ought to be. Heck of a job.

And to the tired old proposals you have the nerve to say this is not a hardship by increasing the fees, and yet your own budget shows we are going to drive 235,000 veterans out of VA Healthcare. It must be a hardship on them if you are driving them out of such a wonderful system that you described. Mr. Secretary, if it is such a wonderful system, why are you driving out 235,000 of them, as the only way that you are going to meet your budgetary needs?

In addition to the tired, old proposals, you add another wrinkle. You are very creative. You have changed the rules so you put more money on the backs of veterans, and that is in regard to third-party collections for care of non-service-connected illnesses and disabilities. Right now your practice, as I understand it, is to bill the veterans' insurance companies, the third-party, and when the insurance com-

pany pays, if they do, the VA takes off the top the co-payment that the veteran would owe. This means that the VA reduces what the veteran has to pay with the insurance company collections. A reasonable approach.

Now what you want to do is to bill them simultaneously, as I understand it, and you get $30 million more out of the pockets of veterans in fiscal year 2007, and $192 million over the next five years. Once again, you are adding a new wrinkle to your enrollment fees and your increase in the co-pays for drugs.

In addition, another thing I couldn't understand, you seem to double-count moneys in here, in another accounting gimmick that I think gives you the "landmark" figure that you claimed. You have in collections an amount of $544 million that seems to be counted twice: once to reduce the medical service appropriations, and again as part of the collections. You subtract it from one to reduce the appropriation, and you add it again. So it seems to me you are double-counting. And if that is a mistake that seems to be there, we will look through the budget in more detail and see if there are any others.

I don't call it a landmark budget. I don't call it the biggest increase ever by a President. I call it more of the same that we saw last year, accounting gimmicks, double-counting, legislative proposals that won't come true, management efficiencies that never are there. I think you are doing a heck of a job of driving veterans out of this system, and I think we ought to reverse that course, Mr. Chairman and Mr. Secretary. Is there anything I said wrong?

SECRETARY NICHOLSON. Let me say, number one, Mr. Filner, the increase in direct appropriation is up 9.4 percent. As to the --

MR. FILNER. Only if all those figures I counted are true.

SECRETARY NICHOLSON. The "driving out", as you call it, of the almost 200,000 people that we project that would not --

MR. FILNER. Your number is 234,566 in your budget. You called it an adjustment; I call it driving out.

SECRETARY NICHOLSON. Well, 95 percent of those people we find have other insurance; either public, private, employer-type insurance, or Medicare. And they make a conscious decision at that point about what works best for them, and do project that there would be this reduction.

And I will say categorically there's no double counting in that budget. I will ask Dr. Perlin if he wants to expand on that in any way.

DR. PERLIN. Mr. Filner, I am happy to go through the budget with you, but the 544 million dollars is the combination of the collections from the pharmacy co-pay and the enrollment fee. I would be pleased to go over that. It is counted once. I should note that that is after the 9.4 percent direct appropriation increase. Including the collections, the increase in this budget over last year goes to 11.3 percent.

MR. FILNER. I am sure you'll be able to tell me more, but if you look

on your budget's submission page: chapter one, page two, you add to the medical service budget the $544,000 that you claim as a savings from the legislative proposal. Then, in another figure below it, collections, it is in there also. So it is an addition because of certain proposals to your budget, but then it is also included in another line-item. If that is not right, I will be happy to hear from you, but it looks to us that is what you are doing.

DR. PERLIN. We are absolutely certain that the resources, that $544 million, are counted once and only once as collections. Let me explain what seems to be some confusion about the difference between 235,000 and 199,000, is. Absent any policy proposals whatsoever, we estimate that about 35,000 fewer priority seven and eights would be in the system as patients next year. The number one reason for attrition for veterans who are with us generally for life is because they pass away.

SECRETARY NICHOLSON. Let me also, if I may, Mr. Filner, point out --

MR. FILNER. So you mean that's not part of your model, the people who die and are taken out? You are double counting again, Now we've got dead people you are double counting.

DR. PERLIN. Absolutely not. There are estimated to be 35,000 people fewer. The residual is 199,600 --

MR. FILNER. So we are talking about 199,000-something that you are driving out, not 235. Okay, I stand corrected.

SECRETARY NICHOLSON. I would just like also to point out to you your comment with respect to collections. We increased collections in the just-finished fiscal year of 2005 by 8.6 percent over the prior year. So I think we've established --

MR. FILNER. How much money is that?

SECRETARY NICHOLSON. Sir?

MR. FILNER. How much money is that?

SECRETARY NICHOLSON. In absolute terms? How much is the increase, or the total --

MR. FILNER. Certain times, you use percentage, other times you use numbers. You are always trying to spin it in a way that sounds better. But what does the eight percent represent? If it's of one dollar, it's not a great increase, you know.

SECRETARY NICHOLSON. Fair enough. The amount collected was $1,897,000,000.

MR. FILNER. And that's an increase from?

SECRETARY NICHOLSON. The prior year it was $1,747,000,000.

MR. FILNER. So how much increase? $200 million?

SECRETARY NICHOLSON. 8.6 percent.

MR. FILNER. How many hundred million was what I asked.

SECRETARY NICHOLSON. $150 million.

MR. FILNER. Out of a $70 billion budget? We've had these miscal-

culations in past budgets so, we don't have a lot of confidence in those figures. How much did you project, by the way, in the previous budget? Was that what you projected?

SECRETARY NICHOLSON. I think I stand corrected if I am -- we were within two percent of what we projected we would collect.

MR. FILNER. And so you overestimated your collections.

SECRETARY NICHOLSON. By two percent.

MR. FILNER. It's that $100 million or something?

SECRETARY NICHOLSON. Oh, no, no.

MR. FILNER. I am saying if you overestimate your collections --

SECRETARY NICHOLSON. Three million dollars. Three million.

In fact, I don't know if you can see this but we should have a chart. You see that line?

MR. FILNER. I can't see it.

SECRETARY NICHOLSON. That's the progression of collections, starting in 2000.

MR. FILNER. What page is that on? Is that in here somewhere?

SECRETARY NICHOLSON. I don't know that you have this, but the point is that it's a very good story. In fact, in 2000, the VA collected $573 million. As I just told you, in '05, it's collected $1,897,000,000, and that line is ascending because we are getting better at it.

MR. FILNER. And how much would that increase if you included Medicare?

SECRETARY NICHOLSON. I don't know, we'd have to get you that.

MR. FILNER. It would be a lot bigger than this.

SECRETARY NICHOLSON. Oh, it would be bigger.

MR. FILNER. If you went for reimbursement from Medicare, that would be very good.

THE CHAIRMAN. Thank you, Mr. Filner.

MR. FILNER. Think about that.

SECRETARY NICHOLSON. We have. You'll have to do it, because we've been told we can't do it.

MR. FILNER. You also can't increase enrollment fees, but you suggested it.

THE CHAIRMAN. Thank you, Mr. Filner. Will now recognize Mr. Miller, who chairs the Disability and Memorial Affairs Subcommittee.

MR. MILLER. Is there time still remaining, Mr. Chairman?

THE CHAIRMAN. Well, we want to give members latitude. This is our opportunity to speak with the Secretary about the budget. We are under the five-minute rule, but we want to give latitude.

MR. MILLER. I see a green light down here. What does a red, blinking light mean?

THE CHAIRMAN. It means I am going to give some latitude.

MR. MILLER. Will you give it to me?

THE CHAIRMAN. I will.

MR. MILLER. Why do I always have to follow my good friend, Mr. Filner?

MR. MILLER. Mr. Secretary, thank you for being here today and presenting the blueprint. I don't imagine that any of us totally agree with what's in here, but we have to have a starting point somewhere, and I appreciate it. Some of my questions may be a little bit off subject, but because you are here I want to be able to ask you a question, in particular about an issue that's floating around VISN eight in Florida, about a potential shortfall at Bay Pines, of some $20 million.

That concerns me, that there is a shortfall, potential shortfall, there. What concerns me probably even more is that this Committee is being told that members and staff down there are not to communicate with members of Congress in regards to the shortfall. And I wanted to know if you would address that this morning. Or Dr. Perlin, or anybody that's at the table.

SECRETARY NICHOLSON. Thank you, Congressman Miller. There is some history at Bay Pines in the last few years. The IG looked into that, and I think it was in August of '04, issued a report, and corrective action was implemented. A plan was developed. There were weekly conference calls were being conducted, I think it went on for about six months. And the IG took another look and said, "All these recommendations have been implemented, and these problems have been satisfactorily resolved."

I am aware of the issue that you are bringing up this morning, but I was just made aware of it this morning. Someone wrote an anonymous letter pointing out that there were some problems and that there's a shortfall at that hospital. I have not yet had a chance to look into this substantively. There are serious allegations in that anonymous letter. We take those seriously and we will look into it. I am going to be down in Florida myself later this month, and will personally talk to some people and look into it. To the best of my knowledge, these are unsubstantiated allegations.

Dr. Perlin, do you have anything to add?

DR. PERLIN. I just note that we were made aware of this, as Secretary said, this morning. And I looked back in terms of the allocation of resources to all of VISN eight, I note that the VISN was allocated $2.647 billion, a 9.1 percent increase over the previous year. Bay Pines received $303.46 million as an allocation within the VISN, and I just note that these are somewhat protean during the course of in a year. And obviously this has grabbed my attention. We want to make sure the veterans at every facility, but particularly given the history of the challenges at Bay Pines, get the best possible care, and in fairness, that we do so efficiently.

So I am going to be devoting some good deal of attention to making sure that not only the resources are there, but that they are used wisely.

MR. MILLER. Thank you. We look forward to hearing what you find, and we will provide you the information that we may be able to pick up, as well, Mr. Secretary.

Also, Mr. Tuerk, thanks for coming to first Florida district. I am sorry I wasn't able to be with you when you were at Barrancas. I am pleased to see the increase in dollars for the National Shrine Commitment, some $14 million additional over last year's request. A long way to go, 300 million is the number that we need to get to, but I do want to say thank you.

And the yellow light is on, so I am going to ask a question of the Secretary. You brought it up. I wasn't going to, but you mentioned New Orleans in several parts of your comments. The purpose of a VA hospital is what? Who is it supposed to serve? Tulane, LSU, Charity, or veterans?

SECRETARY NICHOLSON. Well, the purpose of a VA hospital is to serve veterans. The history has shown that this service is enriched when those hospitals can be co-located and collaborate, and get the specialty services of those people in those other hospitals. For example, there are some very esoteric kinds of diseases, or surgical procedures that are needed by our veterans, where we don't staff that narrow specialty. We are able to get those because we've accredited doctors that are at those nearby teaching hospitals with that specialty. I mean, that has just absolutely redeemed itself.

MR. MILLER. The light is blinking, but since the Chairman is giving us latitude, since there is a somewhat clean slate today, is New Orleans exactly the place the VA would want to site a medical facility?

SECRETARY NICHOLSON. I would say, Mr. Miller, that the answer is in the affirmative, at least in greater New Orleans. I can't tell you where that hospital will be sited, but from what we know, there will be a justifiable need to replace that hospital in the residual veteran population of the New Orleans area that we serve, yes.

MR. MILLER. For the record, New Orleans is in a declining -- was prior to Katrina -- declining veteran population. There was a lot of use of the facility by facilities other than VA. My statement, for the record, is I don't know if 800 million to $1 billion in the New Orleans area is an appropriate expenditure of funds, and I hope that VA is looking at the broader picture. And as long as the greater New Orleans area includes the panhandle of Florida and the needs that are there, we will continue to broach the subject. Thank you.

[The statement of Mr. Miller appears on p. 76]

THE CHAIRMAN. Thank you, Mr. Miller. I have a statement to be submitted for the record from Ms. Corrine Brown. Hearing no objections, so ordered.

[The statement of Ms. Brown of Florida appears on p. 77]

THE CHAIRMAN. Mr. Secretary, I would like to recognize the Ranking Member of the Health Subcommittee, Mr. Michaud. He also, to let you know, was at the genesis in Charleston for this collaborative effort that, as you said, Dr. Perlin, is this template. He was there at the beginning of that and has also had a great interest in increasing the revenue cycle management. A very thoughtful member. Mr. Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman. I would like to thank you and Ranking Member Evans for having this hearing, and would like to thank you, Mr. Secretary, for coming over to testify. I would ask unanimous consent to submit my opening remarks for the record.

I have basically four types of questions, Mr. Secretary. I will run through them and then go back so that way it will give you time, or Dr. Perlin, to answer them.

My first one, and it's similar to Mr. Miller's question: last February when you were here you were asked if any VISNs had a shortfall. You both stated that no VISN had requested additional money, and I think part of the reason is they were told not to request any additional funding. Like last February, this year we are hearing that facilities are delaying hiring, and deferring purchases to cover differences between operating funds and demand for services. My question is, how many VISNs will be forced to tap into reserves or non-recurrent maintenance funds in order to make ends meet? That's my first question.

The second question is, last year, VA had a shortfall due in part to underestimating the demand for services from the veterans who were returning from Iraq and Afghanistan. I am glad that you have included estimates in the budget. I have a couple of questions about the budget assumptions for returning OIF and OEF veterans, because we all agree we need to take care of these veterans.

As of October 2005, the VA treated over 119,000 OIF-OEF separated veterans. But your budget for fiscal year 2007 projects 109,000 OIF-OEF patients. So your estimates are 10,000 fewer than what the VA has already seen. The recent published Quadrennial Defense Review states repeatedly that we are in a long war, and I think they're probably right; we are in a long war, so it seems to me like you are starting at a low number for your budget assumptions, that could negatively impact the VA's ability to care for veterans. Could you explain how you arrived at these assumptions? Do you need to revise your budget projections to meet the increased demand on OIF-OEF veterans?

The third question is on the CARES process which identified the needs for hundreds of community-based outpatient clinics and other expanded access points, including many in rural states, like the state of Maine. How many new CBOCs are funded in fiscal year 2007 bud-

get?

And beyond the increased number of access points, what other initiatives are included in the budget that will assist in easing the travel burden facing many veterans, particularly in rural states?

My last question is on the special Committee on PTSD which has begun recommending that each vet center have a family therapist on staff. Each year the VA concurs in principle, but does not commit the funds or staff to make this recommendation a reality. Instead, the Administration says it is actively monitoring the vet center program workload, to identify potential gaps, and those identified gaps are forwarded to the Under Secretary of Health.

It is our understanding that the vet centers are functioning at capacity. We met with several groups last year, and that came out. My question, relating to that are what gaps have been identified and are these initiatives to close the gaps in your fiscal year 2007 budget?

Do you want me to go back and restate the questions?

SECRETARY NICHOLSON. I think I have them, sir, if we are not responsive to one, please feel free to ask us again.

First, on the VISNs, you related back to experiences last year, saying that you are hearing rumblings that there is delayed hiring, and we are tapping into nonrecurring funding now in this fiscal year. That is news to me. I am not aware of that. That's something that we will look into, that I don't believe is the case, and should not be. We are going to dig into that and we will get back to you.

The OIF-OEF question is a very important one, and the nuances of that I am going to ask Dr. Perlin to address. It

has to do with cumulative patient load versus new patients. Well, maybe we will just take that right now. You can speak to that, John, if you would.

DR. PERLIN. Thank you, sir. In brief, exactly right. The difference between the numbers, that I understand they lead to some confusion, is how many OIF-OEF we have treated cumulatively, are indeed, we have treated 119,000, more than 119,000 in VHA. How many do we expect in a particular budget year? Using best estimates at the moment, that 109,000 for the fiscal year 2007 is correct. Obviously, we are going to keep monitoring any changes in tempo, and information from the Department of Defense, that would lead us to change as need be. But that's why the discrepancy between the two numbers are --

MR. MICHAUD. How did you arrive at your assumptions, particularly when you look at the insurgencies that's occurring over in Iraq?

DR. PERLIN. Right. Easy enough. About a quarter of those numbers were really projected based on the use patterns of the current OIF-OEF veterans in VA. The other three quarters are based on the history, or the rates of separation, from Department of Defense. All

components, active as well as reserve components, coming into VA.

SECRETARY NICHOLSON. The next question I think you addressed was to the CARES process, the Capital Asset Review for Enhanced Services, with respect to CBOCs. At the beginning of this fiscal year we had 712 freestanding Community-based Outpatient Clinics. We plan to add 15 additional this year, and in this budget that we are here discussing, the '07 budget, we have 43 planned in that budget.

MR. MICHAUD. So, 43 plus the 15?

SECRETARY NICHOLSON. Yes, sir.

MR. MICHAUD. Great. And the second part of that question was, are there any other things that the VA is going to do to help increase the access points, particularly in rural states?

SECRETARY NICHOLSON. Well, we are very active in rural health care. The CBOCs of course are a real tangible extension of that, trying to push them out, get them more out into the communities. You know, I think the department has a very commendable record in the way that these CBOCs have grown. And the way we are planning to grow them, we also are burnishing our efforts in telemedicine, rural home medical care, and it's a real growth area of ours, and one that's getting quite a bit of attention.

I think the final question was on PTSD.

MR. MICHAUD. That's correct.

SECRETARY NICHOLSON. And that's an area getting a considerable amount of our attention, because it's quite prevalent in both the medical side and the benefits side of what we are doing, say, sort of overarching what we are endeavoring to try to do, is to be a very affirmative in our entire outreach efforts, in our seamless transition, and trying to get these young returning folks, particularly returning from the combat area, oriented towards coming in and seeking counsel, if you will, and I didn't say, "therapy" yet, but just come in and talk about it without some feeling of a stigma, that they are losing their mind or something because of an experience that they've had, or have a recurring feeling from some, sort of nonnatural human occasion they've had in combat.

And people have that. And most people can get over that if we can get our arms around it quickly enough, and get them the right treatments. So we are really trying to emphasize that, and we are doing that in our Vet Centers as well as, of course, in all of our clinics and in the -- I think we had over 8000 briefings last fiscal year to units that were deploying back, in an endeavor to try to emphasize the health part of that, the recovery part of that, before the compensation part of it, because our real goal is to make people healthy.

MR. MICHAUD. Could you provide for me, Mr. Chairman --

MR. STEARNS. The gentleman's time has expired. You are five minutes over, and it is double the time that was allotted.

MR. MICHAUD. If the Secretary could, my specific question was,

what gap has been identified out of the initiatives in the '07 budget, taking care of that gap? So if the Secretary could provide us with the special Committee's report, talking about the gap, so that we can look at it.

MR. STEARNS. Yeah, I think you can do that in writing to the gentleman.

SECRETARY NICHOLSON. Yes, we will be happy to.

MR. STEARNS. There is a lot of members here who wish to speak, and we all have busy schedules, so we are just trying to stay to the time limit.

[The statement of Mr. Michaud appears on p. 78]

MR. STEARNS. [Presiding] Mr. Chairman, I was here slightly ahead of the gentleman from Arkansas, so I was going to start my questions.

Let me first of all commend you. I've been on the budget now, this is my 18th year, and this is the largest increase I've ever seen a secretary offer Congress in his budget. And I think this is probably a reality, because of the war on terrorism and the war in Afghanistan and in Iraq. So I commend you for doing this. But having said that, looking at the three areas that you have in your budget proposal: a $250 annual enrollment fee for priority seven and eight, increasing in pharmacy co-pays from eight to $15, and your third-party offset; all three of those together is a little less than one percent, like, .98 percent. And it is controversial. I submit that you probably, if you work this third-party offset you probably could make up a large portion of this.

And let me first of all ask, what is the status of the Cleveland demonstration project that we keep hearing about on third-party offset? Is somebody prepared to give us an update of this demonstration project that we are hoping will give us information so we can save a lot of money in this third-party offset?

SECRETARY NICHOLSON. Mr. Chairman, I am going to ask Dr. Perlin if he would respond to that, and then ask your leave, if I could run out for a minute and come back.

MR. STEARNS. Absolutely, absolutely. Sure, yeah.

SECRETARY NICHOLSON. As I said, I am a Vietnam veteran, I am --

MR. STEARNS. No, I understand.

DR. PERLIN. Thank you, Mr. Chairman. The PFSS, to spell it out is the Patient Financial Services System program, and the idea is to improve all of our collections by allowing our great electronic health record interface electronically with billings and collections. And that is working, and completion of testing is actually scheduled for May of 2006.

MR. STEARNS. So this year, the Cleveland project will start?

DR. PERLIN. Yes, sir.

MR. STEARNS. Okay. And do you have the resources and in place, the people -- are you happy with that?

DR. PERLIN. The project, to be fair, had a challenging start because I think people underestimated the complexity of creating programming that was idiosyncratic with hospital or health care billing, or anywhere else.

MR. STEARNS. Okay.

DR. PERLIN. The issue you mentioned, the first-party offset, presents that unique challenge.

MR. STEARNS. You know, having been into these discussions before, there is two areas -- any way to turn this volume down? I guess not. Just a shade, maybe?

The two areas I find have always been a problem is, can you identify the cost it takes to get the third-party collections? Because I hear the veterans come up to me and say, "Oh, we got so many millions of dollars back." But no one has ever told me what the cost is per outpatient -- third-party, rather -- to get this money back. Had you done an analysis to say, "Okay, Congress, it's costing us 'X' dollars to get this money back and maybe we would be better off not to even do it, and we should outsource this," or something like that?

DR. PERLIN. Yes, sir. I do follow what it costs us to collect. We want to be efficient about doing that. I think it's worth stating that whomever did the collections would have to do a number of things that don't occur in other sectors. For instance, we have to generate a bill to include what Medicare might have reimbursed, even though we don't get the value of that back. So all of the effort that goes into a bill that's, say, $100; actually at the outset, because we don't collect Medicare as an example, only returns $20. But you still have to go to the effort on the other 80 percent, the $80.

And so on average, across all the different sorts of collections we have, it's approximately 10 to 11 percent.

MR. STEARNS. Okay. Before I forget it now, will this Cleveland demonstration, when will it be complete, and you be able to come back to us and give us a some quantitative information?

DR. PERLIN. Yes, we are hoping to go live in approximately July, and we would be pleased to report on the success with that, after that goes live.

MR. STEARNS. Okay. So you intend to get us a report then perhaps to one of the Subcommittees, the full Committee, on this, as soon as you have got information?

DR. PERLIN. We would be pleased to discuss with the Committee any of the performance of that as soon as it is available.

MR. STEARNS. Okay. And the other thing before I conclude is, do you keep accurate reimbursement values that are done throughout industry? For example, if a veteran comes in and he has to get Blue Cross Blue Shield to pay and then you pay them, I mean, how are

you determining these DRGs? Are you doing it with in-house? Are you taking information from industrywide, from TriCare? In other words, are you tying all these systems together so that you can say the DRGs are accurate and you have got enough information to say, "We are not overpaying for reimbursements"?

DR. PERLIN. Sir, thank you very much for that question because it's tremendously important. I think Mr. McClain might speak to statute that determines how we set the rates that are there. And -- substantially complex that we should respond to them in writing to you, if that would be okay, as to how the rates are actually matched. I know they do shop markets to try to identify fairly accurately and precisely the usual and customary rates.

MR. STEARNS. My time has expired. Ms. Berkley?

MS. BERKLEY. Thank you, Mr. Chairman. I appreciate the time. And thank you, gentlemen, and Ms. Reed, for being here. I appreciate the opportunity to speak with you.

During our break I was watching television, and I just caught you on TV as you were touting the Las Vegas VA medical complex project, and I was very happy to hear your enthusiasm about it. You know, this is a great passion of mine that I have worked very hard towards. And I attended a week and a half ago a blessing ceremony that the Southern Nevada Paiute Tribal Council conducted in order to bless the land that the VA complex is going to be located on, and it was quite exciting, and a unique opportunity to share this with our Native Americans.

But I need to share with you something that transpired just in the last few days. On Monday, we received a call, my office received a call from your office explaining that there was a $27 million shortfall for the nursing home. Well, we knew that and were anticipating it, and were told initially that this additional $27 million would be contained in this year's budget. It was not contained in the budget. My staff then reviewed the rest of the budget and found that there is actually a $147 million shortfall.

Now, we contacted your office immediately to get an explanation of what was going on, what exactly was the shortfall, what's the breakout of the numbers, are we still on schedule, when do we break ground, when do we initiate the vertical construction? And imagine my chagrin when we didn't hear from you, but later that afternoon, Senator Ensign from Nevada issued a press release that contained the information that we had requested.

Now I am sure that was an accident, but I don't appreciate having my questions that are directed to your office answered in Senator Ensign's press release. And this is, quite candidly, Mr. Secretary, the second time this has happened and I, quite frankly, am tired of that. If I contact your office and request information, I would appreciate a timely response before Mr. Ensign's office is notified with the

information.

Having said that, it is important for me to have on this record: where the additional $47 million is, why we need an additional $47 million? And I understand it, but I would like it for the record. And I would like to know when we anticipate breaking ground, where we are, and when we start vertical construction? And when will that $147 million be appropriated along with the other money that has already been appropriated?

Secretary Nicholson, Thank you, Congresswoman. First, may I ask you a question, did you call me?

MS. BERKLEY. Yeah, we called your office. It's my understanding --

SECRETARY NICHOLSON. I didn't get your call. I do not have a record of your calling me.

MS. BERKLEY. Yeah, ordinarily I wouldn't be particularly chagrined, but this is the second time, and it is beginning to get under my skin.

SECRETARY NICHOLSON. I apologize for that, because I wasn't aware that you were calling, or I would have called you back.

Onto your questions, we are very committed to the new hospital in Las Vegas, and we are appreciative of your support and your efforts in helping getting the land transferred from BLM, and so we have the land. In looking at the hospital and re-scoping it, or making the hospital somewhat bigger and adding a long-term care facility to it, we have noted, given I think in a lot of measure due to the vitality of your market out here, the cost --

MS. BERKLEY. Yeah, the construction. Plus labor costs are going up.

SECRETARY NICHOLSON. -- costs have gone up --

MS. BERKLEY. Do you have a breakdown of the $147 million? I mean, I appreciate the challenges, believe me. There's not a bigger advocate for the VA than I. But I think I need to know where the money is.

SECRETARY NICHOLSON. We will provide that.

MS. BERKLEY. You will provide that? Great. And do we still know when we are breaking ground?

SECRETARY NICHOLSON. Yes. We plan to break ground in either August or September of this year.

MS. BERKLEY. Okay, all right. And vertical construction will commence?

SECRETARY NICHOLSON. Well, the first thing we will be doing is the infrastructure, site preparation. Utility extensions, as you know, we have to run utilities for about two miles to get out to that site --

MS. BERKLEY. I am very familiar with the area, yes.

SECRETARY NICHOLSON. -- so it will be site preparation, very important work. Not very visible, but very important. And the additional $147 million that it will take to -- over the $259 million already ap-

proved for the project, we are requesting in the '08 budget.

MS. BERKLEY. For sure?

SECRETARY NICHOLSON. Yes, ma'am.

MS. BERKLEY. All right. Another question is, I appreciate your support of collaboration, but we have been -- the Nevada Cancer Institute, and I think we have spoken about this a number of times already, the Nevada Cancer Institute called me yet again last week, saying they have gotten nothing from the VA, and they are most anxious to collaborate. When I first started talking about this, the Nevada Cancer Institute didn't exist. Now they are up and running. They have a building, and they still wish to collaborate with the VA. Is there anybody in your office that you can assign to this to make this happen? And who would that person be, so I can give that name to the Nevada Cancer Institute, and we can move forward?

SECRETARY NICHOLSON. There is certainly someone in our office that they can talk to. I can't tell you -- making it happen, because I don't know what they want to happen. But they certainly --

MS. BERKLEY. Well, we know what they want. They have made very clear in meetings, they have flown in here, they have met with your people, they have commemorated their requests in writing, and we are still no further than we were.

SECRETARY NICHOLSON. I am going to ask Dr. Perlin if he has some history on this, because I do not.

DR. PERLIN. Thank you, Congresswoman. I personally had the pleasure of speaking to representatives at your request. In fact, one of the things that is lacking in our environment for us to have the full collaboration is the hospital. We look forward to having that, and there looks like in the future there will be opportunity for them --

MS. BERKLEY. But there are some things, Dr. Perlin, as you know, that we could be doing now. To whom do they speak, so we can get this moving?

DR. PERLIN. I would be happy to receive information, and their call, and get the right people engaged.

MS. BERKLEY. I am going to hold you to that, because we have had this conversation before, as well. Or I have had this conversation with VA representatives before.

Very quickly, there are a couple of things that I would like to discuss in my capacity as Ranking Member of the Benefits Subcommittee. As we know, the budget calls for a cost-of-living increase in compensation and other benefits. But I was somewhat dismayed at the small $250 additional payment made to surviving spouses with children is not included in the proposed COLA. Last year I proposed at this Committee, and the House agreed, that those surviving spouses who qualify for the additional $250 per month should not should not see the value of the payments erode. Unfortunately, when the COLA was proposed in this budget, this was not included, and the value of the

benefit, you know, is going to erode. I am concerned about that.

I also have to lend my concern about a budget that anticipates an enrollment fee and doubling the payment for prescription medication. You know the likelihood of that happening in Congress is a slim and none, and I fear you are going to be back here, just as we were last year, asking for additional supplemental money because the numbers just aren't going to match. So if your budget is based on the reality that an enrollment fee and a doubling of the co-pay for prescription medication is going to happen by this Congress, I can tell you this Congresswoman will not be supporting that. And I would hate to see you having to come back again as we did last year.

Two other very quick things, Mr. Chairman, if I may. Secretary Nicholson, you indicated that improved productivity would enable the VBA to cut the number of employees needed to handle compensation claims by 142 in fiscal year 2007. Now, according to VA's own data, employees at some of the regional offices are expected to decide two or three times more claims and appeals than other offices.

I've got a little chart here that I would like to share with you. But in our Reno office, the employees in the Reno office are handling twice as many claims as the Salt Lake City office, and we have the fourth highest remand rate, which indicates to me that they are already overstretched. And how we are going to have less personnel, and what efficiencies can possibly be initiated that's going to help this Reno office, and as God is my witness, this is my fourth term in Congress and I started talking about this four terms ago, and I am still having the exact same conversation. So I have very serious concerns about the numbers.

Also, when it comes to laying our nation's veterans to rest, they don't have adequate burial benefits. They haven't increased since 1978. We need to provide some relief, and I know that this is something Congress could and should be doing, but I would appreciate the support. I hope this Committee is going to consider HR 808, which I introduced last year. Burial costs have increased substantially since 1978, and recently have not kept up with it, and I think it is a shame.

I am going to submit in writing a couple of other questions. The VA received a report concerning it's pension programs. The report found that veterans' surviving spouses do not receive income sufficient to cover their basic necessities. The pension program was designed to fulfill our nations promise to those who honorably served this country. Isn't it about time that we provide, and the VA help Congress to provide enough money for these veterans to live on? I think that answer is rather self-evident.

One other question --

THE CHAIRMAN. Thank you.

MS. BERKLEY. All right. Thank you very much. If you wouldn't

mind, I am going to submit the other questions in writing, would appreciate a response. Thank you very much for being here.

[The attachment appears on p. 194]

THE CHAIRMAN. Thank you, Ms. Berkley.

To my colleague on Ms. Berkley's point, we will work with Mr. Evans. One of the first full Committee hearings we will have out of the box, we will deal with the issue about collaboration, further collaboration with regard to facilities. So we will work with Mr. Michaud, and Mr. Brown, and Mr. Evans, and myself, to kickoff -- it will be one of our first or second hearings. Because we have a very expensive construction in front of us, when you think of Denver, New Orleans, Orlando, Las Vegas, and Charleston. And when the secretary mentioned re-scoping, you know, I was pleased to come out to your district so I can see firsthand what was planned to build for that VA. Now it is almost outdated.

And at the same time, you have the Chancellor of UNLV interested in building the medical University, and making sure that it's done in a manner that can be not only just in close proximity, but somehow it could be that shared facilities. And so we need to move in a direction for which we have the best understanding, and we educate all the members with regard to what knowledge Mr. Michaud and Mr. Brown have. So I just wanted to share with the gentleman here --

MS. BERKLEY. Mr. Chairman, I meant to say in my opening remarks what a pleasure it was having you share that experience with me in Las Vegas. I think it was educational for the both of us, but I think the operative word in your comments is, "move." Let's move on this.

THE CHAIRMAN. Now recognize Dr. Boozman, Chairman of economic opportunity, and then I will go to Mr. Strickland.

MR. BOOZMAN. Thank you, Mr. Chairman. I really just got one kind of technical thing that concerns our Committee, and so let me ask that, and then I've got a comment while you are trying to figure out the answer. But the question I've got is, the rehabilitation counselors that are going to be hired, how many out of the additional 130 FTEs, how many direct claim adjudicators will be hired out of the additional 46 FTEs? Does that make sense?

While you are pondering that, if you understand the question --

SECRETARY NICHOLSON. I am not sure I understand the question. Could you --

MR. BOOZMAN. How many rehabilitation counselors will be hired out of the additional 130 FTEs? And how many direct claims adjudicators out of the additional 46 education FTEs?

Let me just say one thing. Over the weekend I was at a veterans event. We have a quarterly thing here where we bring in our representatives from our VSOs, and anyone else that wants to come. And we held that at our hospital. And just in the course of that, after I

was visiting with one of the administrators, and they told me that the Inspector General had come in and, you know, done their thing, looked at the hospital and stuff, and basically had given them a clean bill of health, you know, a kind of a superior thing in every category that they had. And they said that might have been, you know, one of the few situations, you know, that that's ever happened.

So again, that's really indicative. Ten or fifteen years ago if they had come in and done that, our scores would not be anywhere near that, okay. So I think it's something that we can all be very, very proud of. You can be very, very proud of, because it's not just true of Fayetteville, Arkansas. That's true across-the-board. So we got our problems, we are going to work those out. You got your budget, we are going to look at it and get back and forth. The Senate will have some ideas, but you all, the people in the room that have pushed so hard for so many years to move this thing forward, you really are doing a good job. The senior members on our Committee, Filner, Mr. Evans, Mr. Buyer, Bilirakis, Mr. Smith, all of these people, and now us, you know, that are coming forward and continuing the banner.

Like he said, I think we just need to not lose sight, as we hash this thing out, that we really have made tremendous gains, and the VA system in Arkansas, the VA system, despite, you know, we are not perfect by any means, but we really have made tremendous gains. Yes, sir?

MR. COOPER. Let me attempt to answer your question. As I break this down and look at the numbers of people that we are bringing on in this '07 budget, of the 100 and some that we are bringing on in Vocational Rehabilitation and Employment, VR&E, a few of those will be counselors. Many of them will be employment specialists, because the primary purpose of Voc Rehab is to get the individuals either into independent living, if they are seriously disabled, or get them employed. And one of the new things we've done as a result of this study completed two years ago is that we've looked very carefully at a five track program leading to employment.

So some of those people, will be counselors, a few will be psychologists, but many of them will be employment specialists that will help us in that particular endeavor.

As for those that we are hiring going into '07 for grade C&P claims processing, most of those are hired at a lower grade than a rating specialist, because it takes us three to four years to develop a rating specialist, and we prefer to bring them in, highly intelligent young men and women, and many veterans, in order to train them to be the type of people that work up the claims, and get all the material necessary to then go to the rating specialist, who makes the decision.

So most of those people, possibly all of those people, will come in at that level, to eventually move up. It takes them about a year plus to become properly trained in order to carry out their function, which

is so important to making the decision. Does that answer your question?

MR. BOOZMAN. Yes, sir. Thank you very much.

SECRETARY NICHOLSON. If I could, Congressman Boozman, I want to thank you for your acknowledgment of things at the Fayetteville, Arkansas hospital. And I just want to also tell you that we have a letter of commendation on its way to Mike Wynne, the director, for the exemplary job that he's done there. Our IG found that to be just a superb hospital, and job being done by its director. Thank you for acknowledging that.

MR. BOOZMAN. Well again, I appreciate that. And like I said, I mention that in the context that again, you know, a few years ago that would not be the case. And yet, that's not only in that hospital and that system, that's systemwide. And again, that's just a lot of hard work and a lot of peoples, so give yourselves a pat. Thank you.

THE CHAIRMAN. Thank you. I will now yield to Mr. Strickland. Mr. Secretary, Mr. Strickland is the ranking on the Oversight and Investigation Subcommittee, and also was very helpful in the CIO legislation, and so he has great knowledge on that issue. Mr. Strickland.

MR. STRICKLAND. Thank you, Mr. Chairman. Mr. Secretary, I am just struck by the fact that you brought us a budget that contains a projected savings of I think the Chairman said about $775 million. That will not happen. I don't know how many times this bipartisan Committee has to say "no" to these increases in co-payment and user fees, but they're not going to happen. So we start out with a budget that is unrealistic, in my judgment.

Now I know you said that you believe in these actions, but the fact is that's not what counts. What counts is what the Congress says they are willing to do. And this Congress is not going to do it. So, it just strikes me as an act of bad faith to come forth with a budget listing increased copayments and user fees as income for the VA. That's not going to happen.

But I would like to just reiterate a brief bit of history. During our February 16th, '05 hearing on the budget, I asked you about the department's continuing claims of savings due to management efficiencies for the fiscal year 2006 budget. Those claimed savings amounted to almost $1.8 billion. I asked you whether the VA was able to document efficiency-based savings claims, and I was promised in that hearing that the VA would get back to me with the details. And as I recall, our Chairman characterized my questions as appropriate, and directed that the VA be responsive.

When our Chairman asked VA about its level of confidence of achieving the 1.8 billion savings for '06, the response from the VA was, "very confident".

When Ranking Member Evans sought explanation for the savings, he was provided a scant five item chart to account for almost

1.8 billion in fiscal year 2006 savings. Both sides of the aisle of this Committee challenged the efficiency savings claims, and further requested that a portion of those claimed savings not be used to offset the budget.

However, the VA did not provide adequate documentation to prove net savings efficiencies. As a result, I supported Ranking Minority Member Evans and Senator Akaka's request that the GAO audit VA's claimed savings efficiencies. The result of that audit, which were released on February 1, confirmed the worst of our concerns about VA's claims. According to the GA audit, the VA lacked a methodology for making savings assumptions. The VA was unable to provide any support for savings estimates that it used to offset the veterans health care. And the VA lacked adequate support for some 1.3 billion it reported as actual management efficiency savings achieved for fiscal years 2003 through 2004.

But perhaps the most significant revelation is that VA officials told the GAO during three interviews that the management efficiency savings assumed in the budget were, and I quote, "Savings goals used to reduce requests for a higher level of annual appropriations in order to fill the gap between the cost associated with the VA's projected demand for health care services, and the amount the President was willing to request," close quote.

In other words, it seems that the VA had identified veterans' health care budget needs, and the President refused to meet those needs. So the VA chose to fill the gap with these phantom savings goals. Unfortunately, in the '07 budget request, this Administration continues to claim more than one billion in management efficiency offsets. Respectfully, Mr. Secretary, I and I think some others on this Committee feel that this shell game should stop.

Including the '07 estimated budget efficiency savings, the total funds potentially skimmed from VA health care by unsubstantiated claims is over $5 billion in total, for the five years of the Bush Administration.

Mr. Secretary, I ask you this question: in this budget, the VA claims 884 million in efficiency savings from fiscal year 2006. The GAO has stated that VA was unable to provide support for its fiscal year 2006 estimate. Now this budget that we have was presented after the GAO report. The VA carries this 884 million claim over a two-year period, which totals $1.768 billion in offsets originating from the fiscal year 2006 estimate, that GAO found unsupported.

Mr. Secretary, can I assume that you can present documentation to this Committee and the GAO audit team to support the 884 claims in efficiency savings the VA relies upon from the fiscal year 2006 to delete the 1.7 billion from the veterans health care budget? I think that's a reasonable question to ask, given the GAO report.

SECRETARY NICHOLSON. Well, thank you, Mr. Strickland. And your

recitation of those GAO comments for I think starting in fiscal year 2003, 2004, and so forth, were I think pretty accurate as the GAO stated them. The VA has disagreed with some of the GAO findings -- the composite of those reports.

But fast forwarding to '06, the GAO said, and I will quote, "Based on the VA's past experiences, 2006 estimate of 590 million in management savings appears achievable." And I would tell you that in this budget that we are here today to consider, there are no offsets in this budget for management efficiencies, and I want to ask Dr. Perlin to expound on that.

DR. PERLIN. Thank you, Mr. Secretary. That is exactly correct. I appreciate the opportunity to explain that The Secretary built this budget from scratch. In fact, I want to separate the concept of management efficiencies from efficiencies in the provision of care. $197 million is in the demand model. It is what is expected of all of the sectors of health care in terms of improving, in terms of pharmaceutical use, in terms of better scheduling of patients, better use of inpatient hospitalization, standardization of pharmaceuticals, and the like. That has always been in the model, and is really well substantiated, well-documented.

What is not in this budget: there is no offset of the demand with additional management efficiencies, so this is categorically different than the exposition of budget last year. Thank you, I appreciate your points.

MR. STRICKLAND. Mr. Chairman, can I just make one follow-up comment. So you are telling me that the management efficiencies that were evaluated by the GAO -- effort to achieve management efficiencies in prior budgets -- that there are no such management efficiencies built into this budget?

SECRETARY NICHOLSON. That is correct, Congressman, yes.

MR. STRICKLAND. Mr. Chairman, I have two or three other questions which I will not ask. I would like to submit those questions if I could do that, and one more thing, Mr. Chairman. If I could ask for unanimous consent that the Web links to the three GAO reports that I've referred to could be included in the record?

THE CHAIRMAN. The Web links? Can you restate that? The addresses?

MR. STRICKLAND. Yes.

THE CHAIRMAN. I have no objection, just state the addresses.

MR. STRICKLAND. So that could be a part of the record in case people wanted to find them.

THE CHAIRMAN. All right. My only hesitation, I didn't want the link and therefore other's documents to be --

MR. STRICKLAND. Got you.

THE CHAIRMAN. All right, thank you.

Mr. Strickland. Thank you, Mr. Chairman.

[The information follows:

GAO-06-124R found at http://www.gao.gov/new-items/d06124r.pdf

GAO-06-359R found at http://www.gao.gov/new-items/d06359r.pdf

GAO-06-360R found at http://www.gao.gov/new-items/d06360r.pdf]

THE CHAIRMAN. Mr. Udall, you are now recognized.

MR. UDALL. Thank you, Mr. Chairman, and I would ask that my opening statement be inserted in the record.

THE CHAIRMAN. Hearing no objections, so ordered.

MR. UDALL. Thank you, Secretary Nicholson, for being here, and I want to express my gratitude of many veterans in my district who suffer from PTSD, for your decision last year to cancel the review. Nearly one in five vets returning from OEF or OIF duty are estimated to suffer from some form of PTSD. And there is some concern that the fiscal year 2007 VA budget is not sufficient to ensure that each of these veterans receives the mental health assistance they need. This means all efforts of the VA to make veterans aware of the disease, to make veterans aware of the assistance offered by the VA, and to de-stigmatize, as you mentioned earlier, PTSD, that these would be rolled back.

How is your office going to deal with the increase in the number of veterans seeking assistance?

SECRETARY NICHOLSON. An important question. Thank you for it. As I said earlier, this is a very big priority area of ours. You will see sharp increases in our budget request for mental health. I think it's, if my memory is right, it's right at $340 million for that. We are emphasizing both the outreach attempts to capture these people who come to us, -- in each of our medical centers we have a PTSD expert. At our four polytrauma centers we've populated them with just really the finest PTSD people that there are. We have probably the world's foremost PTSD research facility at White River Junction, Vermont. We are ramping, and ramped up for this, and I will let Dr. Perlin further expound with more detail.

MR. UDALL. Please, Dr. Perlin.

DR. PERLIN. Thank you, Mr. Secretary and Congressman. I appreciate your passion for assuring that mental health services are always improved. Just as the Secretary stated, the increase in mental health funds in the '07 budget is almost $340 million, bringing the specialty mental health services to $3.16 billion. This augments all sorts of improvements in programmatic activity including, as the secretary indicated, PTSD specialists at each and every medical center, 160 full-blown PTSD teams throughout the system.

As well, you made the point about de-stigmatizing, and it is, as the Secretary indicated earlier, completely normal for people to have combat stress reactions, reactions to some of the horrific circumstances

they will experience. Our goal with the Vet Centers, and the Global War on Terrorism Outreach Coordinators, or at the hospitals, is to make sure that we don't stigmatize, and that we treat so that people are able to be as highly functional as possible.

The numbers are at this point much lower than I believe you suggest. And I am pleased to note that the Vet Centers are doing outreach at the transition assistance briefings that are increasingly coordinated, not only with DOD directly, but the adjutant general and state veterans' directors of each state.

MR. UDALL. This review, as both of you know, caused a great deal of concern in the veterans community. And we have heard other rumors out there about possible other reviews. We have heard that, and I have heard this from veterans, that there is a suspicion that the Veterans Administration is now being much more aggressive in terms of PTSD analysis, and that in the past, if claims were approved, they were approved on one standard and one criteria, and that that criteria is getting much tougher.

Can you give us any assurances today that we are not going to have any other review on the PTSD issue, and that you are applying the same standard you have always applied?

SECRETARY NICHOLSON. Well, I can assure you that those 72,000 cases that were given 100 percent disability ratings that were reported in the IG report, that we are not going to review those, no.

As to PTSD in chief, we are going to continue to try to understand the dynamics of this condition, and so that we get better at understanding it, and being affirmative in our outreach, and in treating it, because it's a very germane matter, given the numbers and what's going on both in our health side and our benefits side.

MR. UDALL. Thank you very much. I have additional questions, and we will submit those for the record. Thank you.

[The statement of Mr. Udall is found on p. 80]

THE CHAIRMAN. Ms. Herseth, you are now recognized.

MS. HERSETH. Thank you, Mr. Chairman. I want to thank all of you for your time and your testimony today, and your hard work. And I hope you know what a great team you have in the Black Hills health care system in South Dakota, who recently in a survey ranked top in the region, as well is in a number of categories nationally. So I commend you and the folks there in particular for your work on behalf of the country's veterans that are served throughout that region.

It will come as no surprise to you, Mr. Secretary and Dr. Perlin, that I want to talk a little bit about long-term care. It's an issue I am particularly worried about for our nation's veterans, as well as our overall health care system in this country. And I want to begin by just making a few observations, and then I will end with a separate question on a separate topic.

Thank you for the increase, the 14 percent increase, as it relates to the average daily census for veterans in home and community-based care. This is particularly important for older veterans in rural areas, and throughout the great plains we have a very high percentage of World War II and Korean War veterans who are in need of long-term care options, and live in very remote areas where perhaps long-term care facilities aren't based, and to have programs designed for the home-based care I think are particularly important, and hope that you'll continue to seek increases in that level of funding.

But I've got a couple of concerns. The first, and if you could address this, is the statutory requirement. The mandatory minimum that Congress has imposed for the number of nursing home beds within the VA is 13,391, but the budget is only funding 11,100 beds. Now, you are moving them into other areas that we do have to address this issue of a statutory requirement that is being ignored in the budget, and how we address that situation.

And the other issue that causes great concern, and it is not just an issue for the VA, it is an issue for Medicaid in particular, and other programs, and that is the fact that your own survey for using the VA's a long-term care model projected the demand for VA-sponsored nursing home care for fiscal year 2007 -- and at the outset, this includes all priority groups I know to be 80,511 average daily census. But the budget is funding roughly 34,000 beds, whether that be VA, state, or community-based care.

Now, I know by law the VA is only required to provide the long-term care to the 70 percent or greater, and then additional. And I know that with the 34,000, that's beyond the 70 percent service-connected disabled. But in your own projections, just as the midpoint projections for older veterans who will suffer from dementia, 42,827 veterans. So you know, we've got to look at our priority groups one and two, and even beyond that in other priority groups that may suffer from different types of conditions where long-term care is perhaps one of the best settings for meeting the health care needs of our older veterans.

So just a couple of observations but perhaps you could address the issue of the statutory requirement, and then the last question I would have would be for Mr. Cooper. And that is on the seamless transition for returning veterans from Iraq. I would like to know what VBA is doing to identify recent veterans who are at risk for homelessness, who have claims pending but no source of income?

So, questions primarily concerning our older veterans and long-term care, and then our most recent veterans who have a risk for homelessness.

THE CHAIRMAN. Ms. Herseth, your question also incorporates veterans of Afghanistan?

MS. HERSETH. Yes, it would.

THE CHAIRMAN. Thank you.

SECRETARY NICHOLSON. Well, thank you, Congresswoman, for those comments. Thank you for your compliments. Our people out there in western South Dakota are doing a great job. I've been out there.

And your points are well presented. There is a statutory requirement, an objective number of beds for long-term care, and we are not filling those beds. But we are meeting the need at this time. But we have that statutory authority to go up, and certainly will, if there is that need.

The other law is that we are really only supposed to put people in those beds who are 70 percent disabled. And those two existing legal conditions, coupled with the real progress that we are making in noninstitutional long-term care, in the composite I think are resulting in us meeting the needs at this time. And this budget reflects what we think we will need in resources to continue to do that.

Dr. Perlin, you have anything you would like to add to that?

DR. PERLIN. Ms. Herseth, I think you have well stated the statute that governs -- Congresswoman, we appreciate your acknowledgment of the increases in noninstitutional care. In fact, it's really pretty incredible. There has been an eighty-five percent increase in noninstitutional care since 1998. The program of care coordination, particularly in rural areas, supporting individuals with frailties, be it of age or otherwise, has actually increased 466 percent from 2005. So really, investing in additional technologies, recognizes that there are challenges to an aging population of veterans, and for those that were authorized. We will look to every possible means to meet that need.

MS. HERSETH. Before you respond, Mr. Cooper, if I might, Mr. Chairman, just to clarify. And I respect the work that you are doing to meet the needs. That's why I began with acknowledging the increases in these different areas. But I do think that for the Committee and the ongoing working relationship that we want to have with all of you, that while it's important to meet the needs, it's also important to come to us if you see the need for a statutory change, so that we can see more clearly how the needs are being met, what areas were increasing, community based or home health care, and to make the changes so that you don't perhaps lose some credibility. Because my understanding is that it's a mandatory minimum. It's not so much discretion to go up to a certain amount. Is my understanding of the statute correct?

SECRETARY NICHOLSON. No, you are correct, Congresswoman. I mean, I would stipulate to you, there are two parts to this that we are not literally fulfilling. One is that objective number of those beds. And the other is that requirement that they be 70 percent disabled. We have considerably more people right now in our long-term care facilities than there are just of that number.

MS. HERSETH. And that's the discretion I think you have under the

statute, that there is the specific number, and then you fill them with the 70 percent or greater service-connected disabled, and then fill in others who may need up to that point.

Secretary Nicholson. We've done that, and they are still there because we just have not put them out.

Ms. Herseth. Okay. Well, I hope that you will take my point in the manner in which it is intended. It is intended to be helpful in an area of long-term care, but yet also looking at what is required by statute, and how you have adjusted that over time in a way a I think that is positive, but yet at the same time I am interested in meeting even more of the needs of our older veterans than what you have already done in a very remarkable way, and a laudatory way. And so that is just the point I wanted to make, as it relates to the statutory requirements that we have to be cognizant of in the Committee.

[The statement of Ms. Herseth appears on p. 86]

The Chairman. Thank you. Mr. Secretary, Ms. Herseth is our ranking on the Economic Opportunity, Subcommittee and gives a valuable contribution.

I would now like to recognize Dr. Snyder. Dr. Snyder is also the ranking on the personnel Subcommittee of Armed Services, so he gives us a valuable insight, because he gets the total military health delivery system, and then as the soldiers transition to the VA. I yield now to Dr. Snyder.

Mr. Snyder. Thank you, Mr. Chairman and Mr. Secretary. I apologize for being late. We simultaneously have the Armed Services Committee hearing with Secretary Rumsfeld and General Pace this morning, and that started at 10:00, and so they took a lunch break and so I ran over here.

One thing that came out of the discussion this morning in General Pace's assessment of the Quadrennial Defense Review; in his written statement, he made a specific reference to educational opportunities or people in the military, to help them both professionally but also in their personal goals. And I understand, Mr. Chairman, that you mentioned the GI Bill earlier on. I think that we have some work to do. One of the problems that we have as an institution is that this Committee handles the GI Bill for veterans. The armed services Committee handles the GI Bill for Reserve component. And they don't run in tandem. And I have been trying for some time to get a joint hearing between this Committee and perhaps the personnel Subcommittee on the other side, to have a full discussion of all the different proposals related to the GI Bill. I had 45 months of GI Bill after I came back from Vietnam, both to finish my undergraduate and three years of medical school, and it was very, very helpful to have, and I think men and women today should have those opportunities.

I wanted to ask one question. I apologize again for not having

heard the discussion today, so perhaps you have already dealt with this. But in your written statement you have a section on medical research. We have the Little Rock VA in my district, in Little Rock, Arkansas, and they do great, great work there. It's right next to -- in fact it's connected by a federally-funded little bridge there, because of a lot of communication with our medical school there.

But in your written statement you say the following: "In addition to VA appropriations, the department's researchers compete and receive funds from other federal and nonfederal sources. Funding from external sources is expected to continue to increase in 2007 through a combination of VA resources and funds from outside sources. The total research budget in 2007 will be almost 1.65 billion, or about 17 million more than the 2006 estimate." And that's the end of your statement.

But when you just look at the federal number that's coming from your all's budget, it's a decrease; is it not? I mean, you are betting on if there's going to be competition for, you know, pharmaceutical companies or other organizations that you are hoping will give you the total increase, but in terms of our federal commitment, it's actually a decrease of $13 million in federal commitment to medical research, and this seems like a bad time to be trying to save money on medical research, when we have got so much going on overseas with our veterans.

Would you comment on that, please? First of all, am I accurate in that, that there is a decrease in the federal commitment?

SECRETARY NICHOLSON. Yes, you would be. I think that based on our history, our track record, being able to leverage our dollars with those of other federal and private entities, we feel pretty confident that we will make that number, and that will result in over 2000 projects. I think actually 2045 different research projects, which will be one and a half percent more than in '06.

So I think your point is well taken. It is not a time to diminish research, and that is certainly not our intention, and even that reduction would not very material, given the total amount. But I think we are going to do well in partnering, as we have done in the past. I will ask Dr. Perlin if he --

MR. SNYDER. I would like to hear your comment, Dr. Perlin, but the issue, though, too becomes, you are kind of saying you are holding your own. You are estimating maybe 17 million more. But medical research inflation is greater, substantially greater than the normal inflation. So when you are just holding your own, as you say it's not very much either way in the total budget, but if the nominal numbers stay static, it's a substantial reduction because of the medical research inflation rate.

And Dr. Perlin, I appreciate your comments.

DR. PERLIN. Thank you, Dr. Snyder. I think you have laid out

exactly how the budget is constructed in this area. 399 is the VA component. I should note that in medical services, we are actually increasing by $13 million to help fund the administrative overhead of that research. The proposition is that VA in 2007 will continue its trend of attracting, "leveraging" the investment that's been made through this direct appropriation to research, toward attracting predominately federal grants. Mostly, National Institute of Health, as well as private foundation grants. So your outlay is correct. I would simply note that Secretary has really worked with us to also ensure that we do increase the focus, specifically on those areas of research that are most germane to the history of the lives of service members: everything from occupational exposures to traumatic injury, and I am pleased to note that this budget supports a $10 million increase in those sorts of areas.

MR. SNYDER. Well, I just hope, if I could, Doctor, I hope you are tracking that. Because we have some very exciting stuff going on as a result of our research on both shingles and artificial retina replacement, and urinary infections. Really, I think we are on the edge of some exciting stuff. No, I agree with that. I think some great work is going on. But if your budget doesn't keep pace with the rate of medical research inflation, you have got researchers out there saying, "Hey, the Secretary just bragged on my work and we are going to have to fire people." You know, I don't think that is the message we need to be sending, so I would hope this is an area we will work on, Mr. Chairman, because in the President's State of Union speech he made I thought a very impassioned endorsement of research in the math science area, and certainly medical research is part of that. Thank you for your time. Sorry I was late.

THE CHAIRMAN. Dr. Snyder, the Committee wants to work with you and Mr. McHugh, because you know, you just heard testimony from the SECDEF, and General Pace, and with regard to the increase in fees on TriCare for Life, on military retirees. I mean, we are faced with that challenge already. TriCare, you have the enrollment fee, you have the increased co-pays over what we do on sevens and eights and the deductibles on TriCare standard and prime.

And this Committee has been unwilling to resolve that inequity, so we are treating military retirees differently than somebody who has been on one tour of duty. And the worst thing that we could ever happen is the Armed Services Committee increases fees in TriCare for life for the military retiree, and then this Committee takes no action; all we are doing is exasperating this. And it's just a challenge, and I want to work with the gentleman on how we properly proceed on this one. I mean, we don't want that scenario to occur, whereby now there is a greater bias or prejudice against the military retiree, versus the seven or eight. This is a real challenge we have in front of us, Dr. Snyder. Thank you.

Mr. Brown of South Carolina, Chairman of the Health Subcommittee.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman, for holding this hearing today. And thank you, Mr. Secretary, and all the associates for being part of this deliberation. And I am particularly pleased at the cooperative spirit that you have entered into with the other institutions, as far as health care delivery. And I just wanted to express my appreciation publicly for that commitment. Mr. Chairman, I don't have any questions at this time.

THE CHAIRMAN. I am sorry, restate?

MR. BROWN OF SOUTH CAROLINA. No questions at this time. I just had a statement. Thank you very much.

[The statement of Mr. Brown appears on p. 90]

THE CHAIRMAN. He's so eloquent, the man from Charleston. It's because we can't understand you anyway, right?

MR. MICHAUD. I concur with that, Mr. Chairman.

THE CHAIRMAN. Like you are any better? No, I was just kidding you.

THE CHAIRMAN. Go ahead, Mr. Michaud.

MR. MICHAUD. Just a clarification, that Mr. Strickland had asked about the question about the management efficiencies, and Dr. Perlin had mentioned the GAO report said that they agreed that the efficiencies could be achieved. I was just wondering if he can get a copy of that report, or what report was he referring to?

THE CHAIRMAN. Doctor?

SECRETARY NICHOLSON. Yes, it's in a letter of March 2nd, '05, addressed to the Appropriations Committee, and I would be happy to provide you with a copy of it.

MR. MICHAUD. Yes, if you could. Because I believe in that letter it said that they did not test the reliability and the validity of the data used to calculate, if my recollection -- but if you could provide that letter to the Committee, I would appreciate it.

SECRETARY NICHOLSON. Yes, sir.

MR. MICHAUD. Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you. I would ask unanimous consent that opening statements of Mr. Brown, Mr. Boozman, and Mr. Reyes be submitted for the record. Hearing no objections, so ordered.

[The statement of Mr. Reyes appears on p. 94]

THE CHAIRMAN. Also, we have a unanimous consent request for Mr. Michaud, and any other members will have three legislative days to submit an opening statement for the record.

I have a quick follow-up, and then we are going to conclude, Mr. Secretary. I appreciate your patience. And maybe we can go to Under Secretary Tuerk on this.

The Military Quality of Life and Veterans Affairs Appropriations Act conference report asked for a study on the feasibility of developing land at Fort Ord, which was closed during the BRAC process of some 10 years ago, for a national cemetery. I have a copy of your response on that, but my question is, are you working with DOD, and you are looking at BRAC-ed properties, with regard to where there is a need and available land?

MR. TUERK. We have looked at BRAC-ed properties, Mr. Chairman, as their availability has been made public. It is my understanding, that we have not yet identified any properties via the BRAC process in areas where we seek to address the most pressing needs for new cemeteries.

There is one opportunity to acquire some DOD land for development of a national cemetery. In Columbia, South Carolina. But that Fort Jackson land is not part of the BRAC process, it is outside of the BRAC process.

THE CHAIRMAN. All right.

SECRETARY NICHOLSON. Mr. Chairman, if I may, I would just add --

THE CHAIRMAN. Yes, sir?

SECRETARY NICHOLSON. -- a little more specific to that. We have actually made seven different applications to the Army, and three to the Air Force, on specific pieces that we would like to have a chance to look at.

THE CHAIRMAN. If someone could give us an update. And we are going to look at this further in some hearings with regard to the PFSS revenue cycle management issues. We have Cleveland ongoing, and with regard to the second competitive pilot, a Committee initiative, I believe there is an anticipated request for proposal. If you could give us an update, I would appreciate that, now.

DR. PERLIN. Thank you, Mr. Chairman. Just to reiterate: while you were out of the room, we are on track on terms of going live at Cleveland early July of this year, and look forward to wiring our electronic health record with electronic billing and collections, taking it into the future, and we appreciate your support, and the support of this Committee.

The revenue improvement pilot is multifaceted. As you know, we are also developing the CPACs, the Consolidated Patient Accounting Centers, to regionalize, not re-duplicate what can be more efficient when regionalized. That's been in development since '05, and piloting in this year.

The revenue improvement pilot projects specified, actually build on the CPAC activity out of Asheville. And the statement for objectives I understand are ready for release. We hope to award the contract within the next month or so.

And finally, what was originally known as contract care coordination, renamed because of the confusion with our very successful care

coordination program, and Telehealth program, to project HERO, Healthcare Effectiveness through Resource Optimization, is slated for competitive award by the end of this calendar year, with three objective-oriented demonstrations appropriate industry and academic collaboration.

I spoke at a kickoff for this on industry day, as it was framed just last week, February 2nd, so I am pleased to report that all these projects are moving forward.

THE CHAIRMAN. So our second competitive pilot on a pending RFP will most likely occur at Asheville? Is that what I am taking away from your statement?

DR. PERLIN. There are two sets. And yes, the revenue improvement pilot will leverage the consolidations there, so that we can really go to scale --

THE CHAIRMAN. No, I have no objection to that. I think you are moving smartly.

DR. PERLIN. Thanks.

THE CHAIRMAN. Thank you.

The last is, and I hate to be redundant, but I have to go back to the CIO issue. The Committee has taken this issue on, been dealing with it for seven years. So Mr. Secretary, we have been in discussions about this before, and the Senate, they are standing over there being good listeners, and will react to what actions or inactions the VA takes.

So help me here. In order for your federated approach to work, you are going to have to move the infrastructure, which is your personnel, budget and assets, under the CIO, Mr. McFarland, now. Is that correct? And then --

SECRETARY NICHOLSON. Correct.

THE CHAIRMAN. The Secretary answered in the affirmative.

The other, then, would be the development, the software development in particular, that is then left in the hands of your three under secretaries. Correct?

SECRETARY NICHOLSON. Well, yes and no. I think it depends on the scale, and if it's a local, unique, what I call tactical application, it would be left to those that are working that project. But the CIO will have, the main responsibility to set --

THE CHAIRMAN. The architecture?

SECRETARY NICHOLSON. -- the central enterprise architecture. That these tactical application would have to comport to.

THE CHAIRMAN. All right. In order for --

SECRETARY NICHOLSON. That's an important step toward standardization, and centralization.

THE CHAIRMAN. And in order for us to support you to do that, would you not concur that when we submit our budget views and estimates to the Budget Committee, to support this endeavor of empowerment

of the CIO so that he can do his job to create the one architecture, we are going to need to fund the data center consolidations, you are proposing four of them so that's around $60 million that we are going to have to come up with; about $30 million for Telecom, for redundant backup, and the continuation of operating plans. And about $12 million for VBA's code conversion within the benefits delivery network. Would that be accurate?

SECRETARY NICHOLSON. I don't have those numbers in front of me, Mr. Chairman, but I think that's pretty close. We have Mr. McFarland here.

THE CHAIRMAN. Mr. McFarland, could you come forward, please? Would you please state your name and your position?

MR. MCFARLAND. Robert McFarland, Assistant Secretary for Information and Technology, and the CIO of the VA.

THE CHAIRMAN. With regard to the funding issues that I just specified, would it be accurate that these are three things that are very important for you to proceed in the development of the one architecture?

MR. MCFARLAND. Yes, sir. Those are accurate projects that we need to move forward on in both '06 and '07 in order to get the economies of scale that we anticipate out of this reorganization.

THE CHAIRMAN. Are there any barriers left in front of us, for this transfer of personnel, assets, and budget to you?

MR. MCFARLAND. I don't anticipate any barriers. We have some decisions that have to be made and are scheduled to be made on the 15th of this month, at a senior management Committee meeting.

THE CHAIRMAN. The last comment that I have, then, to Dr. Perlin, is with regard to our software development. We are going to make sure that we have a near-term plan I mean, since we don't have the standardization process, rules, and structures for the developing of new software applications, I believe it's pretty important for you to come up with one.

DR. PERLIN. Mr. Chairman, that's one of the areas where I couldn't agree more emphatically. We need to comport with enterprise architecture. And just as Mr. McFarland is brilliantly leading a reorganization, standardization, it is our goal within VHA, under the aegis of Craig Luigart, who has a background as a fighter test pilot, and CIO at the Department of Education, to create a standardized, tight, responsible, accountable, (and built on a history of effectiveness) system that comports to the organizational architecture, and advances our health IT.

THE CHAIRMAN. Mr. Secretary, I want to thank you for being here with your staff. I want to extend some compliments, not only to Mr. McFarland but also to Mr. McClain, your general counsel. Your general counsel has been very responsive to the Committee. I've been doing this for 14 years, and I can't remember a Secretary being here this

long. This was your budget, and you took ownership of this budget. And given what we went through last year, I wanted all the members to be availed of the greatest opportunity to discuss this budget with you. And so for that, I appreciate your being here.

Right now the Committee will recess for five minutes, and then we will bring the second panel. Thank you, Mr. Secretary.

[RECESS]

THE CHAIRMAN. The Committee will come back to order.

I want to thank the Secretary for his indulgence of the Committee and all their questions. We look forward to working with him in this coming year. And the Committee will also be submitting questions, for the record, to the Secretary.

Our second panel today consists of representatives of the Independent Budget (IB), as well as the American Legion, and the Vietnam Veterans of America. Representing the IB, we have David Greineder, who is the National Legislative Director of AMVETS. Before his posting with AMVETS, David served as congressional aide to several members of Congress advising them on veterans issues.

We also have Rick Surratt, who is the Legislative Director of DAV. Rick is the combat-disabled Vietnam veteran who enlisted in the United States Army in 1966. In 1967, he was wounded by shell fragments in the thigh during a Vietnam combat field operation, while serving with the 101st Airborne Division, and was honorably discharged in 1969.

Carl Blake is the Senior Associate Legislative Director for PVA. He is a West Point graduate, was commissioned as a second lieutenant in the United States Army. He was assigned to the first brigade of the 82nd Airborne Division at Fort Bragg, North Carolina. He retired from the military in October of 2000 due to a service-connected disability.

Finally, we have Dennis Cullinan, who is the legislative director of the VFW. He was discharged from the United States Navy in 1970. Before his discharge he served as an electronic technician aboard the USS Intrepid, and completed three tours of duty in Vietnamese waters.

I would like to thank your organizations for visiting with us last month, and giving the full Committee staff an overview of the methods used in developing the IB, as well as a preliminary idea of what the IB would recommend this year. I don't know if such a briefing has ever been done before, and it is a good example of how the veterans' groups and the Committee can work proactively together, for the good of our veterans.

We also have as part of the second panel Mr. Steve Robertson representing the American Legion as the Legion's Legislative Director. Steve served 12 years in the United States Air Force from 1973 to

1985 as a security police officer in Louisiana, Turkey, and North Dakota -- three very remote locations. He was a missile combat crew commander for the Minuteman III ICBM in North Dakota, and was a flight commander on the ground launch cruise missile silo in Sicily. Steve was also a military policeman in the D.C. Army National Guard. When he was activated in January, 1991, for the Persian Gulf war, and served from February to June in Saudi Arabia.

Finally, representing the Vietnam Veterans of America, we have Rick Weidman, Director of Government Relations. During the Vietnam War, Rick served as an Army medical corpsman, including service with Company C of the 23rd Medical Battalion of the AMERICAL Division, located in I Corps of Vietnam in 1969.

Who wants to go first? We will turn it over to the IB, and let you go first.

MR. GREINEDER. I guess everybody's looking at me so it's my turn.

THE CHAIRMAN. All right.

STATEMENTS OF DAVID G. GREINEDER, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, AMVETS (AMERICAN VETERANS); RICK SURRATT, DEPUTY LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; CARL BLAKE, SENIOR ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DENNIS CULLINAN, LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS OF THE UNITED STATES; STEVE ROBERTSON, LEGISLATIVE DIRECTOR, THE AMERICAN LEGION; AND RICK WEIDMAN, LEGISLATIVE DIRECTOR, VIETNAM VETERANS OF AMERICA

STATEMENT OF DAVID G. GREINEDER

MR. GREINEDER. Mr. Chairman, members of the Committee, thank you for the opportunity to be here today. As a co-author of the Independent Budget, AMVETS is pleased to give you our best estimates on resources necessary to carry out a responsible National Cemetery Administration budget for fiscal year 2007. The Administration requests $160.7 million in discretionary funding for NCA operation and maintenance of 125 national cemeteries and 33 soldiers and sailors lots, 53.4 million for major construction, 25 million for minor construction, as well as 32 million for the State Cemetery grants program.

The members of the Independent Budget recommend Congress provide $214 million for the operational requirements of NCA, the National Shrine Initiative, and the backlog of repairs.

In total, our funding recommendation for NCA represents a $54 million increase over the Administration's request, an increase almost entirely aimed at the National Shrine Initiative.

The members of the Independent Budget and the more than 60 veteran and military groups who endorse our recommendations ask Congress to establish a five-year, $250 million National Shrine Initiative, to restore and improve the condition and character of NCA cemeteries. We recommend $50 million for fiscal year 2007 to begin this important program.

As the veterans' population ages, and the global war on terrorism continues, demand for NCA services unfortunately remain high. In recent years, the burial rate has averaged more than 90,000 interments per year, and is expected to exceed 110,000 before too long. To meet the demands for services, the Independent Budget recommends hiring an additional 30 FTE for fiscal year 2007, an increase of seven FTE over the Administration's request. Additional employees are necessary to staff and maintain existing and new national cemeteries across the country. For funding the State Cemetery Grants Program, the Independent Budget recommends $37 million for fiscal year 2007. The State Cemetery Grants Program is an important component of NCA. It has greatly assisted states to increase burial service to veterans, especially those living in less densely populated areas not currently served by a national veterans' cemetery.

The Independent Budget also strongly recommends Congress review a series of burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full cost of burials, they now pay for only a fraction of what they covered in 1973. These recommendations are contained in my written testimony, but I would like to say our recommendations, which represent a modest increase, would restore the allowance to its original proportion of burial expenses, and tell veterans that their sacrifice is given the appreciation it so well deserves.

The NCA honors veterans with a final resting place that commemorates their service to this nation. More than 2.6 million soldiers who died in every war and conflict are honored by burial in a 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 a final resting place. They are hollowed grounds for those who died in our defense, and a memorial to those who survived.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views.

THE CHAIRMAN. Do you offer a written statement for the record?

MR. GREINEDER. Yes.

THE CHAIRMAN. It shall be entered.

MR. GREINEDER. Thank you.

[The statement of David G. Greineder appears on p. 142]

THE CHAIRMAN. Mr. Surratt.

STATEMENT OF RICK SURRATT

MR. SURRATT. Good afternoon, Mr. Chairman --

THE CHAIRMAN. Hello. No objection, your written statement will be entered into the record.

MR. SURRATT. I will just touch briefly on the budget request for the Veterans Benefit Administration. We view adequate staffing levels for the VBA business lines as a most important issue for consideration in this particular component of the VA budget. In the five-year period from the end of fiscal year 2000 to the end of fiscal year 2005, the volume of disability claims increased 36 percent, or an average of 7.2 percent annually. VA projects that the number of disability claims will increase only three percent during 2006, and two percent in 2007. But even with those modest projections for increased work, the Administration's budget requests 149 fewer direct program FTE to adjudicate compensation claims in 2007 than was authorized for 2006.

What makes this proposed reduction of staffing all the more questionable is VA's estimate that above these projected increases in regular claims work, it will receive an additional 98,000 claims from its outreach to veterans in the six states with the lowest average compensation payments, as mandated by last year's legislation. Apparently, VA projects that all this additional work will be completed in 2006, which we believe is doubtful.

We have not had time to analyze VA's workload projections, production assumptions, and staffing requests carefully. But they admittedly contemplate and accept increases in the already unacceptable claims backlogs in these two years, despite the fact that VA projects it will increase its 2005 production by 75,000 completed claims in 2006, and 85,000 completed claims in 2007.

In the IB, we have recommended a substantially higher staffing level that we believe reflects a more realistic assessment of what VA needs to deliver benefits to entitled disabled veterans in a reasonably timely manner. The IB recommends that the fiscal year 2006 staffing of 9431 FTE for C&P service be increased to 10,820, and I would invite your attention to the IB and my written statement for the bases of that recommendation.

Similarly, we have recommended staffing levels for the educational program and the vocational rehabilitation and employment program that we think are necessary to get the job done in an acceptable manner. Though the Administration's budget seeks increases for these programs, the IB recommendations are slightly higher. We recommend an increase of 155 FTE for education service, compared with the Administration's requested increase of 46. And we recommended an increase of 250 FTE for vocational rehabilitation, compared with

the Administration's request of 130 FTE.

Thank you, Mr. Chairman. That completes my statement. I would be happy to answer any questions the Committee may have.

[The statement of Rick Surratt appears on p. 151]

THE CHAIRMAN. Thank you, sir. Mr. Blake?

STATEMENT OF CARL BLAKE

MR. BLAKE. Mr. Chairman, Mr. Michaud, the PVA would like to thank you for the opportunity to testify today on behalf of the Independent Budget regarding the fiscal year 2007 Department of Veterans Affairs health care budget request.

For fiscal year 2007, the Administration has requested --

THE CHAIRMAN. Do you have a statement?

MR. BLAKE. Yes, sir. I have a statement to be submitted for the record.

THE CHAIRMAN. It shall be entered, hearing no objections.

MR. BLAKE. For fiscal year 2007, the Administration has requested 31 and a half billion dollars for veterans' health care, a $2.8 billion increase over the fiscal year 2006 appropriation. Although we recognize this as a significant step forward, we believe that more can be done. The Independent Budget for fiscal year 2007 recommends approximately $32.4 billion, an increase of 3.7 billion over the fiscal year 2006 appropriation, and about 900 million above the Administration's request.

Furthermore, the Administration's request is approximately $1.3 billion less than what the IB recommends for the medical services account.

We believe the recommendations of the IB have been validated once again this year as the Administration indicated that it will actually need real resource requirements of $25.5 billion to fund the medical services account. Where we disagree is on their desire to how to achieve this level of funding, particularly through the use of a new enrollment fee, and an increase in prescription drug co-payments.

We are deeply concerned that once again the President's request includes a recommendation for a $250 enrollment fee for priority seven and eight veterans, and to increase the prescription drug co-payments from $8 to $15. These proposals will put a serious financial strain on many veterans, including PVA members who are high-end users of the VA health care system. The VA estimates that these proposals will force nearly 200,000 veterans out of the system, and will result in more than one million veterans choosing not to enroll in the system.

Congress has soundly rejected these proposals in the past years and we urge you to do the same once again. Although our health care

recommendation does not include additional money to provide for the health care needs of category eight veterans being denied enrollment into the system, we believe that adequate resources should be made available to overturn this policy decision. The VA estimates that a total of over one million category eight veterans will be denied enrollment into the VA health care system by fiscal year 2007. Assuming the utilization rate of approximately 20 percent for this group of veterans, we believe that it will take approximately $684 million to meet the health care needs of these veterans if the system were reopened.

We believe that the system should be reopened to these veterans, and that this money should be appropriated on top of our medical care recommendation. For medical and prosthetic research the Administration has requested $399 million, a cut of approximately $13 million below the fiscal year 2006 appropriation. The IB is recommending $460 million. Research is a vital part of veterans' health care, and an essential mission for our national health care system. Despite a reasonable request this year, the budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of how much money it is going to get, and when it is going to get that money. In order to address this problem, the IB has proposed that funding for veterans' health care he removed from the discretionary process, and be made mandatory.

Mr. Chairman, I would like to thank you again for the opportunity to testify. We look forward to working with you and the Committee to ensure that adequate resources are provided for the VA health care system, and I would be happy to answer any questions that you might have.

[The statement of Carl Blake appears on p. 157]

THE CHAIRMAN. Thank you, sir. Mr. Cullinan?

STATEMENT OF DENNIS CULLINAN

MR. CULLINAN. Good afternoon, Mr. Chairman, Mr. Michaud. We, too, would request that our written statement be made part of the record.

THE CHAIRMAN. It shall be entered. Hearing no objection, so ordered.

MR. CULLINAN. Mr. Chairman, you and your staff have seen our written statement, and are familiar with our views on the recommended funding levels and some of the problems therein. So for the purposes of timeliness and emphasis, there are a couple of points I would like to make with an eye towards this Committee taking a look at some of these things.

The first thing is to do with the recapitalization of the VA's infra-

structure. The industry standard for medical care is that a facility be recapitalized at a rate from two to four percent. In recent years, the VA has been pursuing a rate of slightly more than six tenths of a percent. You know, obviously this will lead to problems in both the short-term and long-term, and we think that this is something that need be addressed.

Another area is nonrecurring maintenance. Nonrecurring maintenance of course is funded out of the health care allotment, and it is allocated through VERA. VERA may work with respect to allocating funds for patient care, but with respect to construction and maintenance, it's problematic.

For example, one could have a facility, a relatively underutilized facility in the northeast, with very high maintenance cost. Under VERA, they would simply get enough money to accommodate its patient workload without really taking into account the actual expense of maintaining that facility. That could lead to problems for the veteran patients, and long-term expenses to the system.

Another thing we would like very much for the Committee to take a look at is the issue of reprogramming. Despite the best efforts on the part of the VA, on occasion a bid gets busted. In other words, an effort is made to build a facility, a CBOC, for example, in a given area. Contracts are undertaken or negotiated with various contractors, and then for a variety of reasons, the money is simply not there to pay for it. That then means that with the exception of some very narrow limitations, that money is frozen up. What we would like to see, and we don't know the exact solution to this, is VA to have increased reprogramming authority in such situations, so that money doesn't simply sit there.

It's especially important now, in lieu of the astronomical rate of construction inflation. In our written testimony we indicate it is nine percent generally, nationwide. In some parts of the Southwest it is up to 35 percent. So if a project gets halted in place, and it need be started all over again in a following fiscal year, not only does the additional effort of looking at this again have to take place, but the cost is going up. So the reprogramming is something we would love for you to take a look at.

Architectural master plan, we address that in our written statement. Architectural master plan would help steer CARES in the right direction. It could accommodate some things that CARES isn't handling, such as long-term care, severe mental health, those kinds of things.

I would like to offer a compliment to this Committee and your counterparts in the Senate. For years, VA construction was saddled with the lowest good obligation in negotiating its contracts, and now has something called, "best value," that it is our understanding that this is working out way, way better than was the case before. We are get-

ting better projects for less money. Thank you for that.

Another issue, the Veterans Benefit Administration, they have not had anything built since 1992. We well understand that oftentimes it is better to rent or lease, to get a modern facility in a timely manner, but perhaps there are instances where the system could save money, and veterans would be better served through construction.

And finally, with respect to collaboration, we strongly support collaborations in those areas where both the veteran population and the active-duty military population are properly served, and their unique identities maintained. The one thing that we would point to, in those instances where a VA facility is located on, say, a military base. Due to increasing security measures, it is getting more and more difficult and indeed more and more daunting to get onto such facility.

And that concludes my statement, Mr. Chairman. Thank you.

[The statement of Mr. Dennis Cullinan appears on p. 167]

THE CHAIRMAN. Thank you. Mr. Robertson?

MR. ROBERTSON. Thank you, Mr. Chairman. We, too, would like our written statement to be added for the record, with a little caveat that we would like to be able to add some additional remarks concerning the President's budget specifically. Because we had the budget presented to us at noon on the same day that the written statement was due to you, we were not able to put a full analysis into the President's budget. We are working on it --

THE CHAIRMAN. The statement that you have today will be submitted for the record. Any additional -- if you could have your commander provide that to the Committee next week at that hearing, I think it would be a good way to cover it.

MR. ROBERTSON. We should have it done today or tomorrow, so we should be able to get it to you very, very quickly. But we will do it at that meeting.

Thank you for inviting the American Legion --

THE CHAIRMAN. Your statement will be submitted for the record, hearing no objections, Mr. Robertson.

STATEMENT OF STEVE ROBERTSON

MR. ROBERTSON. Thank you for inviting the American Legion to offer views and estimates on the President's budget request. As a member of the Partnership for Veterans Health Care Budget Reform, the American Legion strongly recommends this Committee to hold a hearing to discuss the annual funding process for the veterans' health care, before the end of this session. We still believe that there are better ways to make sure that no veteran is turned away from the health care he needs or she needs in a VA medical facility.

In the 1980s, most of the complaints that I received from veterans was concerning the complicated rules and regulations which regard the care each individual veteran was entitled to. Things were done to bend the rules, and thus, proper care and treatment was not always provided in an appropriate setting. VA medical facilities were few and far between, requiring long trips for care and treatment.

In 1996, Congress wisely reopened the doors to all veterans with the goal of timely access to health care in the most appropriate setting. The transformation of VA changed from a hospital-based system into the integrated system we have today, and clearly it is a health care industry leader on so many fronts.

Today, there's a tremendous demand for the care VA provides to a very small percentage of America's veterans. Mr. Chairman, last year at this time, the entire veterans' Committee was deeply troubled with the President's budget request, and nearly every veterans' organization expressed concerns over the shortfall in the fiscal year 2005 budget and the fiscal year 2006 budget request.

The American Legion applauds the President's budget request for its clear increases in certain areas. However, we remain deeply concerned over other aspects. VA's close collaboration with OMB has paid big dividends, and the funding model now reflects a nation at war, to some degree. However, VA should not be a system that welcomes new, younger patients in the front door, by shuffling older patients out the back door.

The President's legislative initiative to charge an annual enrollment fee of $250 did not make sense the first time it was proposed, and it still doesn't make sense. Likewise, the initiative to double the prescription co-payments still does not make sense. Both of these initiatives are clearly targeted to priority group seven and eight veterans. VA anticipates that these proposals will drive more than a million veterans from the system, just as DOD predicts TriCare's proposals will drive hundreds of thousands of military health care beneficiaries away from the DOD health care system.

Their decision is not going to be based on the best health care options available, but the best financial decision. Mr. Chairman, rather than trying to figure out ways to shed veterans, the American Legion believes this Committee and Congress should be trying to figure out ways to make sure no veteran is ever turned away. This is an issue of fairness. Why should a Medicare-eligible veteran pay an enrollment fee if he or she pays part A and part B to Medicare? Why should a veteran with private health insurance that reimburses VA be required to pay an enrollment fee? Why should a veteran enrolled in TriCare be required to pay an enrollment fee? If VA is their best health care option, why should we try to penalize them?

After all, Mr. Chairman, many of these veterans had other options than military service. They chose to serve this nation with honor.

The American Legion believes the annual VA budget should reflect the thanks of a grateful nation. Much has been said about the increases in VA medical funding since 1996. Most notably, in the last five years. Compared to the cost of other public and private health care plans, VA stands clearly alone as the most cost-effective and best value for the dollar, especially taxpayer dollars. VA is the ongoing cost of the price of peace.

National Commander Tom Brock provided you and your colleagues with views and estimates of the American Legion on September 20th at the joint hearing. Hopefully, VA and OMB had an opportunity to review those recommendations, as well. Mr. Chairman, the American Legion applauds the President's serious approach to properly funding VA. The American Legion is confident that the mandatory funding portion of the appropriation is probably right on target. Unfortunately, it is the discretionary funding portion that troubles us the most, because miscalculations have a direct impact not only on health care, but on other services and benefits VA provides. Undocumented management efficiencies result in real budgetary shortfalls of limited resources. While third-party collection goals continue to increase, the uncollected dollars result in real budgetary shortfalls.

Where in the budget does VA receive credit for the billions of dollars in savings to Medicare for the treatment of non-service-connected medical conditions? If VA can't receive third-party reimbursements from the nation's largest health care insurance company, why can't VA take credit for the real savings in mandatory appropriations? Delayed claims as well, as we all know, delays earned benefits and services for months, sometimes for years, and unfortunately even decades. Mr. Chairman, you have said over and over that the job of this Committee and this Congress is to get it right. The American Legion is here to assist you. Thank you for allowing us to testify. We are prepared to answer any questions you may have.

[The statement of Mr. Steve Robertson appears on p. 171]

THE CHAIRMAN. Thank you, Mr. Robertson. Mr. Weidman, you are now recognized.

STATEMENT OF RICK WEIDMAN

MR. WEIDMAN. Mr. Chairman, on behalf of Vietnam Veterans of America, I thank you for allowing us to present our views here today. We would be grateful if you would take our written submission and enter it into the record.

THE CHAIRMAN. It shall be entered into the record, without objection.

MR. WEIDMAN. Much has been heard about the President's budget

and how it is much better than many of us anticipated in the veterans Committee. Unfortunately, our view of it at Vietnam Veterans of America is that the bad news is that the good news is wrong. In fact, what we really need is approximately $35.7 billion without collections, I say that again, $35.7 billion for VHA, without collections. And then with collections, it would then add up to 37.9.

That would be 5.6 billion more than fiscal year 2006, which includes the 1.2 billion that the President recently signed off on. The President requested 31.5 billion for VA medical care, business line, which includes medical services. And that from our point of view is simply not adequate to meet the needs even of the truncated enrollment, with the freeze on sevens and dates.

The 35.7, or a total of 37.9, would allow us to reopen to the seven and eights who have been frozen out, which would be about 260,000 people per year. Perhaps as many as a million, over the last couple of years.

Even without reopening at the registration and enrollment at usage to the sevens and eights, we believe that it still would take approximately 3.6 billion above the current level of the 2002 budget, added into VHA, in order to meet the need.

We will comment more specifically in the statement for the record for the Health Subcommittee, which we will be filing at the end of this week for the hearing next week, and when our president, John Patrick Rowan, testifies at the hearing next Thursday on the 16th, sir.

In addition to that, the other place where the bad news is the good news is wrong: it was testified here earlier today that the 197,650 VHA, or Veterans Health Administration staff is remaining steady. That is not what we are hearing around the country. It is not just in VISN eight, as Mr. Miller pointed out. It is currently in VISN five, where there is a two percent reduction in staff at every single hospital. And we are hearing that all over the country.

So, in order to increase the staff to 198,302 in the next fiscal year, it's going to take a much larger increase than has been requested by the President.

On the other side of the House I would first of all, Mr. Chairman, greatly applaud on behalf of Vietnam Veterans of America your comments in regard to the GI Bill this morning, and giving the young men and women who are serving today, in active duty, as well as the Guard and Reserve, a GI Bill like that which your father and my father had coming out of World War II, which transformed this nation, which was a most cost-effective, cost efficient social program perhaps ever tried by this nation. And so we would like to associate ourselves with your remarks, and stand ready to help you in any way we can.

In regard to the Veterans' Benefits Administration, we believe that 300 more C&P than had counselors, Competition and Pension, adju-

dicators, and VSOs need to be provided, other than that which -- instead of what the VBA has asked for in the President's request. How to use those most effectively, as to whether they are VSOs or C&P adjudicators, we would certainly leave up to the under secretary. One thing that we would say, however, there is that some portion of additional funds there needs to be set aside for much more effective training and competency-based testing of everybody concerned. We are not going to do well with just additional bodies, if they are not trained well, and they do not have the additional -- if there is not competency-based training at the end of training completed.

We also believe that we cannot rely on the VA DVOP/LVER system and the state workforce development agencies to deliver the kinds of services necessary to disabled veterans who are returning from OIF-OEF, so we would strongly encourage many more Voc Rehab counselors across the nation, with a much greater focus on helping people return to work.

There are a number of specific items that we would just mention very, very briefly, that we would recommend very strongly that the Committee try and get report language on. First of all, is $18 million set aside specifically for the vet centers, which would allow them to have 250 more permanent, permanent slots, of which 206 would be family counselors, one for each of the 206 vet centers in the country? We have made this recommendation before. VHA, it is clear now after all these years, will not do it unless so directed by the Congress, and we ask your assistance in that, sir.

The second is that we would recommend a 10 percent increase over the current level of research and development funds, with report language that 25 million of that in no-year money be set aside to complete the national Vietnam veterans longitudinal study, which was suspended by means of an IG report issued on the 30th of September of 2005, and it was due to the Congress on October 1, 2005. We would also hope that the oversight and investigations Committee will look into the independence of the IG in that particular effort, as well as others.

Next is that we ask that $3 million be set aside for the Disability Compensation Commission, for two reasons: one, at this key juncture when they are just getting their research back, they have limited the commissioners to 20 hours of billable hours back to the commission, from this point forward. This is a time we had believed that there is a fine bipartisan group of commissioners, who are people of real integrity, but it is becoming increasingly a staff-driven process, and it is a staff that only includes two people who are not permanent employees of the VA. So if it is going to be an independent commission, and clear that it is an independent commission, then it needs to have independent funding, and certainly the latitude for the commissioners to do their jobs.

There are several other points having to do with report language that we strongly recommend. I am over time, and I ask your indulgence for that, but we will submit that with the statements for next week. I thank you again, Mr. Chairman, be happy to answer any questions.

[The statement of Mr. Rick Weidman appears on p. 184]

THE CHAIRMAN. I appreciate your comments on the National Shrine Program. It is an issue that we took up in last year's, views and estimates that I submitted to the Budget Committee. And the appropriators, for whatever reason, didn't put the money there, and so we are going to take on that endeavor again. And you know, as you travel differently than I do, and you can go to Normandy, you can go to some of these other sites; compare those cemeteries to a national cemetery in America. I think they should all be the same. And so I want to thank you for bringing that up.

I don't know if the efforts of Mr. Weidman's task force are going to be done in time for us to be able to get this in our budget views and estimates, but I want to work with you. I want to make sure that we get an idea of where we are going. I was disappointed that DAV pulled out of that task force. I think your insights would have been valuable, and so I expressed to you my disappointment that had occurred.

I am most hopeful that you have got some positive recommendation from this task force to us. You don't have to talk about it today, we are going to set that aside, and are going to address that.

I want all of you also to know that in our hearings coming up, one of our full Committee hearings that we are going to do is, have a 10-year look back over the eligibility reform. And I am not going to beat this one again, because all of you know exactly where I stand. And it is challenging for me, because I lived through it, and I was obedient at the time, and gave great deference to Chairman Stump when that went through, and have now seen the reality that we all embrace, that it was a revenue enhancement, when in fact it was not.

And I am also continuing to live with this pain of how the military retiree is getting treated differently than someone who may have only served one tour of duty. It is the biggest elephant in the room that nobody is paying attention to. So I am going to pay attention to it. And it is even more highlighted now, guys, because of what the Armed Services Committee may do. And you know, turn to the American Legion. The American Legion in Indiana had to increase their annual fees. I don't remember anybody saying, calling the Indiana commander, "You are anti-veteran because you had to increase your fees annually." I mean, probably the error that occurred with regard to enrollment fees on sevens and was not created when the law was. And I created the enrollment fee when we did Tricare for

Life. And enrollment fees, deductibles, and co-pays are utilization tools in a health system, and they are important.

It is unfortunate how language, rhetoric and demagoguery, pound this one, and then in an effort, you also are playing to a greater membership at the prejudice of the military retiree.

And I will appreciate -- no, I welcome your response to it, because I have to figure out how I work with my colleagues to take away this inequity and make the system right. I will go back to you, Mr. Robertson.

MR. ROBERTSON. Mr. Chairman, thank you very much for -- because this is a bone that I have in my throat as well. First of all, when I came in in 1973, there was a promise for health care at no cost to military retirees and their beneficiaries. That's a fact. Somewhere along the way in the eighties, the boat got turned around sideways. The American Legion actually came up with a plan to address the CHAMPUS problem, that led to the genesis of TriCare. And that plan was to incorporate military retirees and their families in the VA health care system; that it would be like TriCare is today, but it would be managed by the Department of Veterans Affairs and the Department of Defense; i.e., taking out contract bidders. We would be doing the same thing with the VA that the contractors are doing for TriCare.

I guess the bone that is in my throat is I don't know whether the increases for TriCare are going to the Pentagon or to the contractors; whether the increase in prescriptions is going to pharmaceutical companies, or going to the Pentagon. Everybody and his brother wants to get in to the pharmaceutical that the VA has because it is able to get such an economy of scale that it is getting the medications and prescription at the rock-bottom price.

So if we are doing so many things right, then why are we being compared to systems that don't seem to be doing it right? TriCare started out with 12 regions. They are down to three bidders now. And it had to restructure its entire area, catchment areas. So you know, people can hold up private plans, and they can hold up TriCare, and they can hold up Medicare, and they can hold up everything they want to. But right now, there are more people trying to get into the VA system than trying to get into TriCare or any other private health care plan that is out there.

You talked about seventh and eights that, you know, somebody, I don't know who you are referring to and I hope it is not the American Legion, is trying to convince sevens and eights that they are entitled to care. The American Legion has never said sevens and eights were entitled to care. They are eligible for care. Title 38 says that they are eligible for care, within existing appropriation. So our responsibility as I see it is to figure out how to come up with those extra dollars to expand the pool. Medicare reimbursements is one area in which, when I think that provision was put into law, they had service-con-

nected disabilities in mind, that there were so many service-connected, Medicare-eligible veterans in the system at that time, that they didn't think that it was fair to pay VA for taking care of veterans that they were already supposed to be taking care of.

When we brought in non-service-connected veterans in large numbers, that Medicare reimbursements for treatment of non-service-connected disabilities seems like a very, very logical thing. To be able to let them use a health care pharmaceutical plan that they understand, rather than trying to figure out what Medicare part D does for them, and which is better: to be in Medicare part D, or in the VA, and "Will I get penalized if I don't immediately sign up for part" -- it is so confusing on the outside that even more veterans that are in the system want to stay in the system.

Dr. Perlin and his people deserve all the credit in the world for doing an outstanding job. Medical research I think it is unprecedented at the VA, and I am very concerned about the future of that. But pitting us up against systems that aren't working as advertised I think is a tragic, tragic mistake. And I think that TriCare could probably learn a few things from the VA, if they would attend the meetings, and communicate with us.

I am sorry, the bone is out of my throat now.

THE CHAIRMAN. Well, as I said, we are going to hold a hearing on this one, and we are going to get into the issues a little bit deeper.

The issue on enrollment fees and co-pays is not going to go away. It is a management tool of a health system. It is just a fact.

We will look closely at the issue, and I will be a good listener to Mr. Michaud and Mr. Brown on the medical research. My sense is that they have had such an increase in grants and other sourcing is the reason it has come down in their budget, but I will yield to Mr. Michaud and Mr. Brown to give the Committee some guidance on that.

At this time, let me yield to Mr. Michaud for any questions that he may have.

MR. MICHAUD. Thank you very much, Mr. Chairman. I want to thank all the VSOs for coming out today. I really appreciate your input, I appreciate your comments that you just gave, Mr. Robertson, I appreciate that very much. I have a couple of questions.

Mr. Blake, you had mentioned that under the Independent Budget, that you did not include priority eights, as far as in the overall line. Why did you exclude them?

MR. BLAKE. Mr. Michaud, if you look at our chart, we do include them in the bottom-line total discretionary funding. However, in the past couple of years, we have included that in our recommendation for developing our medical services line. And we felt that if we continued to do this, we are being a little bit disingenuous, because we were asking for money that was going to be going towards care for people that aren't actually going to be getting care in the VA.

So we recognize that that is money that still has to be appropriated for those people, but for us to claim, to build our request on that alone would not be fair.

MR. MICHAUD. Thank you, I appreciate it. Mr. Surratt, the VA 2007 proposed budget calls for a reduction of 142 employees to handle compensation claims in 2007. What impact would you expect such a reduction to have on the quality and timeliness of claims, including those filed by returning veterans?

MR. SURRATT. Well, first of all let me say that it is 149 direct program FTE for the compensation program. Now, there is a requested increase for pension, but you would assume that if they requested more FTE for pension, they need that there. So VA must have assumed that they can do with 149 fewer for compensation claims.

It is hard to quantify, but we know already that they are losing ground, that they are having difficulty handling the workload that they have. So that can't be good, and it has to be detrimental. To what extent, I can't say, but certainly intuition would tell you that it is going to have a further detrimental impact on a system already very much strained.

And again, as I noted in my oral statement, last year VA's budget said that one of their top priorities was reducing the claims backlog. Well, this budget this year acknowledges that with the staffing they have requested, that the pending caseload, and that is only rating caseload, at the end of the year of 2006 and 2007 will be higher than it was at the end of 2005. So now they have accepted that the backlog, already unacceptable, will grow with the resources they have asked for.

MR. MICHAUD. Thank you. Mr. Weidman, you mentioned earlier and I only caught part of it, it sounded to me like you needed a -- were you recommending in dealing with the IG that you need an oversight Committee to look at the oversight Committee? Could you elaborate a little more on that?

MR. WEIDMAN. The National Vietnam Veterans' Longitudinal Study was mandated by the Congress, and it is a replication of the National Vietnam Veterans Readjustment Study, which was done back in the 1980s, which was a seminal work on post-traumatic stress disorder among combat veterans. And the cohorts involved were those who served in Vietnam, those who served in the military during Vietnam but did not serve in a combat theater of operations, and a non-veteran cohort group.

Having all three cohort groups is key. This is really essential given the fact that we are in a war now, and that estimates of PTSD and PTSD-like problems among OIF-OEF returnees ranges from 17, and that is the official estimate by the army, up to 30 percent, or much more. The CARES model that we have currently that is using -- and incidentally that is the same thing that they use for projecting need,

is essentially a civilian formula. It is a civilian formula developed for middle-class people who can afford HMOs and the PPOs. That is not who comes to VA, one. Two, we have had exposures that, from my lips to God's ear, the civilian population in our great nation will never be exposed to. But you have to factor that in.

So, the NVVRS, or the National Vietnam Veterans Readjustment Study, is really essential to projections for the future. I noticed last week, NPR did a story on a study that came out in the archives at General Psychiatry, where they look back at records of civil war veterans, and documented that all of those who had a heavy combat exposure, particularly the younger they were, had significant physiological and other problems throughout their lifetime, much greater than the general population at the time.

This is not a new problem, but it has not been documented, and it has not been projected for the future.

The National Vietnam Veterans' Longitudinal Study was supposed to be due October 1 of last year, to this Committee. In October of 2003, then Under Secretary suspended it, and we tried to talk to him about what was going on. There were some questions that we had at VVA about what was going on, including Dr. Linda Schwartz, who is currently the Commissioner of Veterans Affairs in Connecticut, who sat on the Science Advisory Committee, believed that the Chairman and some of those folks were expanding the study and the cost of the study in a way that was not legitimate, and not called for.

Instead of adjusting, and looking to the fact that it was lousy contract management on the part of the Veterans Health Administration, and tightening that up, then Under Secretary Roswell suspended and then cancelled the contract altogether with the Research Triangle Institute, turned it over to the Inspector General and said he couldn't talk to anybody about it because it was under IG investigation.

Repeatedly, we reached back to him and to his successor, Under Secretary Dr. Perlin, about "Where are we at with the National Vietnam Veterans' Longitudinal Study?" And there was all kinds of questions expressed, "It's too expensive, it's too expensive, it can cost more than 17 million." Well, how expensive is it to underestimate the needs of VA, repeatedly? Never mind in human terms, just in fiscal terms.

By their own admission in the summary of the IG report that was issued September 30th of 2005, they had completed all their work between May and September 2004, and sat on that IG report for over a year before they released it. And they released it on a Friday afternoon, September 30th. October 1 was on a Saturday. That Monday, VA Congressional Affairs was up here asking you to change the law requiring that they do that study.

If that doesn't seem a little bit suspicious, and coordination between a supposedly independent Inspector General's office and parts of the

agency that didn't want that study to happen, because we believe that many people at VA didn't want it to happen because of what they believed it would show in terms of physiological and psychological long-term damage, and morbidity and mortality, of combat veterans, and how that could be extrapolated to the coming population.

So that is the reason why we would ask for your Committee that you are ranking minority member on to look at it, number one. And number two, we have wasted so much time, and would encourage the full Committee to seek report language to require VA to get that study underway, no matter who they contract with. We are not wedded to the Research Triangle Institute, it is whoever is going to get the study done right in a timely way.

Thank you very much. Thank you for your indulgence, Mr. Chair, in allowing me to tell out that whole story.

THE CHAIRMAN. Thank you. Who is responsible for the IT section?

MR. BLAKE. I guess I can take responsibility for it, Mr. Chairman.

THE CHAIRMAN. Do you want to take responsibility for this statement?

MR. BLAKE. I will be glad to take responsibility for it. It is an inexact science.

THE CHAIRMAN. You didn't write this, did you? Obviously you didn't write this.

MR. BLAKE. No, sir.

THE CHAIRMAN. I know you didn't write this. A West Point grad would never write like this.

MR. BLAKE. I don't even know where the IT section is in here, sir.

THE CHAIRMAN. Let the gentleman's statement speak for itself.

Well, I invite you to review that section, and I really am challenged to believe that you would embrace it in its entirety. I just want you to know that when this Committee voted unanimously, and the House voted unanimously to do the centralized approach, there is no one here that would want any decrease in the quality of care that Dr. Perlin and his staff are providing. So it is sort of disingenuous, and a very broad statement.

There is another statement in here that is really very peculiar. Well, I don't even want to go into it. It just looks like somebody had a little bit of information and thought that they really needed to cover this because it's never been covered before, and it is sort of disjointed.

You know, you do this bottom line, this is really bizarre,"A centralized approach will give you an inevitable overlay of bureaucracy." You know, it doesn't even fit what Gartner consulting even testified to this Committee, and they are the consultant to the top 500 companies in the world. And so what we are trying to do is to cut through the bureaucracies and provide some streamlining. So something is not right here.

The goal here is to create the one architecture. The CIO needs to be the partner in the room with Dr. Perlin's clinical chiefs. So when the clinical chiefs, have an idea, or somebody at the business table out of finance has an idea, the CIO's job is not to say "no." It is to ensure that it fits under the one architecture so that we have this standardization.

I've been a very good listener to Dr. Perlin about how he has such great minds in the field, and these are the crucibles of innovation, and I understand this decision on this, "federated model" that is very new to Gartner. Gartner is also going to advise the VA on how to do this. But getting To this one architecture, gentlemen, is so important. We have 127,000 PCs out there that can't even run on the new Microsoft program.

So getting to this one architecture, letting Dr. Perlin get the infrastructure in place, getting these four data processors up and running, I think the clinicians are going to be pretty excited. Once they get the one architecture, we can then begin to sophisticate the patient medical record for which the rest of this country, has this appetite for.

So, watch this one as it goes. Don't stake your guidon in the ground like you have done here, and, "Heck, no." Watch this one as it progresses. I mean, this is very important for all of us to get the IT right, because it is so meaningful to increase the quality of care.

Where we are going to end up on this one by the end of the year, I can't foretell. Listening to Dr. Perlin -- why, he's still in the room. Thanks for staying, Dr. Perlin. And Admiral Cooper. Who else have we got? Well, thank you for staying around and listening to the testimony.

Listening to Dr. Perlin's testimony along with the Secretary and the CIO, they have a decision, a strategic decision, they need to make. They need to get on with it. We will fund that. What Chairman Craig is going to do in the Senate with regard to this, I don't know yet. We will take up another hearing to examine it.

This is a strong bipartisan issue of the Committee, and it is one of where you shouldn't be pitting yourselves against us on this one, because I think that we are all in a concentrated effort in the same direction. So I just invite you to take -- whoever this is -- please, Mr. Blake, take another look at that one.

The last one I had was Mr. Cullinan, I want to make sure I get this right. With regard to New Orleans and the Gulf Coast region, that they should only be considered for repair and rebuilding if it does not upset the existing CARES process? I never interpreted CARES as an inflexible model. I mean, it was a snapshot in time, and it is one we can rely on, but can you help me explain that one to us?

MR. CULLINAN. Allow me to elaborate on that, Mr. Chairman.

Our primary concern is that if the -- and let me talk about that -- if the decision is made, and to what extent New Orleans is going to be

rebuilt, that it not absorb all the money from the construction budget for everything else, that's the problem.

Having said that, with respect to New Orleans, I will state the obvious. The VA is in a tough spot. There is a huge debate raging within New Orleans, throughout the nation, as to "Is New Orleans going to be rebuilt? To what extent? What are we going to do about the wetlands?" There is the huge issue about demographics coming into play, who is going to live there, who is not. It is our view that VA should not take the lead in that debate but should at least be given some sort of clarity with respect to what they are going to be dealing with in VA. With respect to the veteran population, the non-veteran population, the degree of protection they are going to get from future flooding. And I will stop, thank you.

THE CHAIRMAN. Okay. Now I understand that a little bit better. Sometimes, I can't get behind a statement on its own.

MR. CULLINAN. I was shocked by that myself, sir.

THE CHAIRMAN. Who made the comment on collaboration? You did, earlier?

MR. CULLINAN. Yes.

THE CHAIRMAN. Okay. But you excluded this endeavor of taking the next logical step of a collaboration of personnel to collaboration with facilities with medical universities owned by states. Did you exclude that on purpose?

MR. CULLINAN. That is not by design. That is just simply something we didn't mention. Where that would work, we would clearly support.

THE CHAIRMAN. Okay. That is something that we are examining, Dr. Perlin and I, and General Love, Mr. McClain, Mr. Michaud, down in Charleston; we went into this not really knowing what this was going to look like with the life cycle costs, and we were all pretty surprised.

MR. CULLINAN. Yeah, and we have been supportive -- oh, I am sorry.

THE CHAIRMAN. No, I just wanted to let you know that, we were pretty surprised by it. So when Dr. Perlin testified, said this is a"template," there are some other issues that we want to examine further, but what we are able to do is break through the no-go's that were identified. And because sometimes we go, "Oh, we can't do that," or "You can't do this, you can do that," well, let's examine.

And we learned a lot. So I welcome some testimony coming up at this collaboration hearing that we are going to have. And as the secretary mentioned, with regard to New Orleans, we want to keep not only the collaboration with personnel, now we have got to get them back in New Orleans, right? Where is a facility going to be built? And to do this with Tulane and LSU, will probably be the first one out of the box.

So it wasn't excluded on purpose?

MR. CULLINAN. Absolutely no. It was not by design. We didn't ex-

clude it by purpose.

MR. ROBERTSON. Mr. Chairman.

THE CHAIRMAN. Yes, sir?

MR. ROBERTSON. Our veterans in South Carolina have expressed a great deal of concern, I am sure you are well aware of the proposals that were being kicked around. And their major concern is the loss of identity. In the joint efforts we have seen with the military, when the military was in charge of the joint effort, it seemed to crash and burn for the most part. But where you had the VA was in charge of the collaboration -- they were the host and the military was the guest -- that it seemed to work a lot smoother.

What our initial concern was with the Charleston was whether or not VA would lose its autonomy in its access for veterans? Would they be on the waiting list?

THE CHAIRMAN. Well, what we've learned is that none of those are true. And for all the veterans' organizations that came to the hearing Mr. Michaud was also attended, those concerns were alleviated. We want to share with you as you go into this hearing that you can learn more about what the VA wants and their options. And we want to make sure that the VA has an identity, that veterans are sure that they are given preference. I mean, a lot of those concerns that were initially laid out I thought were pretty well laid to rest. Would you, Mr. Michaud -- did you --

MR. MICHAUD. Yes, if I might, Mr. Chairman. Yes, that was an interesting hearing. And actually, what I learned going into it was a little different then when I was talking to veterans beforehand versus some of the veterans that were there afterwards, is the biggest problem is actually a lack of communication between everyone involved. And, I think once they heard what was going on, I am not going to say that all the concerns they had were all alleviated, but clearly the communication effort was needed.

MR. ROBERTSON. Well, you are 100 percent right, that if we are at the table expressing our views and concerns so that they are being addressed up front, rather than chasing the dog and hoping to catch it and check for fleas, you know, that will go a long, long way. And we would ask very much to be part of that dialogue, as well as the IT dialogue. Our testimony --

THE CHAIRMAN. I think there was some gentleman that testified, I can't remember. He was from one of the veterans organizations, and then there was concern by one of the state commanders -- he really wasn't speaking for me, and I think there got to be a little confusion from it. But I just want to let you know, a lot of those initial concerns got laid to rest. Some of them did, for some people. Thank you, sir. Mr. Robertson?

MR. MICHAUD. If I may, Mr. Chairman.

THE CHAIRMAN. Yes?

MR. MICHAUD. One of the things that we did request at that hearing was for the VA and those involved in that process, that they do

include, you know, the players into the process, which I felt was extremely important. And we made that clear that it is important to have people involved.

MR. ROBERTSON. May I just add one more --

THE CHAIRMAN. Yes.

MR. ROBERTSON. You know, from the national perspective, we have staff here in D.C. that deal with the entire system. And a lot of times when you go to the local Blue Cap Legionnaire, they may understand the problems that are unique to that area, but sometimes they are not as knowledgeable of the bigger picture than what we have here at the national office. So I would hope that we would be engaged here, as well.

THE CHAIRMAN. Yeah, it seems like whenever you go to a state, there are also interstate rivalries, you know, upstate South Carolina versus the low country, and not a knowledge of the totality of that VISN.

MR. ROBERTSON. There is no politics inside these organizations.

THE CHAIRMAN. Okay. Sure.

MR. WEIDMAN. Mr. Chairman, I certainly wouldn't be so rash as to agree with my colleague from the Legion on that one. But where others are in charge of collaboration, it seems that the veterans are left out. At Nellis Air Force Base Hospital in Las Vegas, it's a classic example.

THE CHAIRMAN. I disagree. I was just there.

MR. WEIDMAN. I can tell you --

THE CHAIRMAN. I was just there.

MR. WEIDMAN. -- it was the impetus for --

THE CHAIRMAN. You had VA employees working right there alongside DOD. Those VA patients were excited to be around their activeduty counterparts. I just want to let you know, Rick, I was just there.

MR. WEIDMAN. It was complaints from folks in there from veterans using their facility that led to the impetus to move forward with doing that new facility.

THE CHAIRMAN. The complaint that I have heard is the one that somebody mentioned -- I think you did, Mr. Cullinan about it being more difficult now to get on that base, and it's tougher for family members to gain access to the base. So those are things that you have asked us to be good listeners to, and I appreciate that.

Well, gentlemen, I think we have come a long way. You know, here, for about three or four years the Congress ended up in some pretty nasty and ugly fights over the budget, more on political lines, unfortunately. And it also then took veterans organizations and pitted them with party lines, and it got pretty ugly.

And when I took over this Committee, I leveraged the knowledge that I brought to this Committee from dealing with the military health

delivery system, and the Surgeons General in health modeling.

And I took that knowledge, and then how to apply it by understanding the health modeling the VA uses, the methodology, and whether the data that is input is correct. We learned about those shortfalls. We have a secretary that embraced that he was going to own a budget. We worked with him behind the scenes, making sure that if there's nothing wrong with the model, then let's get the data right, and get our most accurate forecast possible. And that's why he delivered the budget we did today.

And so I think some of you may have been surprised when you first heard about the budget number in some areas, and perhaps not surprised in others. I mean, I am not surprised that they are continuing to do the co-pays and the enrollment fees, and that type of thing. But for them to come up with the number that they did, even in mandatory spending, because we have so many of our brothers and sisters, comrade in arms, who have been hurt on the job, and have been wounded. And so we need to make sure that that the disability system and health care system is there to take care of them.

I want to thank you for your partnership in this endeavor in the budget. Next week we will hear from all the commanders and the presidents. That is extremely important, next Wednesday and Thursday, because then Thursday, this Committee will hold its business meeting on the budget views and estimates. Getting all of your testimony on all of your resolutions in a snapshot in time, prior to this budget's views and estimates, is extremely important. It is the first time it has ever been done. And we only have, then, less than a week after that Thursday to deliver our letters on budget views and estimates to the Budget Committee. So it is a very fast train. So I look forward to your commanders' testimonies next week.

This Committee now stands adjourned.

[Whereupon, at 2:26 p.m., the Subcommittee was adjourned.]

APPENDIX

OPENING STATEMENT OF CHAIRMAN STEVE BUYER
COMMITTEE ON VETERANS' AFFAIRS
ON
THE DEPARTMENT OF VETERANS AFFAIRS FY 2007 BUDGET
FEBRUARY 8, 2006

Good morning. I'd like to welcome everyone to our first hearing of the 2nd year of the 109th Session of Congress.

Today we will hear testimony from Secretary Jim Nicholson on the Administration's fiscal year 2007 budget request for the Department of Veterans Affairs.

We will then hear testimony on the Independent Budget, provided by representatives of the four veterans' service organizations which develop that document: AMVETS, Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States.

And we will also hear testimony on the budget from the American Legion and Vietnam Veterans of America.

Mr. Secretary, I am glad you can be with us today to share with the Committee the President's proposed budget for 2007. I commend you for taking *with both hands* the challenge presented last year as we examined the problems with VA's budgeting process. It appears that improving the integrity of the process has borne fruit with this budget.

Mr. Secretary, you just marked your one-year anniversary as chief steward of our nation's veterans. It has been a year of challenge and you are to be thanked for your willingness to squarely meet the challenges.

A year ago, I expressed my confidence that you would join Mr. Evans, this committee, and me in making VA the best it can possibly be. You have done so: veterans' health care is excellent care by any standard. Your National Cemetery Administration and VA's insurance program continually rate among the nation's best-run government programs.

Your leadership and that of Dr. Perlin and many within the department in response to the catastrophe of Hurricane Katrina was magnificent. The VA set the standard.

It is our job to preserve those arenas of excellence and to work together in a bipartisan fashion to ensure every service we provide meets high standards.

It's worth noting that the President has proposed substantial increases in the budgets of four agencies: The departments of Defense, State, and Homeland Security --agencies focused on fighting the war on terror; and the Department of Veterans Affairs – an agency focused on caring for those who have borne the battle.

As chairman of this committee, my top three priorities remain:

- Caring for veterans who have service-connected disabilities, those with special needs, and the indigent.
- Ensuring a seamless transition from military service to the VA.
- And providing veterans every opportunity to live full, healthy lives.

Mr. Secretary, these priorities mirror your own. As stated in your written testimony: *"the cornerstone of VA's medical care budget is providing care for veterans who need VA the most – those with service-connected disabilities, those with lower incomes, and veterans with special health care needs."* You further emphasize the importance of priority consideration for ill and injured veterans returning from combat in the global war on terror.

We have an obligation to those who bear the burdens of war and of military service -- and to their survivors. Our work must move us toward the fulfillment of that obligation.

There are some concerns in the budget before us today: Mr. Secretary, last year you brought us a similar request for enrollment fees and increased co-pays. While I personally agree that it is appropriate to ask for cost-sharing of veterans without service-connected disabilities, who also have access to other health care options, members of this committee did not support the proposal last year. That is around $800 million I must buy back if we do not authorize the enrollment fees.

Your request also relies on funds generated by management efficiencies recently called into serious question by the GAO. I welcome your response to the GAO report.

Further, VA's projections of nearly 3 billion dollars in collections, given the agency's track record, appears . . . overly optimistic.

Nowhere in your statement, Mr. Secretary, did you mention your plans to enhance management of information technology within your department. Yet, VA's increasingly large and complex mission demands an IT system that more efficiently enables the department's ability to provide increased access to quality care and faster, more accurate benefits actions.

With a new generation of veterans looking to us for care, this is a management efficiency we *must* realize without delay.

Nowhere do you mention enhancements to educational benefits for our veterans, especially those now returning from their service.

As you know, I created the Subcommittee on Economic Opportunity to emphasize programs that focus on empowering veterans to take advantage of this nation's opportunities – on creating and fostering *ability and self-sufficiency.*

Increasing the skills of veterans as a means to get good jobs, own their own homes, and support their families is an investment in America's future. History has shown that veterans, empowered to take the opportunities offered by this great nation, repay the investment many times over.

That is why I am announcing today that I will support initiatives to modernize the GI Bill. I welcome ideas and proposals such as one made by the Partnership for Veterans Education, led by Vice Admiral Norb Ryan. The Montgomery GI Bill, as good as it is, does not reflect the realities facing today's servicemembers, especially those in the Guard and Reserves. We must modernize the GI Bill.

I have directed my staff to work with Ranking Member Evans' staff on this endeavor.

This will be a complex effort given the need to coordinate with numerous House and Senate committees as well as various departments and agencies within the executive branch. Mr. Secretary, I will also call on your help in this effort.

Budgets, systems, and programs are, after all, about service to *people*: I have visited with soldiers wounded in Iraq, who are recovering at the VA polytrauma rehabilitation center in Minneapolis. This is one of VA's four such centers dedicated to treating patients with multiple, complex traumas, which often include brain injuries. The staff has also visited the three other polytrauma centers.

The quality of care these heroes receive is impressive, and we are grateful to the VA professionals who zealously provide that care. What was perhaps more impressive to me was the spirit of these young warriors. They wanted to rejoin their unit. They are optimistic about their recovery. They are proud of their service. They have not taken counsel of their fears.

We owe these men and women, and their dependents, and all of America's veterans – our best.

I would now like to recognize Mr. Evans for his opening statement.

Introduction of 1st Panel:

Our first witness is the Secretary of Veterans Affairs, the Honorable R. James Nicholson. He is a 1961 graduate of the United States Military Academy at West Point, New York. Secretary Nicholson served eight years on active duty as a paratrooper and Ranger-qualified Army officer, then 22 years in the Army Reserve, retiring with the rank of colonel.

While serving in Vietnam, he earned the Bronze Star Medal, Combat Infantryman Badge, the Meritorious Service Medal, Republic of Vietnam Cross of Gallantry and two Air Medals. He is a former ambassador to the Holy See. Welcome, Mr. Secretary.

The committee looks forward to hearing your testimony today. As you begin, Mr. Secretary, please introduce those staff accompanying you at the table.

Introduction of 2nd Panel:

Mr. Secretary, thank you for your attendance today. We look forward to working with you in the year ahead. The Committee will also be submitting questions for the record as soon as possible.

While our second panel moves forward, I would like to provide a brief introduction to its members. Our second panel consists of representatives of the Independent Budget, as well as The American Legion and the Vietnam Veterans of America. Representing the IB, we have David G. Greineder (Gren-eh-deer), who is the national legislative director of AMVETS. Before his posting with AMVETS, David served as a congressional aide to several members of Congress advising them on veterans' issues.

Rick Surratt is the legislative director of the DAV. Rick is a combat-disabled Vietnam veteran, who enlisted in the U.S. Army in 1966. In 1967, he was wounded by shell fragments in the thigh during a Vietnam combat field operation, while serving with the 101st Airborne Division. He was honorably discharged in 1969.

Carl Blake is the senior associate legislative director of the PVA. Carl, a West Point graduate, was commissioned as a second lieutenant in the United States Army. He was assigned to the 1st Brigade of the 82nd Airborne Division at Fort Bragg, North Carolina. He retired from the military in October 2000, due to a service-connected disability.

Finally, we have Dennis Cullinan, the legislative director for the VFW. Dennis was also discharged from the U.S. Navy in 1970. Before his discharge, he served as an electronic technician aboard the U.S.S. *Intrepid* (CVS-11) and completed three tours of duty in Vietnamese waters.

I want to thank your organizations for visiting us last month and giving the full committee staff an overview of the methods used in developing the Independent Budget, as well as a preliminary idea of what the IB will recommend this year. I don't know if such a briefing has ever been done before, but it's a good example of how veterans' groups and the committee can work proactively together for the good of veterans.

We also have as part of the second panel Mr. Steve Robertson, representing The American Legion, as the Legion's legislative director. Steve served twelve years in the U.S. Air Force from 1973 to 1985 as a security police officer in Louisiana, Turkey, and North Dakota; a missile combat crew commander for the Minuteman III ICBM in North Dakota; and as a flight commander for the ground launched cruise missile in Sicily. Steve was a military policeman in the DC Army National Guard, when he was activated in January 1991, during the Persian Gulf War, and served from February to June in Saudi Arabia.

Finally, representing the Vietnam Veterans of America, we have Mr. Rick Weidman (Wideman), director of government relations. During the Vietnam War, Rick served as a 1-A-O Army medical corpsman, including service with Company C, 23rd Medical Battalion, AMERICAL Division, located in I Corps of Vietnam in 1969.

Gentlemen, please proceed to the witness table.

Closing:

We would like to thank the members of the Independent Budget for appearing before the Committee today, as well as The American Legion and the Vietnam Veterans of America. We will also be sending you questions for the record.

We would like to thank all witnesses for their attendance today.

This hearing is adjourned.

Statement of Representative Lane Evans
Ranking Democratic Member
House Committee on Veterans' Affairs
Hearing on the VA's Budget Submission for FY 2007
February 8, 2006

As we meet here today I know that I express the sentiments of many on this Committee that we will do all that we possibly can to make sure that the funding shortfalls the VA has experienced over the last two years are not seen once again in FY 2007.

Yesterday, I stated that I was baffled by the Administration's claim that this budget was a "landmark" budget for veterans. I am still baffled today. Although I appreciate that the Administration has submitted a budget this year that actually requests an increase in appropriated dollars, a review of this budget indicates that a significant increase in discretionary funds is due to accounting gimmicks and requiring veterans to pay more for their health care – an approach which has been rejected out of hand time and time again.

Although the President's requested increase looks good at first glance, it does not deliver the resources needed to provide veterans with the health care and benefits they have earned. In fact, upon closer study, the "increase" turns out to be largely illusory.

Once again, this Administration has submitted legislative proposals to the tune of $796 million that would have the effect of driving veterans out of the VA health care system. This $796 million is used to offset appropriations for Medical Services. In addition, the Administration counts $544 million of the $796 million twice – once to offset the appropriation and once again in its claims for total collections. Taken together, this represents more than $1.3 billion this Administration has not asked for in real dollars.

Once again, the Administration claims "management efficiencies" in order to reduce its request for appropriations. In fact, it claims $884 million in efficiencies carried over from FY 2006, and an additional $197 million in new efficiencies for a total of $1.1 billion. What troubles me is that just last week the GAO issued a report that concluded that the "VA lacked a methodology for making the health care management efficiency savings assumptions reflected in the President's budget requests for fiscal years 2003 through 2006 and, therefore, was unable to provide [GAO] with any support for those estimates." So there is no actual proof this $884 million exists, but it is in the budget this year, and is used to offset increased appropriations.

Once again, the Administration appears to have underestimated the continuing costs of war as they relate to our servicemembers returning from active duty. The VA estimates that it will see fewer OIF/OEF veterans than last year, and the VA's prosthetics account seems to me not to include sufficient resources to meet the ever-increasing costs of prosthetic devices.

Once again, the Administration estimates a decline in the number of unique patients, from the current estimate of 5.4 million to 5.3 million. Last July, the Administration conceded that it had underestimated the number of patients and requested an additional $677 million. I hope we are not going to have to seek an additional $700 million because of this lower estimate. But if we do, I hope the Administration will be more timely and forthcoming with its request than it was last year.

Once again, the Administration relies on a change in "unobligated balances," totaling $442 million, to offset its appropriation request. This was a strategy employed in last year's budget, a strategy that proved to be shortsighted and unrealistic.

Once again, the Administration proposes continuing its ban on enrollment of new Priority 8 veterans, a ban instituted in January 2003. I know I speak for many of my colleagues when I voice my strong opposition to this ban.

Once again, like last year, we are beginning to hear reports from the field that some VA regional health care networks and the medical facilities they oversee could be facing budget shortfalls in the current fiscal year and again will be forced to delay equipment purchases and hiring of hospital staff to close the gap. I seek VA's assurance that if this is indeed happening, VA will immediately seek supplemental funding in order to fix the problem.

Across the gamut of VA health care I see actual cuts in such areas as VA medical and prosthetic research, or slight increases that I believe are not sufficient to meet our obligations. We need to meet the needs of our returning servicemembers, reduce waiting lists and the time it takes to receive earned benefits, address in a vigorous manner the mental health care needs of our veterans and do what is necessary to end homelessness. I want to be assured that the FY 2007 VA budget will contain real dollars to meet real needs.

In fact, if we have learned anything on this Committee over the last year, it is to treat VA's budget estimates warily. I certainly hope my colleagues approach this request with the skepticism which to me seems warranted. Let us work together to make sure that we meet our responsibilities to our veterans, and that, as a Committee, we do the needed work to ensure that the dollars are there to care for our veterans.

Honorable Jeff Miller
FY07 VA Budget Hearing

February 8, 2006

Thank you, Mr. Chairman.

I want to welcome you Secretary Nicholson, and thank you and your dedicated staff for all they do for our returning servicemembers and veterans.

Too often, people look to criticize the Department without taking into account all the positive accomplishments you can point to.

The backlog of pending claims continues to grow, yet the budget proposes a slight reduction in compensation staff in FY07.

As you are aware, next week my subcommittee will be holding a hearing on the compensation and pension portion of the budget where we will examine this request further.

I am pleased to see that the budget proposes $27.8 million, almost $14 million more than last year's request, for restoration and repair projects at our national cemeteries. Still, this will not fund the outstanding infrastructure deficiencies identified by the Logistics Management Institute in 2002. My understanding is you have completed about 35 percent of the 900 repairs. The last thing we can do for a veteran is offer a dignified final resting place, and I look forward to working with the Committee and Under Secretary Tuerk in that regard.

Thank you, Chairman Buyer, for convening this hearing today. I have some questions for the Secretary following his testimony.

Statement of Rep. Corrine Brown
House Committee On Veterans' Affairs
Hearing On The Budget For Fiscal Year 2007: Department Of Veterans Affairs
Wednesday, February 8, 2006, 10:30 A.M.
334 Cannon House Office Building

Thank you Mr. Chairman. I want to thank Mr. Evans for his continued diligence for this committee and for our nation's veterans.

Thank you, Mr. Secretary for submitting the President's budget. I am sorry that the news you bring could not be better for our nation's veterans.

All I see here are smoke and mirrors.

You claim that this is a landmark budget request, yet you still insist on including a user fee for veterans who have earned their care by protecting the freedoms we hold most dear.

You continue to insist on including a co-pay on prescriptions that those who need those prescriptions can least afford to pay.

Your policies that are outlined in your budget request will cause over a quarter of a million veterans to leave the VA system. Most of them will not have any other recourse but to use emergency rooms as a provider of last resort.

Last year you came before this committee and said that the amount you requested was sufficient to cover the health care of our veterans. Yet in June, you came before this committee to say that you were short and needed more.

How do we know that this funding level is sufficient when you keep bringing the same tired proposals costing the veteran money and pushing them out of the system?

I am reminded of the words of the first President of the United States, George Washington, whose words are worth repeating at this time:

``The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their country."

You, sir, are not treating our current veterans with respect, and are putting our future national security at risk.

Statement ~~and Questions~~ of Congressman Michael Michaud for
HVAC FY2007 Budget Hearing
February 8, 2006

Mr. Chairman, thank you for holding this hearing and Mr. Secretary thank you for your testimony.

Mr. Secretary, I have several questions and because of time, I would like to get them all in and then I would welcome a response.

I am pleased to see that the VA's proposed budget for FY 2007 includes increases in an attempt to meet the needs of our veterans; however I hope you forgive me if I am not as glowing in my assessment of the budget as you have been.

In the brief time that I have had to review your proposal, I already have concerns that a significant portion of your requested increase in funding is not backed up with enough real dollars to meet the needs of our veterans. A large portion of your increase seems to consist of needed increases to cover payroll and inflation which is good, but also of several proposals which are non-starters (increased co-pays and user fees), of yet to be identified management efficiencies, and of carry over from last year.

And given the recently published GAO report requested by Ranking Member Evans and the anticipated GAO report requested by the Chairman both seriously questioning VA's accounting practices, you can understand my concern.

VA is also proposing to continue the "temporary" ban on allowing new Priority 8 veterans to enter VA. Rather than seek needed funds for these veterans the Administration is seeking to keep the doors closed to these veterans. I disagree with this. In fact, we have a program in Maine called Project I Served which encourages all veterans regardless of category to attempt to enroll with VA so that we can understand the real need out there. I fully support this program.

Some may say the affected veterans are so-called higher income veterans. In Lewiston Maine a single veteran could earn as little $28,601 and be considered a higher income veteran. This policy has shut out 2,403 veterans who have turned to the VA asking for their earned benefits and continues to do so.

We all want to do right by our veterans. We applaud and thank you for the high quality care the VA does provide but there is clearly work to be done.

Returning veterans and veterans from previous wars are counting on us to get this right. I look forward to working with the Secretary and the members of this committee to meet the real demand of returning veterans.

Congressman Tom Udall (NM-3)
House Veterans Affairs Committee
Oversight Hearing on FY07 Veterans Affairs Budget Request
February 8, 2006

Mr. Chairman,

Each year, as we welcome the Department of Veterans Affairs to explain its budget request, every member of this committee expresses the need for open, honest discussion. As we now undertake the Fiscal Year 2007 budget, I want to strongly reiterate and emphasize the hope for such

veterans from every era. And it saddled local VA facilities with lose-lose situations they should never have to face.

Unfortunately, in compiling the FY07 budget, the experiences of the past year were waved aside by the VA. We are again starting the budget process with a plan that is fundamentally flawed and that will, if left as requested by the VA, ultimately hurt those we are here to serve – the veterans.

Perhaps the most glaring problem within this budget request, Mr. Secretary, is the increased enrollment fees and co-payments which this committee has repeatedly rejected and has repeatedly informed you must be omitted from any new budget. Yet, you continue to make this request, this year to the tune of nearly $800 million. Mr. Secretary, will we be back here in June when the VA is again lacking the funding it needs because it did not take this committee's advice? I hope not.

I also want to note the presence today of several leaders from the national veterans' service organizations. As they celebrate the twentieth year of the Independent Budget, I thank all of these men and women for serving, and I urge this committee to strongly take into consideration the proposals being made within the Independent Budget.

Mr. Chairman, the budget being proposed by the VA, quite simply, does not meet the standards our veterans deserve. In his testimony, Mr. Surratt of the Disabled American Veterans states, "Insufficient resources

are the result of misplaced priorities, in which the agenda is to reduce spending on veterans' programs despite a need for greater resources to meet a growing workload in a time of war and a need for additional resources to overcome the deficiencies and failures of the past." We must make sure that we do not allow this budget to be added to the "failures of the past."

Our veterans have earned the right to quality health care, educational assistance, and home ownership benefits. Most importantly, they have

earned our respect and we must honor them. This budget does not do this, and I hope we can change that.

Thank you, Mr. Chairman.

Opening Statement of Congresswoman Stephanie Herseth
Veterans' Affairs Committee Budget Hearing
February 8, 2006

Thank you to everyone for being here to discuss the Department of Veterans Affairs budget request for Fiscal Year 2007.

First, I would like to thank the Department of Veterans Affairs (VA) for the tremendous work it does on behalf of our Nation's veterans. We owe an enormous debt of gratitude to the men and women who everyday provide health care and benefit services to our country's veterans.

I would like to take this opportunity to gloat about the great work being done by VA employees in South Dakota. According to a "Survey of Healthcare Experiences of Patients" veterans rank the Black Hills Health Care Systems first in the region and near the top in the nation. The Black Hills system ranked first overall in the VA Midwest Healthcare Network, scoring first in nine of 11 outpatient categories and narrowly missing first in the two other categories. The Black Hills system also ranked first in the Midwest in six of nine inpatient categories. Among stand-alone facilities, Fort Meade was first in the Midwest network in "continuity of care" and the medical center scored 99.8 in

"courtesy." Hot Springs ranked first in the network in "pharmacy pickup."

While the VA has made some tremendous improvements in recent years, especially in South Dakota, I have several concerns I would like to share. First, I am disappointed that the President's budget is once again asking veterans to pay more out of their own pockets for the services they have earned.

The budget proposal, which was released on Monday, once again requests authority to implement a $250 enrollment fee for Priority 7 and 8 veterans and an increase in pharmacy copayments for these same veterans. Many veterans can not afford these extra costs, which I assure you will be opposed by me and many other Members.

The most obvious indicator that the health care budget is not adequate is the fact that veterans are being locked out of the system. As you know, about 250,000 (1,201 in South Dakota) new Priority 8 veterans were denied access to the VA health care system in fiscal year 2005. Simply put, if the budget we received on Monday was adequate then you would not need to deny care to these veterans.

In talking with veterans in my state, I know that many of their concerns deal with the lack of access to medical care. In rural states such as South Dakota many veterans have to travel hundreds of miles to simply reach medical facilities. These rural veterans are often ignored when it comes to debating what is best for veterans' health care. The development of two important Community Based Outreach Clinics in South Dakota (Watertown and Wagner) have been delayed by at least one year because of a lack of funding. This has placed a severe burden on my constituents who must continue to drive hundreds of extra miles for care.

I hope that as we discuss the budget today we do not forget our veterans in rural America who struggle to merely access VA medical facilities and depend heavily on Community Based Outreach Clinics.

Finally, a recent GAO report found that the VA made unsubstantiated savings assumptions over the past few budget cycles, and has been unable to show that the estimated savings actually were achieved. Instead of relying on invisible savings, I

hope in the future that you will instead simply request the funding level you need to adequately provide for our nation's veterans.

Again, the Department of Veterans Affairs has made some tremendous improvements in recent years. However, I believe the budget includes much room for improvement. I look forward to working with my colleagues and the Administration to find solutions to these challenges.

I am pleased that we have the opportunity to hear from today's witnesses and am grateful to have the opportunity to hear your answers and insight to many of the challenges facing our nation's veterans.

Again, I want to thank everyone for taking the time to be here and discuss these important matters.

HONORABLE HENRY BROWN
Opening Statement

Full Committee Hearing on FY 2007 Department of Veterans Affairs Budget Request
February 8, 2006

Thank you, Mr. Chairman and thank you for establishing this front-loaded series of budget hearings so that over the course of the next few weeks all the subcommittees can solicit input from the VA, and equally important, the veterans service organizations.

Mr. Secretary, it seems we have come along way since last year. I want to publicly applaud you and the President for assembling a budget request that I feel speaks loudly to the needs of our nation's veterans and that attempts to keep pace with the emerging health care requirements of those who have faithfully served this country.

I think a 12.2 percent increase in a time of budgetary belt-tightening is impressive, and characteristic of an administration that is committed to defending the nation. I am a bit concerned however, about the administration's continued reliance on legislative proposals requiring veterans to pay more out of their pockets for their health care. I am afraid the political will of the Congress simply will not support such a proposal and I am equally concerned about the signal it sends to the country.

I am also a bit concerned about a reduction in appropriated dollars for medical and prosthetic research. While I understand the research budget predicts an overall increase in research funding, the reliance on other federal grants and private partners gives me pause. In my mind, there a few greater pursuits-- aside from the provision of direct medical

care-- that can have a greater impact on meeting veterans health care needs in the future than good, old-fashioned clinical research.

All that having been said, I am encouraged by the proposed, increased funding levels put forward for fiscal year 2007 that will address important, ongoing issues like long term care, mental health and major and minor construction projects. I look very forward to the discussion here today on all these issues.

I also look forward to hearing from the veteran services organizations that are assembled here today; those who represent the Independent Budget and those who have alternative ideas on what VA's budget should look like. Over the course of the next few weeks, I look forward to

working with all of you on issues on which common ground can be found and I look forward to forging a solid budget of which all of us can be proud.

Mr. Secretary, I would again like to thank you for your service to this nation. I would also like to remind you of a statement made by the Chairman of this committee during last year's budget hearings. Chairman Buyer acknowledged that you had "inherited" the budget you were forced to defend last year, but he also warned that you would "own it" from now on. I think you and the administration have taken our collective urgings seriously, and I think that is reflected in the budget proposal that is here before us today. I look forward to the discussion.

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

SILVESTRE REYES
16TH DISTRICT, TEXAS

COMMITTEE ON ARMED SERVICES
RANKING MEMBER
SUBCOMMITTEE ON STRATEGIC FORCES
SUBCOMMITTEE ON READINESS

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

PERMANENT SELECT COMMITTEE
ON INTELLIGENCE
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STATEMENT OF CONGRESSMAN SILVESTRE REYES (TX-16)
On the Administration's Department of Veterans Affairs Fiscal Year 2007 Budget Proposal

February 8, 2006

Mr. Chairman, let me begin by thanking my good friend Secretary Jim Nicholson, as well as Dr. Perlin, Admiral Cooper and other distinguished officials for testifying today. The dedicated service provided to our veterans by the Secretary and his staff is commendable.

I would also like to thank the representatives of the Veterans Service Organizations (VSO) that have joined us here today. Their knowledge into the needs of our nation's veterans and input in the budget process is greatly appreciated.

I am here with mixed feelings on the Administration's Department of Veterans Affairs fiscal year 2007 budget proposal. While I feel the Administration's budget request is a step in the right direction, I feel it is not enough to meet the needs of our veterans population.

As in previous years, the Administration's budget request includes legislative proposals that would impose additional fees on our nation's veterans. Implementing a $250 enrollment fee and increase in pharmaceutical co-payments from $8 to $15 for veterans that are deemed as having a "higher income." In El Paso County a Priority eight veteran who is considered "higher income" would be making as little as $26,902. I am dismayed that the VA expects to achieve savings almost entirely from retirees dropping out of the VA healthcare system. I find this absolutely unacceptable and will assure you that I will work with the Committee to remove this language in a bipartisan fashion as we have done in the past.

I am also concerned about an article published in the Washington Post dated January 9, 2006, concerning the Department of Veterans Affairs regional offices. The article brought to light an internal memo which indicates that only 19 percent of callers into the regional offices were given accurate information on disability claims. This is to say that 81 percent of incoming calls were give inaccurate information. In addition, the article stated that incoming callers were received by unhelpful and rude VA workers. I am sure that all of my colleagues will find this information extremely disturbing and look forward to hearing how the VA is addressing this issue.

Again, I would like to thank Secretary Nicholson, his staff, and the representatives of the VSOs for taking the time to be here with us today. I think we have a good foundation to work with and look forward to working with my colleagues in providing the Department of Veterans Affairs a budget that will meet all the needs of our nation's veterans.

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Opening Statement
FY 2007 Budget Proposal
Department of Veterans' Affairs
Full Committee Hearing
February 8, 2006, 10:30 AM, 334 Cannon House Office Building
Rep. Michael Turner, (3rd Ohio)

Thank you Mr. Chairman and thank you Secretary Nicholson for being with us today. As we discuss the FY 2007 budget proposal for the Department of Veterans' Affairs, I want to highlight some priorities that I am concerned about in our efforts to provide our nation's veterans with the high level of care they deserve. I want to thank you for your support of the Dayton VA Medical Center, and in particular your assisting St. Mary's Development Corporation in utilizing a $5.7 million grant from HUD by providing senior low income housing on the Dayton VA Medical Center grounds for veterans and area seniors.

It is important that the Veterans Administration think creatively about how to use land on medical center campuses to benefit veterans. The HUD grant recently secured by this faith-based, non-profit in Dayton to create housing for low income seniors on the medical center campus gives our community the opportunity to better utilize land at the medical center. Also, our veterans and seniors will benefit from this project which will provide them with quality housing in a secure environment. I urge you and your staff to continue to support these types of creative and productive uses of land at VA Properties to help our veterans.

When you visited at the Dayton VA Medical Center last July, we toured the nursing home at the center. During our tour, I emphasized the importance of continuing to provide first-class nursing home care for our veterans. Nursing homes provide medical care in a setting that fosters camaraderie and provides activities in which veterans can participate. The residential and active atmosphere of these nursing homes is valued by our veterans and their families. As our veteran population ages, the need for quality nursing home beds will increase. I look forward to working with you to ensure that the nursing home at Dayton VA Medical Center and nursing homes at veterans' medical centers throughout the nation remain an integral part of the medical treatment to our nation's veterans.

The Dayton Medical Center, as you recall from your trip, is one of the original three established by President Lincoln. During your visit, you saw the Catholic and Protestant Chapels. With the Protestant Chapel being the first church constructed in the United States using federal money. Historic structures are located at VA medical centers throughout the country; many are in need of repair and maintenance. As John Nau, Chairman of the Advisory Council on Historic Preservation explained in a meeting in December, the renovations of these structures is a project in which the historic preservation community is deeply interested. The renovation of historic structures on VA campuses can provide additional space to meet the needs of veterans while also providing opportunities for private investment and support. I look forward to continuing our dialogue on expanding the Veterans Administration's commitment to preserving historic structures in the administration's inventory, and ask that you made this effort a priority. Doing so would honor our past while improving the facilities that veterans can use.

Once again, I look forward to continuing to work with you to help our veterans in Dayton and throughout the nation.

STATEMENT OF THE HONORABLE KEVIN BRADY

TESTIMONY BEFORE THE HOUSE COMMITTEE ON VETERANS AFFAIRS

February 8, 2006

Chairman Buyer, thank you for allowing me to provide testimony today. As the committee moves forward with its planning for 2007, I would like to address one specific concern that we have in rural Southeast Texas. Our growing population of Veterans is extremely underserved by the current VA health care offerings in the region. While the Debakey VA Medical Center in Houston is top notch, it simply cannot be all things to all Veterans in the area.

The Veterans Administration itself estimates that nearly 400,000 veterans live in the Houston Metro Region, yet only 75,000 are enrolled for care at the Houston VA Medical Center. I believe the distance many senior veterans must drive (average of 45 miles in our area, not counting traffic snarls) for care keeps them from taking advantage of the excellent care they are entitled to from the Veterans Administration.

Additionally, in Houston, outpatient care grew by 24% from 2001 to 2004 while resource levels have only grown by 12% and staffing levels by 2% during this time. Inpatient care has only grown slightly in that time.

To quote the CARES Commission's February 2004 recommendations: "Significant gaps were found in access to outpatient primary care in all four markets in VISN 16...The Central Lower Market shows that only 55 percent of veterans met the access criteria...In the Central Lower Market, outpatient care is projected to increase by 95 percent in FY 2012...Increasing demand for primary care and specialty care in all four markets will be met by the addition of 11 new CBOCs in the Eastern Southern and the Central Lower markets, expansion of existing CBOCs via contract, lease and new construction...The CBOCs slated for the Central Lower Market would accommodate 31,000 new enrollees and would increase access to above 70 percent."

My understanding of the CBOC process is that each VISN and each "parent hospital" prioritizes CBOCs within their jurisdiction. Therefore, while the CARES plan designated 156 CBOCs as priority for implementation by 2012, we were told that the order for the Houston area CBOCs was Galveston 2004, Conroe 2005, Tomball 2006, Katy 2007, Richmond/Rosenburg 2008 and Lake Jackson 2009. Galveston was completed and opened earlier this year which should mean that Conroe is slated next.

I'd like to request that the committee look further and deeper into the Community Based Outpatient Clinic (CBOC) process. As we get closer to final passage of our spending bills, I wanted to voice my strong support for full funding for the Conroe, Texas Clinic which was included in the CARES plan and is currently one of the highest priority clinics in VISN 16.

As I have been working on CBOCs over the past several years, I have found that the CBOC process seems to be a very confusing and wasteful process. Over 800 have been built--some without regard to sound science or need--while many areas are still very underserved. I am also concerned that the CARES report overpromises; especially knowing now what we know about the budget. I hope that we will continue to work to fully fund the VA, including the CARES projects. Thousands of veterans in my district feel that the CARES Plan was a promise of accessible health care by 2012 at the absolute latest. Knowing that Conroe was at the top of the list, many of my constituents are upset that they've seen no movement on this project to date.

As you know, in the recently House-passed H.R. 2528 Military Quality of Life Appropriations Act for Fiscal Year 2006, the following report language was included:

> *"Community Based Outpatient Clinics.--The Committee has received numerous requests for funding specific Community Based Outpatient Clinics (CBOCs) but has retained the practice of not earmarking funds for these facilities. However, the Committee is concerned that the promises made as a result of the final recommendations of the Capital Asset Realignment for Enhanced Services Commission may not be kept due to a variety of reasons. The Committee directs the Department to report on the status of CBOCs in Bessemer, Alabama; Richmond County (Hamlet), North Carolina; Conroe, Texas; Athens, Tennessee; and North Central Washington, including the reasons for any delay associated with their establishment. In addition, the*

Committee urges the Department to re-evaluate the need for CBOCs in Capitola, California; Jackson County, Florida; Levittown (Bucks County), Pennsylvania; Sunbury (Northumberland County), Pennsylvania; Bellingham, Washington; and Gladstone, Michigan."

While I greatly appreciate Congress' willingness to inquire on our behalf, however, I think that it is crucial at this time of fiscal restraint and military activities, to insure that our veterans' care dollars are efficiently spent to the best use possible. Providing the most efficient access to Veterans, where they can see doctors at home that they know and trust when necessary and have access to the larger VA Medical Center network when necessary continues to be a priority for Veterans in my area. We strongly urge the VA to complete the planned clinics in our area, specifically the Conroe clinic in a timely fashion and would appreciate the committee's support in these efforts.

Thank you in advance for your consideration of this matter. The need is obvious and I hope that we can continue to work together to find a solution to care for the veterans who've given all to serve our country and protect our freedom.

STATEMENT OF THE HONORABLE R. JAMES NICHOLSON

SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

February 8, 2006

Mr. Chairman and members of the Committee, good morning. I am pleased to be here today to present the President's 2007 budget proposal for the Department of Veterans Affairs (VA). The request totals $80.6 billion—$42.1 billion for entitlement programs and $38.5 billion for discretionary programs. The total request is $8.8 billion, or 12.2 percent, above the level for 2006. This budget contains the largest increase in discretionary funding for VA ever requested by a President.

With the resources requested for VA in the 2007 budget, we will be able to strengthen even further our position as the nation's leader in delivering accessible, high-quality health care that sets the national benchmark for excellence. Whether compared to other federal health programs or private health plans, the quality of VA health care is unsurpassed. In addition, this budget will allow the Department to maintain its focus on the timeliness and accuracy of claims processing, and to expand access to national and state veterans' cemeteries.

As an integral component of our 2007 goals, we will continue to work closely with the Department of Defense (DoD) to fulfill our priority that service members' transition from active duty to civilian life is as seamless as possible.

Ensuring a Seamless Transition from Active Military Service to Civilian Life

The President's 2007 budget request provides the resources necessary to help ensure that service members' transition from active duty military status to civilian life is as smooth and seamless as possible. Last year through our aggressive outreach programs, VA conducted nearly 8,200 briefings attended by over 326,000 separating service members and returning Reserve and National Guard members. We will continue to stress the importance of an informed and hassle-free transition for all of our forces coming off of active duty, and their families, and especially for those who have been injured.

If active duty service members, Reservists, and members of the National Guard served in a theater of combat operations, they are eligible for cost-free VA health care and nursing home care for a period of 2 years after their release from active military service provided that the care is for an illness potentially related to their

combat service. VA has already facilitated transfers from military medical facilities to VA medical centers several thousand injured service members returning from Operation Enduring Freedom and Operation Iraqi Freedom.

There are many other initiatives underway that are aimed at easing service members' transition from active duty military status to civilian life. Within the last year, VA hired an additional 50 veterans of Operation Enduring Freedom and Operation Iraqi Freedom to enhance outreach services to veterans returning from Afghanistan and Iraq through our Vet Centers. They joined our corps of Vet Center outreach counselors hired earlier by the Department to brief servicemen and women about VA benefits and services available to them and their family members. They also encourage new veterans to use their local Vet Center as a point of entry to VA and its services. Our outreach counselors visit military installations, coordinate with military family assistance centers, and conduct one-on-one interviews with returning veterans and their families.

Last year VA signed a memorandum of agreement with Walter Reed Army Medical Center to give severely injured service members practical help in finding civilian jobs. Under this agreement, VA offers vocational training and temporary jobs at our headquarters in Washington, DC to service members recovering at the Army facility from traumatic injuries.

VA and DoD are working together to establish a cooperative separation exam process so that separating service members only need to have one medical exam that meets both military service separation requirements and VA's disability compensation requirements.

Separating military personnel receive enhanced services through the Benefits Delivery at Discharge (BDD) program. This program enables separating service members to file disability compensation claims with VA staff at military bases, complete physical exams, and have their claims evaluated before, or closely following, their military separation. With the assistance of VA staff stationed at 140 military installations around the nation as well as in Korea and Germany, service members can begin the VA disability compensation application process 180 days prior to separation. These applications are now processed at two locations to improve efficiency and the consistency of our claims decisions. In addition, our employees conduct transition assistance briefings in Germany, Italy, Korea, England, Japan, and Spain.

Medical Care

The President's 2007 request includes total budgetary resources of $34.3 billion for the medical care program, an increase of 11.3 percent (or $3.5 billion) over the level for 2006 and 69.1 percent higher than the funding available at the beginning of the Bush Administration. The 2007 budget reflects the largest dollar increase for VA medical care ever requested by a President and includes our

funding request for the three medical care appropriations—medical services ($27.5 billion, including $2.8 billion in collections); medical administration ($3.2 billion); and medical facilities ($3.6 billion).

The cornerstone of our medical care budget is providing care for veterans who need us the most—veterans with service-connected disabilities; those with lower incomes; and veterans with special health care needs. A key element of this effort is to make sure every seriously injured or ill serviceman or woman returning from combat in Operation Enduring Freedom and Operation Iraqi Freedom receives priority consideration and treatment.

Initiatives

The 2007 budget includes two provisions that, if enacted, will be instrumental in helping VA meet our primary goal of providing health care to those who need our medical services the most. The first provision is to implement an annual enrollment fee of $250 and the second is to increase the pharmacy co-payment from $8 to $15 for a 30-day supply of drugs. Both of these provisions apply only to Priority 7 and 8 veterans who have no compensable service-connected disabilities and do have the financial means to contribute modestly to the cost of their care. Priority 7 and 8 veterans typically have other alternatives for addressing their medical care costs, including third-party health insurance coverage and Medicare, and were not eligible to receive VA medical care at all or only on a case-by-case space available basis until 1999 when new authority allowed VA to enroll them in any year that resource levels permitted.

As you know, these two initiatives are not new, and I recognize that Congress has not enacted them in the past. However, we are reintroducing them because I believe they are justifiable, fair, and reasonable policies. They are entirely consistent with the priority health care structure enacted by Congress several years ago, and would more closely align VA's fees and co-payments with other public and private health care plans. The President's budget includes similar, small incremental fee increases for DoD retirees under age 65 in the TRICARE system. The VA fees would allow us to focus our resources on patients who typically do not have other health care options. Furthermore, these two provisions reduce our need for appropriated funds by $765 million as a result of the additional collections they would generate, and a modest reduction in demand.

The 2007 budget also includes a provision to eliminate the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans. Veterans receiving medical care services for treatment of nonservice-connected disabilities would receive a bill for their entire co-payment. If enacted, this provision would yield about $30 million in additional collections that could be used to provide further resources for the Department's health care system.

The combined effect of all three provisions reduces our need for appropriated funds by $795 million in 2007. I want to work with your committee and the rest of Congress to gain your support for these proposals.

Workload

During 2007, we expect to treat nearly 5.3 million patients, of which 4.8 million are veterans, including over 100,000 combat veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom.

The 3.8 million veteran patients in Priorities 1-6 will comprise 79 percent of our total veteran patient population and 72 percent of our overall total patient population in 2007. This will be an increase of 2.1 percent in the number of patients in Priorities 1-6 and will represent the fourth consecutive year during which those veterans who count on us the most will increase as a percentage of all patients treated.

We have made significant improvements to the actuarial model that was used to support our 2007 budget request, including development of an enhanced methodology for determining enrollee morbidity and a more detailed analysis of enrollee reliance on VA health care compared to other medical service providers. Also, we have added new data sources, including the Social Security Death Index, which resulted in a more accurate count of enrolled veterans. Finally, we have more accurately assigned veterans into the income-based enrollment priority groups by using data from the 2000 decennial census.

VA continues to take steps to ensure the actuarial model accurately projects the needs of veterans from Operation Enduring Freedom and Operation Iraqi Freedom. However, many unknowns can impact the number and type of services the Department will need to provide these veterans, including the duration of the military action, when these veterans are demobilized, and the impact of our enhanced outreach efforts. Therefore, we have made additional investments in key services, such as mental health, prosthetics, and dental care to ensure we will be able to continue to meet the health care needs of these returning veterans and veterans from other eras seeking more of these same services.

Funding Drivers

There are three key drivers of the additional funding required to meet the demand for VA health care services in 2007:

- inflation;
- expanded utilization of services; and
- greater intensity of services provided.

The impact of the composite rate of inflation within the actuarial model increased our resource requirements for medical care by $1.2 billion, or 3.9 percent. This includes the effect of additional funds needed to meet higher payroll costs as well as the influence of growing costs for supplies, as measured in part by the medical Consumer Price Index.

VA will experience a significant increase in the utilization of health care services in 2007 as a result of four factors. First, overall utilization trends in the U.S. health care industry continue to increase. Veterans who previously came to VA for a single medical appointment now more typically require multiple appointments in many different specialty clinics. And, they return more often for follow-up appointments in any given year. To illustrate, in 2005 we treated about 5.3 million individual patients but had a total of over 58 million outpatient visits. These trends expand VA's per-patient cost of doing business. Second, we expect to see changes in the demographic characteristics of our patient population. Our patients as a group will continue to age, will have lower incomes, and will seek care for more complex medical conditions. These projected changes in the case mix of our patient population will result in greater resource needs. Third, veterans are displaying an increasing level of reliance on VA health care as opposed to using other medical care options they may have available. This increasing reliance on VA medical care is due at least in part to the positive experiences veterans have had with the Department's health care system and is a reflection of our status as the nation's leader in delivering high-quality care. And fourth, veterans are submitting compensation claims with more, as well as more complex, disabilities claimed. Our Veterans Health Administration does the majority of disability examinations required in order to evaluate these claims. This results in the need for a disability compensation medical examination that is more complex, costly, and time consuming.

General medical practice patterns throughout the nation have resulted in an increase in the intensity of health care services provided per patient, due to the growing use of diagnostic tests, pharmaceuticals, and other medical services. This rising intensity of care is evidenced in VA's health care system as well. This has contributed to higher quality of care and improved patient outcomes, but it requires additional resources to provide this greater intensity of services.

The combined impact of expanded utilization and greater intensity of services increased our resource requirements for medical care by nearly $1.2 billion.

Quality of Care

VA's standing as the nation's leader in providing safe, high-quality health care is evident and has been well documented. For example:

- in December 2004 RAND investigators found that VA outperforms all other sectors of American health care across a spectrum of 294 measures of quality in disease prevention and treatment;

- the Department's health care system was featured in the January/ February 2005 edition of Washington Monthly in an article titled "The Best Care Anywhere";
- the May 18, 2005, edition of the prestigious Journal of the American Medical Association noted that VA's health care system has ". . . quickly emerged as a bright star in the constellation of safety practice, with system-wide implementation of safe practices, training programs and the establishment of four patient-safety research centers";
- the July 18, 2005, edition of the U.S. News and World Report included a special report on the best hospitals in the country titled "Military Might—Today's VA Hospitals Are Models of Top-Notch Care;" and
- on August 22, 2005, The Washington Post ran a front-page article titled "Revamped Veterans' Health Care Now a Model."

It should be noted that for the sixth consecutive year, VA set the public and private sector benchmark for health care satisfaction based on the American Customer Satisfaction Index survey conducted by the National Quality Research Center at the University of Michigan. VA's inpatient index was 83 compared to 73 for the private sector, and our outpatient index was 80 compared to 75 for the private sector.

These external acknowledgments of the superior quality of VA health care when compared to other public and private health plans reinforce the Department's own findings. We use two primary measures of health care 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 medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the Clinical Practice Guidelines Index, an internal accountability measure focusing on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to reach 78 percent in 2007, or a 1 percentage point rise over the 2006 estimate. Similarly, VA's Prevention Index, a set of measures aimed at preventive health care, including immunization, health risk assessments, and cancer screenings, is projected to remain at the estimated 2006 high rate of performance of 88 percent.

Access to Care

With the resources requested for medical care in 2007, the Department will also be able to maintain its current high performance dealing with access to medical care—93.7 percent of appointments are scheduled within 30 days of the patient's desired date. For primary care appointments, 96 percent will be scheduled within 30 days of the patient's desired date and for specialty care, 93 percent of all appointments will be scheduled within 30 days of the patient's desired date. No veteran will have to wait for emergency care.

VA is also committed to ensuring that no veteran returning from service in Operation Enduring Freedom and Operation Iraqi Freedom has to wait more than 30 days for a primary care or specialty care appointment.

We have achieved these waiting times efficiencies by developing a number of strategies to reduce waiting times for appointments in primary care and specialty clinics nationwide, to include implementing state-of-the-art appointment scheduling systems, standardizing business processes associated with scheduling practices, and ensuring that clinicians focus on those tasks that only they can perform to optimize the time available for treating patients. To further improve access and timeliness of service, VA will fully implement Advanced Clinic Access nationally, an initiative that promotes the efficient flow of patients. This program optimizes clinical scheduling so that each appointment or inpatient service is most productive. In turn, this reduces unnecessary appointments, allowing for relatively greater workload and increased patient-directed scheduling.

Major Changes in Funding

VA's 2007 request includes over $4.3 billion for long-term care ($229 million more than the 2006 level). I can assure you that the patient and cost projections associated with long-term care have been checked to ensure that they represent our real need in this area. While we aim to expand all types of extended care services, we plan to increase the rate of growth of non-institutional care funding about twice as much as that for institutional care. With an emphasis on community-based and in-home 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. During 2007 we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 36,700. This represents a 14.4 percent increase above the level we expect to reach in 2006 and a 33.7 percent rise over 2005.

The Department's 2007 request includes nearly $3.2 billion ($339 million over the 2006 level) to provide comprehensive mental health services to veterans, including our effort to improve timely access to these services across the country. These additional funds will help ensure that VA continues to realize the aspirations of the President's New Freedom Commission Report as embodied in VA's Mental Health Strategic Plan and to deliver exceptional, accessible mental health care.

The Department will continue to place particular emphasis on providing care to those suffering as a result of their service in Operation Enduring Freedom and Operation Iraqi Freedom from a spectrum of combat stress reactions, ranging from readjustment issues to Post-Traumatic Stress Disorder (PTSD). 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. This includes the December 2005 designation of three new centers of excellence in Waco (Texas), San Diego (California), and Canandaigua (New York) devoted to advancing the understanding and care of mental health illness.

VA's medical care request includes $1.4 billion ($160 million over the 2006 level) to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. VA has already provided prosthetics and sensory aids to military personnel who served in Operation Enduring Freedom and Operation Iraqi Freedom and the Department will continue to provide them as needed.

Medical Collections

As a result of improvements in our medical collections processes and the legislative proposals presented in this budget request, we expect to collect over $2.8 billion in 2007 that will substantially supplement the resources available from appropriated sources. In 2005 we collected just under $1.9 billion. The collections estimate for 2007 is $779 million, or 37.9 percent, above the 2006 estimate. About 70 percent of the projected increase in collections is due to the provisions calling for implementation of a $250 annual enrollment fee, an increase to $15 in the pharmacy co-payment, and elimination of the practice of offsetting VA first-party co-payment debts with collection recoveries from third-party health plans. The remaining 30 percent of the growth in collections will result from continuing improvements in billing and collections.

We have several initiatives underway to strengthen our collections processes. These include:

- the Department is implementing a private-sector-based business model pilot, tailored to our revenue operations, to increase third-party insurance revenue and improve VA's business practices. The pilot Consolidated Patient Account Center will address all operational areas contributing to the establishment and management of patient accounts and related billing and collections processes;
- we are working with Centers for Medicare/Medicaid Services contractors to obtain a Medicare-equivalent remittance advice for veterans who are covered by Medicare and are using VA health care services. This project will result in more accurate payments and better accounting for receivables through use of more reliable data for claims adjudication;
- our Insurance Identification and Verification project is providing VA medical centers with an automated mechanism to obtain veterans' insurance information from health plans that participate in the electronic data exchange;

- we are testing the e-Pharmacy Claims software that provides real-time claims adjudication for outpatient pharmacy claims; and
- VA is implementing the Patient Financial Services System pilot that will increase the accuracy of bills and documentation, reduce operating costs, generate additional revenue, reduce outstanding receivables, and decrease billing times.

Medical Research

The President's 2007 budget includes $399 million to support VA's medical and prosthetic research program. This amount will fund more than 2,000 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of mental illness ($51 million), aging ($40 million), health services delivery improvement ($36 million), heart disease ($30 million), central nervous system injuries and associated disorders ($29 million), and cancer ($28 million).

The requested funding for the medical and prosthetic research program will position the Department to build upon its long track record of success in conducting research projects that lead to clinically useful interventions that improve veterans' health and quality of life. Examples of some of the recent contributions made by VA research to the advancement of medicine are:

- use of the antidepressant paroxetine decreases symptoms related to Post-Traumatic Stress Disorder and improves memory;
- physical activity and body-weight reduction can significantly cut the risk of developing type II diabetes;
- new links have been discovered between diabetes and Alzheimer's disease; and
- vaccination against varicella-zoster (the same virus that causes chickenpox) decreases the incidence and/or severity of shingles.

In addition to VA appropriations, the Department's researchers compete and receive funds from other federal and non-federal sources. Funding from external sources is expected to continue to increase in 2007. Through a combination of VA resources and funds from outside sources, the total research budget in 2007 will be almost $1.65 billion, or about $17 million more than the 2006 estimate.

General Operating Expenses

The Department's 2007 resource request for General Operating Expenses (GOE) is nearly $1.5 billion. It is $131 million, or 9.7 percent, above the 2006 current estimate. Within the 2007 total funding request, $1.168 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. This is an increase of $114 million (or 10.8 percent) over the 2006 level. Our request for

GOE funding also includes $313 million to support General Administration activities, an increase of $17 million, or 5.7 percent, from the current 2006 estimate.

Compensation and Pensions Workload, Performance, and Staffing

VA is focused on delivering timely and accurate benefits to veterans and their families. Improving the delivery of compensation and pension benefits has become increasingly challenging during the last few years due to a steady and sizeable increase in workload. This growing workload is the result of several factors—more claims are being filed; we are experiencing more direct contact with veterans and service members, particularly those who served in Operation Enduring Freedom and Operation Iraqi Freedom; the complexity of claims is increasing; and more appeals are being filed.

The volume of claims receipts has grown substantially during the last few years and is now the highest it has been in the last 15 years as we received over 788,000 claims in 2005. This trend is expected to continue. We are projecting the receipt of over 910,000 compensation and pension claims in 2006 (which includes over 98,000 claims resulting from the special outreach requirements of recently enacted legislation) and more than 828,000 claims in 2007.

One of the key drivers of new claims activity is the size of the active duty military force. The number of active duty service members as well as Reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom have increased. This has led to a sizeable growth in the number of new claims, and we expect this pattern to persist. An additional reason that the number of compensation and pension claims is climbing is the Department's commitment to increase outreach efforts. Our outreach efforts are critical to the men and women who are entitled to VA benefits and services. We have an obligation to extend our reach as far as possible and to spread the word to veterans about what VA stands ready to provide.

Disability compensation claims from veterans who have previously filed a claim comprise almost 60 percent of the disability claims receipts each year, and the number of such claims is climbing at a rate of two to three percent annually. Many veterans now receiving compensation suffer from chronic and progressive conditions, such as diabetes, mental illness, and cardiovascular disease. As these veterans age and their conditions worsen, we experience additional claims for increased benefits.

The growing complexity of the claims being filed also contributes to our workload challenges. Since the beginning of 2000, the number of veterans receiving compensation has increased 14 percent, from slightly over 2.3 million to more than 2.6 million. However, the total number of disabilities for which veterans are

being compensated has increased 37 percent during this time, from nearly 6.0 million disabilities to 8.2 million disabilities. In addition, we expect to continue to receive a growing number of complex disability claims resulting from Post-Traumatic Stress Disorder, environmental and infectious risks, traumatic brain injuries, complex combat-related injuries, and complications resulting from diabetes. Each claim now takes more time and more resources to adjudicate. Additionally, as the Department receives and adjudicates more claims, this results in a larger number of appeals from veterans and survivors.

In addition to the growing complexity of compensation and pension claims, there are special outreach requirements that will have a significant impact on our workload and program performance. These outreach requirements will result in nearly 100,000 additional claims. As a result of the increasing volume and complexity of claims, the average number of days to complete compensation and pension claims is now projected to rise from 167 days in 2005 to 185 days in 2006, and to fall slightly to 182 days in 2007. In addition, we anticipate that our pending inventory of disability claims will climb throughout 2006 as we receive new claims, reaching nearly 418,000 by the end of this year. The inventory will fall by 5 percent during 2007 to around 397,000. Despite these significant workload challenges, we remain committed to reaching our strategic goal of processing compensation and pension claims in an average of 125 days.

We will address our ever-growing workload challenges in several ways. First, we will continue to improve our productivity as measured by the number of claims processed per staff member. Second, we will continue to move work among regional offices in order to maximize our resources and enhance our performance. Third, we will simplify and clarify benefit regulations and ensure our claims processing staff has easy access to the manuals and other reference material they need to process claims as efficiently and effectively as possible. And fourth, we will further advance our efforts to improve the consistency and quality of claims processing across regional offices.

Even though we will implement several management improvement practices, we will need additional staffing in order to address our workload challenges in claims processing. Our 2007 budget includes resources to support over 13,100 staff members (including nearly 7,900 staff in direct support of the compensation and pensions programs), or about 170 above the staffing supported by our 2006 budget.

Education and Vocational Rehabilitation and Employment Performance

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 8 days during the next 2 years, falling from 33 days in 2005 to 25 days in 2007. In addition, the rehabilitation rate for the

vocational rehabilitation and employment program will climb to 69 percent in 2007, a gain of 6 percentage points over the 2005 performance level.

Funding for Initiatives

The 2007 request for VBA includes $3.4 million to continue development of comprehensive training and electronic performance support systems. This ongoing initiative provides technical training to compensation and pension staff through a multimedia, multi-method training approach that has a direct impact on the accuracy and consistency of our claims processing.

The 2007 resource request for VBA includes $2.0 million to continue the development of a skills certification instrument for assessing the knowledge base of current and new veterans' service representatives and will also result in a skills certification module for a variety of program staff. This initiative will help identify those employees who need additional training in order to better perform their duties and will allow us to improve our screening process involving applicants for higher-level positions.

National Cemetery Administration

The President's 2007 budget request for VA includes $160.7 million in operations and maintenance funding for the National Cemetery Administration (NCA). This represents an increase of $11.1 million (or 7.4 percent) over the 2006 current estimate. The additional funding will be used to meet the growing workload at existing cemeteries by increasing staffing and augmenting funds for contract maintenance, supplies, and equipment. We expect to perform over 107,000 interments in 2007, or 5.4 percent more than the 2006 estimate and 15.1 percent more than the number of interments in 2005.

Our resource request also has $9.1 million to address gravesite renovations as well as headstone and marker realignment, an increase of $3.6 million from our funding for 2006. These improvements in the appearance of our national cemeteries will help us maintain the cemeteries as shrines dedicated to preserving our nation's history and honoring veterans' service and sacrifice.

We will expand access to our burial program by increasing the percent of veterans served by a burial option in a national or state veterans cemetery within 75 miles of their residence to 83.8 percent in 2007, which is 6.7 percentage points above the 2005 level. In addition, we will continue to increase the percent of respondents who rate the quality of service provided by national cemeteries as excellent to 97 percent in 2007, or 3 percentage points higher than the 2005 performance level.

Capital (Construction and Grants to States)

The President's 2007 budget request includes $714 million in capital funding for VA. Our request includes $399 million for major construction projects, $198 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 2007 request for construction funding for our medical care program is $457 million—$307 million for major construction and $150 million for minor construction. All of these resources will be devoted to continuation of the Capital Asset Realignment for Enhanced Services (CARES) program to renovate and modernize VA's health care infrastructure and to provide greater access to high-quality care for more veterans. When combined with the $293 million that was enacted in the Hurricane Katrina emergency funding package in late December 2005 to fund a CARES project for a new hospital in Biloxi, Mississippi, the total CARES funding since the 2006 budget totals $750 million and since the 2004 CARES report amounts to nearly $3 billion.

Our major construction request for medical care will fund the continued development of two medical facility projects—$97.5 million to address seismic corrections in Long Beach; and $52.0 million for a new medical facility in Denver. In addition, our request for major construction funding includes $38.2 million to construct a new nursing home care unit and new dietetics space, as well as to improve patient and staff safety by correcting seismic, fire, and life safety deficiencies at American Lake (Washington); $32.5 million for a new spinal cord injury center at Milwaukee; $25.8 million to replace the operating room suite at Columbia (Missouri); and $7.0 million to renovate underutilized vacant space located at the Jefferson Barracks Division campus at St. Louis as well as provide land for expansion at the Jefferson Barracks National Cemetery.

We are also requesting $53.4 million in major construction funding and $25.0 million in minor construction resources to support our burial program. Our request for major construction includes funds for cemetery expansion and improvement at Great Lakes, Michigan ($16.9 million), Dallas/Ft. Worth, Texas ($13.0 million), and Gerald B. H. Solomon, Saratoga, New York ($7.6 million). Our request will also provide $2.3 million in design funds to develop construction documents for gravesite expansion projects at Abraham Lincoln National Cemetery (Illinois) and at Quantico National Cemetery (Virginia). In addition, the major construction request includes $12 million for the development of master plans for six new national cemeteries in areas directed by the National Cemetery Expansion Act of 2003—Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Sarasota County, Florida; and southeastern Pennsylvania.

Information Technology Services

The President's 2007 budget for VA provides $1.257 billion for the non-payroll costs associated with information technology (IT) projects across the Department. This is $43.2 million, or 3.6 percent, above our 2006 budget.

The 2007 request for IT services includes $832 million for our medical care program, $55 million for our benefits programs, $4 million for our burial program, and $366 million for projects managed by our staff offices, most notably non-payroll costs in our Office of Information and Technology and Office of Management to support department-wide initiatives and operations.

The most critical IT project for our medical care program is the continued operation and improvement of the Department's electronic health record system, a Presidential priority which has been recognized nationally for increasing productivity, quality, and patient safety. Within this overall initiative, we are requesting $51.0 million for ongoing development and implementation of HealtheVet-VistA (Veterans Health Information Systems and Technology Architecture) which will incorporate new technology, new or reengineered applications, and data standardization to continue improving veterans' health care. This system will make use of standards that will enhance the sharing of data within VA as well as with other federal agencies and public and private sector organizations. Health data will be stored in a veteran-centric format replacing the current facility-centric system. The standardized health information can be easily shared between facilities, making patients' electronic health records available to all those providing health care to veterans.

Until HealtheVet-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 $188 million in 2007 for the VistA legacy system.

In support of the Department's education program, our 2007 request includes $3 million in non-payroll costs to continue the development of The Education Expert System. This will replace the existing benefit payment system with one that will allow the Department to automatically process education claims received electronically.

VA's 2007 request provides $57.4 million for cyber security. This ongoing initiative involves the development, deployment, and maintenance of a set of enterprise-wide security controls to better secure our IT architecture in support of all of the Department's program operations.

Summary

In summary, Mr. Chairman, the $80.6 billion the President is requesting for VA in 2007 will provide the resources necessary for the Department to:

- provide timely, high-quality health care to nearly 5.3 million patients, including 4.8 million veteran patients of which 79 percent are among those who need us the most—those with service-connected disabilities, lower incomes, or special health care needs;
- address the large growth in the number of claims for compensation and pension benefits; and
- increase access to our burial program by ensuring that nearly 84 percent of veterans will be served by a burial option in a national or state veterans cemetery within 75 miles of their residence.

I look forward to working with the members of this committee to continue the Department's tradition of providing timely, high-quality benefits and services to those who have helped defend and preserve freedom around the world.

Department of Veterans Affairs

FY 2007 Budget Request

February 6, 2006

VA's 2007 Budget

The 2007 budget will allow VA to address its three highest priorities:

- Provide timely, high-quality health care to those who need us the most – veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs
- Address the significant increase in claims for compensation and pension
- Ensure the burial needs of veterans and their eligible family members are met, and maintain veterans' cemeteries as national shrines

Major Outcomes for FY 2007

- Schedule 93.7% of all appointments within 30 days of patient's desired date
- Complete nearly 850,000 claims for compensation and pension benefits, or more than 11 percent above the number completed in 2005; improve the timeliness of processing claims for education benefits (from 33 days in 2005 to 25 days in 2007)
- Increase to nearly 84 percent the share of veterans with a burial option in a national or state veterans cemetery within 75 miles of their residence

2007 Policy Proposals

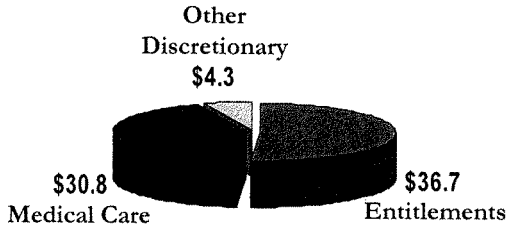
- An annual enrollment fee of $250 (for Priority 7 and 8 veterans)
- An increase in pharmacy co-pays from $8 to $15 (for Priority 7 and 8 veterans)
- Veterans receiving treatment for nonservice-connected disabilities will receive bills for the entire co-pays

$ in millions	Workload	Collections	Appropriation
Assess $250 Annual Enrollment Fee	184	226	-410
Increase Pharmacy Co-Payments	67	288	-355
Third-Party Offset of First-Party Debt	0	31	-30
Policy Proposals Total	**251**	**544**	**-795**

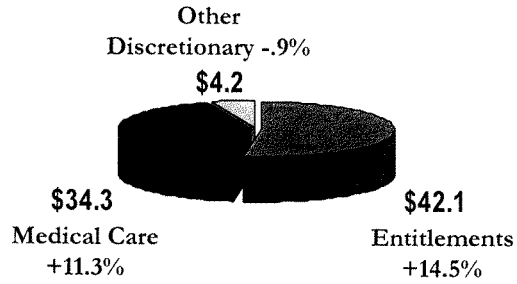
2007 Performance Goals

	2005 Actual	2006 Plan	2007 Plan	Strategic Target
Health Care				
Percentage of Appointments Scheduled Within 30 Days of Desired Date:				
All Appointments	93.7%	93.7%	93.7%	93%
Primary Care Appointments	96%	96%	96%	94%
Specialty Care Appointments	93%	93%	93%	93%
Clinical Practice Guidelines Index	87%	77%	78%	80%
Prevention Index II	90%	88%	88%	88%
Benefits Processing				
Average Processing Times (days)				
Disability Compensation & Pension Claims	167	185	182	125
Education Claims (Original)	33	27	25	10
Insurance Claims (Disbursements)	1.8	2.7	2.7	2.7
Burial Benefits				
Percent of Veterans Served by Burial Option Within 75 Miles of Their Residence	77.1%	81.6%	83.8%	90.0%
Percent of Graves in National Cemeteries Marked Within 60 Days of Interment	94%	90%	90%	90%

Discretionary/Entitlements



2006 Estimate
$71.8 Billion
With Collections



2007 As Requested
$80.6 Billion
With Collections
+9.8% in Discretionary

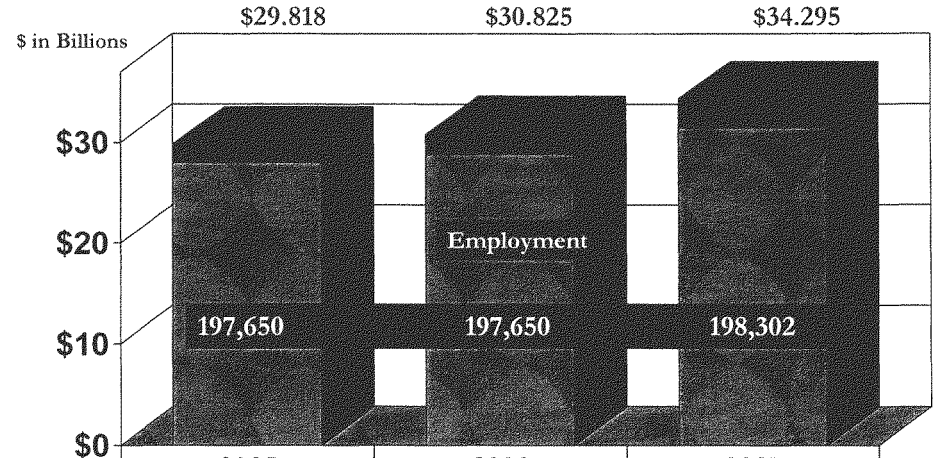
2007 Request
($ in millions)

	FY 2005 [1/2]	FY 2006 [1]	FY 2007	Increase/ Decrease	Percent Change
Medical Care	27,950	28,772	31,462	2,690	9.4%
Collections	1,868	2,054	2,833	779	37.9%
Total	29,818	30,825	34,295	3,470	11.3%
Medical Research	390	412	399	-13	-3.2%
VBA	1,033	1,054	1,168	114	10.8%
NCA	142	150	161	11	7.4%
Construction-Major	455	607	399	-208	-34.3%
Construction-Minor	229	199	198	-1	-0.5%
Grants for State Extended Care Facilities	104	85	85	0	0.0%
Grants for State Cemeteries	32	32	32	0	0.0%
General Administration	267	296	313	17	5.7%
Information Technology	1,284	1,214	1,257	43	3.6%
Inspector General	68	69	69	0	0.6%
Credit Reform	154	155	154	0	-0.2%
Total Discretionary	33,976	35,097	38,530	3,433	9.8%
Total Mandatory	36,826	36,716	42,050	5,334	14.5%
Total VA	70,802	71,813	80,580	8,767	12.2%
FTE	222,024	222,754	223,327	573	0.3%

[1] FY 2005 and FY 2006 exclude hurricane and pandemic influenza supplementals

[2] FY 2005 BA has been adjusted to account for non-pay IT for comparison purposes only.

Medical Care Appropriations Budget Authority

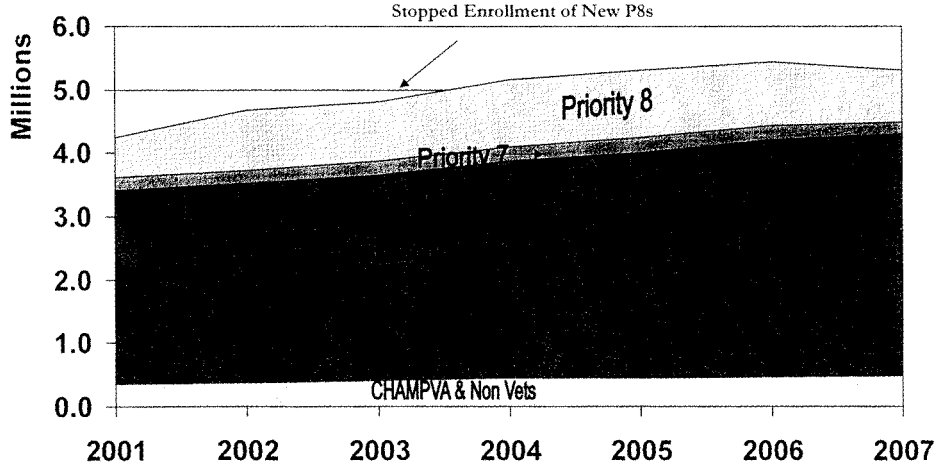


	2005	2006	2007
Collections	1.868	2.054	2.833
Appropriations	27.950	28.772	31.462

Medical Care Three Appropriations Budget Authority

	2005 Actual	2006 Estimate	2007 Request	Percent Change
Medical Care				
Medical Services	$21,376.5	$22,547.1	$24,716.0	9.6%
Medical Administration	3,310.4	2,926.9	3,177.0	8.5%
Medical Facilities	3,263.0	3,297.7	3,569.0	8.2%
Total Medical Care Appropriation	**27,950.0**	**28,771.8**	**31,462.0**	**9.4%**
Collections	1,868.4	2,053.6	2,832.8	37.9%
Total Medical Care with Collections	**$29,818.4**	**$30,825.4**	**$34,294.8**	**11.3%**

Medical System Users



Long-Term Care (LTC) Census

Census	1998 Actual	2007 Estimate	Percent Change
Institutional Care	**47,269**	**46,034**	**-3%**
VA Nursing	13,391	11,100	-17%
Community Nursing Home	5,605	3,844	-31%
State Nursing Home	14,674	19,414	32%
Total Nursing Home Care	33,670	34,358	2%
Residential Care and Other	13,599	11,676	-14%
Non-Institutional Care	**19,810**	**36,722**	**85%**
Total Census	**67,079**	**82,756**	**23%**

MCCF Collections

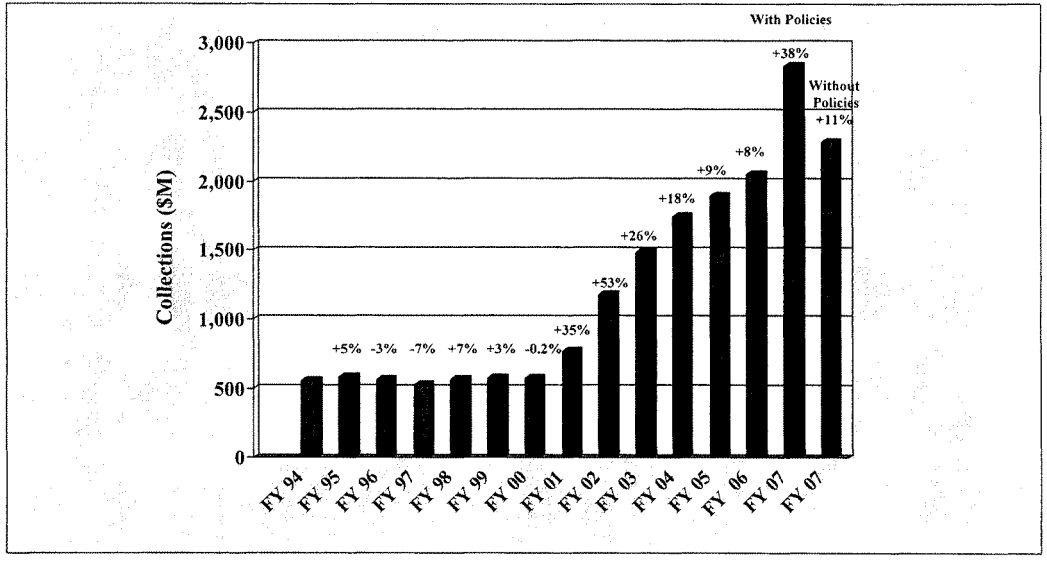
($ in millions)

	2005 Actual[1]	2006 Estimate	2007 Estimate	Change	Percent Change
First-Party Co-Payments	$774	$827	$934	$107	13%
Pharmacy Co-Payments	650	701	808	107	15%
Other Co-Payments	124	126	126	0	0%
Third-Party Insurance Collections	1,056	1,178	1,305	127	11%
All Other collections	38	49	50	1	2%
Total Collections	**1,868**	**2,054**	**2,289**	**235**	**11%**
Proposed Legislation					
Assess $250 Enrollment Fee			288	288	
Increase Pharmacy Co-Payment			226	226	
Total User Fees	0	0	514	**514**	
Third-Party Offset of First-Party Debt			30	30	
Subtotal Proposed Legislation	**0**	**0**	**544**	**544**	
Total Collections	**$1,868**	**$2,054**	**$2,833**	**$779**	**38%**

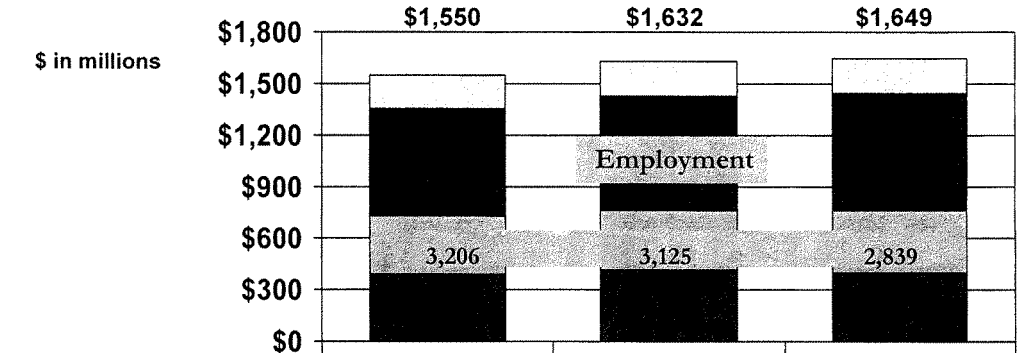
[1]In FY 2005, $1,897 million was collected in the MCCF. Of the $1,897 million, $1,868 million was transferred in 2005 to the medical services account due to the difference in timing from when the funds are received and transferred. The remaining $29 million of the 2005 funds will be transferred to medical services in FY 2006.

Medical Care Collections Fund
FY 1994-2007

($ in millions)



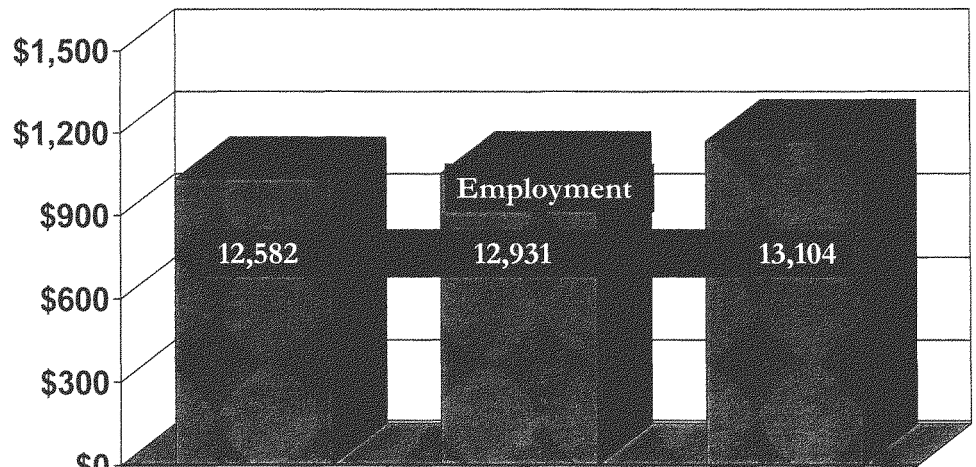
Medical and Prosthetic Research Total Resources



	2005	2006	2007
□ Other Grants	195	205	208
■ Federal Grants	625	662	676
▒ Medical Care Support	341	353	366
■ Appropriation	390	412	399

Veterans Benefits Administration Budget Authority

($ in millions)



	2005	2006	2007 Request
BA	1,033	1,054	1,168

Veterans Benefits Administration

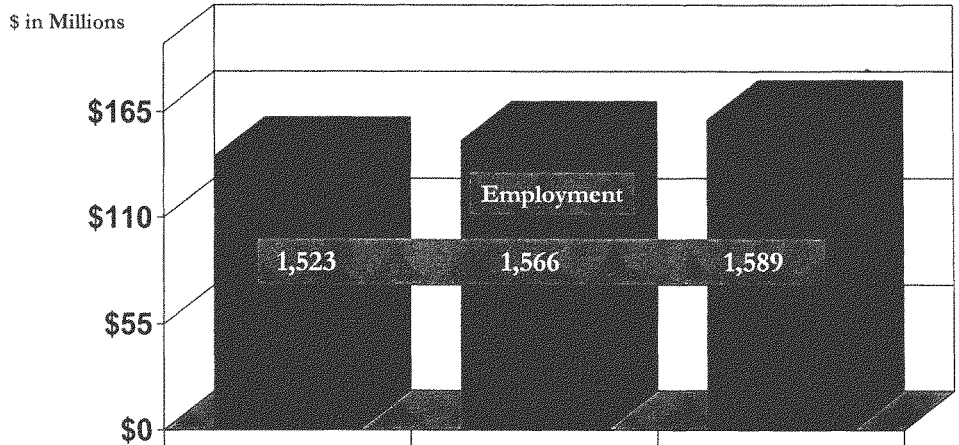
($ in thousands)

	FY 2005	FY 2006	2007 Request	% change from 2006
Operating Expenses				
Compensation	691,606	699,832	778,971	11.3%
Pensions	143,600	125,700	145,383	15.7%
Education	74,445	85,606	90,113	5.3%
Voc Rehab	120,163	138,516	149,037	7.6%
Credit Programs	153,765	154,528	154,175	-0.2%
Insurance	2,825	4,284	4,355	1.7%
Total Operating	$1,032,639	$1,053,938	$1,167,859	10.8%

Veterans Benefits Administration
(Employment)

	FY 2005	FY 2006	FY 2007 Request	% change from 2006
VBA Total	12,582	12,931	13,104	1%
Compensation	7,538	7,989	7,890	-1%
Pensions	1,540	1,442	1,555	8%
Education	852	884	930	5%
Voc Rehab	1,115	1,125	1,255	12%
Housing	1,049	988	971	-2%
Insurance	488	503	503	0%

National Cemetery Administration Budget Authority



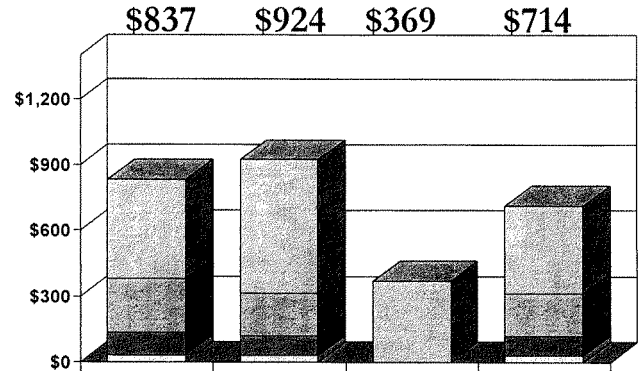
	2005	2006	2007
BA	142	149.6	160.7

Information Technology Account
(in thousands)

Managing Authority	FY 2005	FY 2006	FY 2007 Requested	% CHANGE FROM 2006
VHA	863,122	809,569	831,890	2.76%
VBA	92,691	59,947	54,833	-8.53%
NCA	3,860	4,478	4,314	-3.66%
Office of Management	38,333	59,668	69,203	15.98%
Office of Information Technology	279,501	273,591	290,193	6.07%
Other Staff Offices	6,010	6,567	6,567	0.00%
Total Budget Authority	1,283,517	1,213,820	1,257,000	3.56%
Total Reimbursements	*24,000*	*27,396*	*25,763*	-5.96%
Total Obligations	1,307,517	1,241,216	1,282,763	3.35%

Capital Programs Budget Authority

$ in millions



	2005	2006	2006 Supp	2007
Major Projects	455	608	367	399
Minor Projects	245	199	2	198
Grants SECF	104	85		85
Grants SC	32	32		32

Construction

($ in thousands)

	FY 2005[2]	FY 2006 Budget	FY 2006 Supplemental	FY 2007 Request	2006 Budget[3] vs. 2006 Supplemental & 2007 Request
VHA Major[1]	397,594	539,800	367,500	307,350	25.0%
VHA Minor	196,486	155,000	0	150,000	-3.2%
Subtotal, VHA	***594,080***	***694,800***	***367,500***	***457,350***	**18.7%**
VBA & Other Minor	19,279	17,048	0	14,000	-17.9%
Subtotal, VBA & Other	***19,279***	***17,047***	***0***	***14,000***	**-17.9%**
NCA Major	55,552	65,300	0	53,400	-18.2%
NCA Minor	25,500	22,581	1,800	25,000	18.7%
Subtotal, NCA	***81,052***	***87,881***	***1,800***	***78,400***	**-8.7%**
Staff Offices Major	1,984	2,000	0	38,250	1812.5%
Staff Offices Minor	4,211	4,309	0	9,000	108.9%
Subtotal, Staff Offices	***6,195***	***6,309***	***0***	***47,250***	**648.9%**
Total Major Construction	455,130	607,100	367,500	399,000	26.3%
Total Minor Construction	245,476	198,938	1,800	198,000	0.4%
Total Other Capital	136,066	117,000		117,000	0.0%
Total Construction	**836,672**	**923,038**	**369,300**	**714,000**	**17.4%**

[1] FY 2005 includes transfer from Medical Care in FY 2004

[2] FY 2005 includes $16.5 million in additional funding for Public Law 108-324 Emergency Hurricane Supplemental

[3] The FY 2006 Hurricane Supplemental has been added to the FY 2007 request for comparison to 2006

Major Construction Projects 2007 Request

Location	Description	Estimate ($ in 000s)
Denver, CO	Replacement Medical Center Facility	$52,000
Long Beach, CA	Seismic Corr, Bldg 7 & 126	97,545
Milwaukee, WI	Spinal Cord Injury (SCI) Center	32,500
St. Louis, MO	Medical Facility Improvement & Cem. Exp.	7,000
American Lake, WA	Seismic Corr, NHCU & Dietetics	38,220
Columbia, MO	Operating Suite Replacement	25,830
Solomon-Saratoga, NY	Phase 2 Gravesite Expansion	$7,600
Dallas/Ft Worth, TX	Phase 2 Gravesite Expansion	13,000
Great Lakes, MI	Phase 1B Development	16,900
Martinsburg, WV	Capital Region Data Center	$35,000
Line Items		
APF	Various VHA, NCA, Staff Office Locations	56,105
Design Fund	Various NCA Locations	2,300
Other Line Items	Various (ASB, HW, ETC.)	15,000
Total Request		$399,000

New Cemeteries – P.L. 106-117

New Cemetery	Current Status	Funding Status
Georgia National Cemetery, GA	Fast Track burial section under construction, interment operations to begin April 2006.	Fully Funded
Great Lakes National Cemetery, MI	Phase 1A opened for burials October 2005. Phase 1B design documents scheduled for award May 2006.	Phase 1A: Fully Funded Request: Construction for expansion (Phase 1B)
Southern Florida	Fast Track construction contract award projected March 2006. Award CDs[1] for remaining features April 2006.	Fully Funded
Ft. Sill National Cemetery, OK	Completed December 2003.	Fully Funded
National Cemetery of the Alleghenies, PA	Interment operations began August 2005. Construction award for remaining features August 2006.	Fully Funded
Sacramento, CA	Fast Track construction contract awarded February 2006. Award CDs[1], for remaining features, projected June 2006.	Fully Funded

[1] CDs - Construction Documents

New Cemeteries – P.L. 108-109

New Cemetery	Current Status	Funding Status
Bakersfield, CA	Environmental assessment is currently being conducted.	Funded: EIS 1, Land Acquisition Request: Master Planning[2]
Birmingham, AL	Environmental assessment is currently being conducted.	Funded: EIS [1], Land Acquisition Request: Master Planning[2]
Columbia/ Greenville, SC	Environmental assessment is currently being conducted.	Funded: EIS [1], Land Acquisition Request: Master Planning[2]
Jacksonville, FL	Environmental assessment is currently being conducted.	Funded: EIS [1], Land Acquisition Request: Master Planning[2]
Southeastern, PA	EA completed 11/2005. Site near Washington Crossing, PA was selected. Land acquisition 2006.	Funded: EIS [1], Land Acquisition Request: Master Planning2
Sarasota County, FL	Environmental assessment completed 12/2005. 30-day public comment period ended 1-17-06. Selection of preferred site pending	Funded: EIS [1], Land Acquisition Request: Master Planning[2]

[1] EIS - Environmental Impact Statement

[2] Master Planning and Design Development

Departmental Administration
FY 2007 Budget Authority Request

($ in thousands)

	FY 2005	FY 2006	FY 2007 Request	% Change FY 2006 BA	FTE
Secretary	$7,155	$7,378	$7,549	2.3%	79
BCA	1,595	1,780	1,820	2.2%	12
BVA	51,074	52,918	55,309	4.5%	444
OGC	57,661	60,898	64,784	6.4%	656
OM	33,895	37,966	40,592	6.9%	317
OI&T	24,185	33,786	35,846	6.1%	496
HRA	50,275	59,435	64,179	8.0%	535
PPP	26,628	27,026	27,615	2.2%	119
PI&A	10,190	10,509	10,775	2.5%	83
OCLA	4,107	4,335	4,436	2.3%	40
GenAdmin GOE Subtotal	$266,765	$296,031	$312,905	5.7%	2,781
Inspector General	68,180	69,074	69,499	0.6%	483

Program Assessment Rating Tool Purpose & Scope

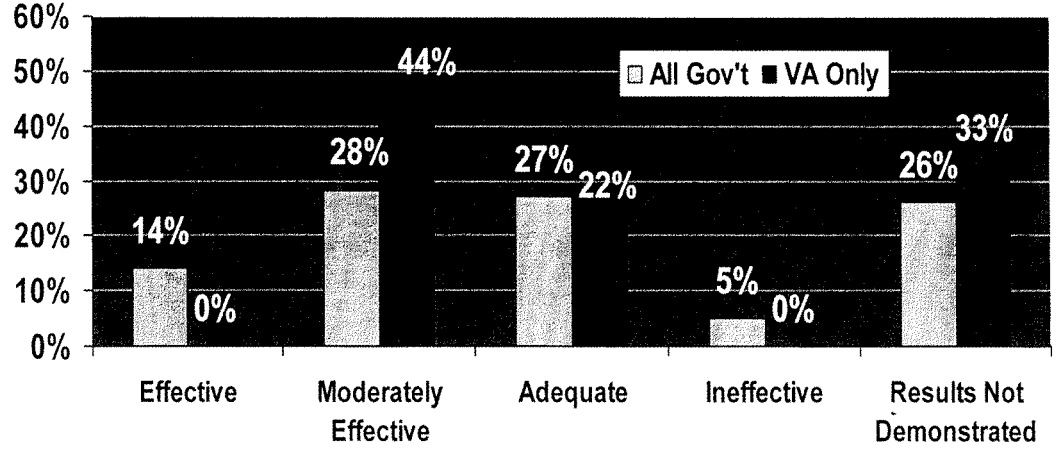
- Analytical Tool Designed by the Administration to Evaluate Programs in a Consistent and Transparent Manner Using a Standardized Questionnaire
- Results Used to Help Improve Program Management and Budget Decision-making
- Heavy Emphasis on Identifying Outcome Goals and Measures That Describe the Intended Effect or Impact That Programs Should Have on Beneficiaries

Results of PART Reviews -Through 2005-

Year	Program	Score	Rating
2002	Burial	79%	Moderately Effective
2002	Disability Comp.	15%	Results Not Demonstrated
2003	Medical Care	63%	Adequate
2003	Education	56%	Results Not Demonstrated
2004	Housing	35%	Results Not Demonstrated
2004	General Admin.	74%	Moderately Effective
2005	Insurance	73%	Moderately Effective
2005	Pension	57%	Adequate
2005	Medical Research and Development	81%	Moderately Effective

PART Rating Distribution
-Total Federal Government versus VA-

Through FY 2005: Total Federal Programs Rated: 821
Total VA Programs Rated: 9



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TESTIMONY

of

David G. Greineder
AMVETS Deputy National Legislative Director

before the

Committee on Veterans' Affairs
U.S. House of Representatives

on

The Department of Veterans Affairs National Cemetery Administration Budget Request for Fiscal Year 2007

Wednesday, February 8, 2006
334 Cannon House Office Building
10:30am

Chairman Buyer, Ranking Member Evans, 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 2007. My name is David G. Greineder, Deputy 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 in fiscal year 2007.

AMVETS testifies before you as a co-author of *The Independent Budget*. Since 1987, AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars have pooled their resources to produce a unique document, one that has stood the test of time.

The IB, as it has come to be called, is our blueprint for building the kind of programs veterans deserve. Indeed, we are proud that over 60 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans must not have to wait for benefits to which they are entitled. Veterans must be ensured access to high-quality medical care. Specialized care must remain the focus of VA. Veterans must be guaranteed timely access to the full continuum of health care services, including long-term care. And, veterans must be assured burial in a state or national cemetery in every state.

Today, I will specifically address the National Cemetery Administration (NCA), however, I would like to briefly comment on the administration's budget request coming out of the Office of Management and Budget (OMB) just a few short days ago.

It is no secret that the VA healthcare system is the best in the country, and responsible for great advances in medical science. It is highly successful in containing cost and provides excellent care. The VHA is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected ailments. The delivery care system can provide a wide array of specialized services to veterans like those with spinal cord injuries and blindness. This type of care is very expensive and would be almost impossible for veterans to obtain outside of VA.

The system also prides itself in research and development, which AMVETS strongly supports because of its contributions to veterans' healthcare and the common good. Public investments in research projects have lead to an explosion of knowledge that promises to advance science and unlock new strategies for treatment and prevention.

Because veterans depend so much on VA and its services, AMVETS believes it is absolutely critical that the VA healthcare system be fully funded. It is important our nation keep its promise to care for the veterans who made so many sacrifices to ensure the freedom of so many. With the expected increase in the number of veterans, a need to increase VA health care spending should be an immediate priority this year. We must remain insistent about funding the needs of the system, and the recruitment and retention of vital health care professionals, especially registered nurses. Chronic under funding has led to rationing of care through reduced services, lengthy delays in appointments, higher co-payments and, in too many cases, sick and disabled veterans being turned away from treatment.

Looking at the administration's fiscal year 2007 budget, released just this Monday, AMVETS notes that the administration re-introduces several proposals aimed at increasing revenues (via collections) that will come directly from the pockets of targeted veterans through a $250 enrollment fee and co-payment increase from $8 to $15. AMVETS disagrees with this policy and we ask Congress to reject it.

The Independent Budget recommends Congress provide $32.4 billion to fund VA medical care for fiscal year 2007. We ask you to recognize that the VA healthcare system can only bring quality health care if it receives adequate and timely funding.

One option, and we believe the best choice, to ensure VA has access to adequate and timely resources is through mandatory, or assured, funding. I would like to clearly state that AMVETS along with its *Independent Budget* partners strongly supports shifting VA healthcare funding from discretionary funding to mandatory. We recommend this action because the current discretionary system is not working. Moving to mandatory funding would give certainty to healthcare services. VA facilities would not have to deal with the uncertainty of discretionary funding, which has been inconsistent and inadequate for far too long. Most importantly, mandatory funding would provide a comprehensive and permanent solution to the current funding problem.

The National Cemetery Administration

Before I address the budget recommendation for the NCA, I would like to acknowledge 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 hurting veterans' families in a very difficult time, and we thank them for their consolation.

The Department of Veterans Affairs National Cemetery Administration currently maintains more than 2.6 million gravesites at 125 national cemeteries in 39 states and Puerto Rico. There are approximately 14,500 acres of cemetery land within established installations in the NCA. Over half are undeveloped and have the potential to provide more than 3.6 million gravesites. Of the 125 national cemeteries, 62 are open to all interments; 19 can accommodate cremated remains and family members of those already interred; and 41 are closed to new interments.

VA estimates that about 26.6 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, and the Global War on Terrorism, as well as peacetime veterans. With the aging veterans population continuing to climb, nearly 676,000 veteran deaths are estimated in 2008, with the death rate increasing annually and peaking at 690,000 by 2009. It is expected that one in every six of these veterans will request burial in a national cemetery.

The administration requests $160.7 million and 23 additional FTE for NCA for fiscal year 2007. The members of *The Independent Budget* recommend that Congress provide $214 million and 30 FTE for the operational requirements of NCA, the National Shrine Initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed Forces.

In regards to the National Shrine Initiative, 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 the national cemeteries. *The Independent Budget* recommends Congress provide $50 million in fiscal year 2007 to begin a five-year, $250 million program to restore and improve the condition and character of NCA cemeteries.

The National Shrine Initiative is in response to the 2002 *Independent Study on Improvements to Veterans Cemeteries*. Volume 2 of the *Study* identifies over 900 projects for gravesite renovation, repair, upgrade, and maintenance. According to the *Study*, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options and maintenance programs.

The State Cemetery Grants Program:

For funding the State Cemetery Grants Program (SCGP), the members of *The Independent Budget* recommend $37 million for fiscal year 2007, an increase of $5 million over the administration proposal. The State Cemetery Grants Program is an important element to the NCA. It complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans.

Six western states do not have a single national veterans cemetery: Idaho, Montana, Nevada, North Dakota, Utah, and Wyoming. The large land areas and spread out population centers in these and most western states make it difficult for them 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. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1973, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials.

Burial Benefits:

There has been serious erosion in the value of 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.

In 2001, the plot allowance was increased for the first time in more than 28 years, to $300 from $150, which covers approximately six 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, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

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 benefit from $2,000 to $4,100, bringing it up to a proportionate level of burial costs. The non-service-connected burial benefit was last adjusted in 1978, and also covers just six percent of funeral costs. *The Independent Budget* recommends increasing the non-service-connected benefit from $300 to $1,270. These modest increases will make a more meaningful contribution to the burial costs for our veterans.

The NCA honors veterans with a final resting place that commemorates their service to this nation. More than 2.6 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.

David G. Greineder
Deputy National Legislative Director

David Greineder joined AMVETS (American Veterans) on May 10, 2004. As the Deputy National Legislative Director (currently serving as Acting National Legislative Director), he is the primary individual responsible for promoting AMVETS legislative, national security, and foreign affairs goals before the administration and the Congress of the United States.

Prior to assuming his current position, David worked nearly five years on Capitol Hill as a legislative staff aide in the offices of Pennsylvania Reps. George W. Gekas and Timothy F. Murphy. He was a key policy advisor for a wide range of issues, including veterans' affairs, and helped manage federal appropriations efforts in both congressional offices.

David completed undergraduate work at Millersville University of Pennsylvania, where he was an assistant of data collection for the Keystone Poll.

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February 8, 2006

The Honorable Steve Buyer, Chairman
House Veterans' Affairs Committee
Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Buyer:

Neither AMVETS nor I have received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the February 8, 2006, House Veterans' Affairs Committee hearing on the VA's budget request for fiscal year 2007.

Sincerely,

David G. Greineder
Deputy National Legislative Director

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STATEMENT OF
RICK SURRATT
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 8, 2006

Mr. Chairman and Members of the Committee:

I am pleased to have the opportunity to appear before you on behalf of the Disabled American Veterans (DAV), as one of four of the organizations that create *The Independent Budget* (IB) for veterans programs, to discuss some of the IB recommendations for fiscal year (FY) 2007. As you know, the IB is a budget and policy document that sets forth the collective views of the DAV, AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW), with each organization having principal responsibility for a major component of the budget. My testimony will focus primarily on the benefit programs for veterans.

To improve administration of the benefit programs, the IB recommends investments in information technology and training programs, adequate resources to support a long-term strategy for improvement in claims processing, and adequate staffing for the programs under the Veterans Benefits Administration (VBA) of the Department of Veterans Affairs (VA).

With the continually changing environment in claims processing and benefits administration, VBA must continue to upgrade its information technology infrastructure and revise its training tools to stay abreast of program changes and modern business practices, to maintain efficiency, and to meet ever increasing workload demands. In recent years, Congress has provided reduced levels of funding for such VBA initiatives, however. With restored investments in initiatives, VBA could complement staffing adjustments for increased workloads with a support infrastructure designed to increase operations effectiveness. VBA could resume an adequate pace in its development and deployment of information technology solutions, as well as upgrading and enhancement of training systems, to improve operations and service delivery. Some of the initiatives for priority funding are:

- Replacement of the antiquated and inadequate Benefits Delivery Network (BDN) with VETSNET for C&P, The Education Expert System (TEES) for Education Service, and Corporate WINRS (CWINRS) for VR&E

  VETSNET serves to integrate several subsystems into one nationwide information system for claims development and adjudication and payment administration. TEES serves to provide for electronic transmission of applications and enrollment documentation along with automated expert processing. CWINRS is a case management and information system allowing for more efficient award processing and sharing of

information nationwide.

- Continued development and enhancement of data-centric benefits integration with "Virtual VA" and modification of The Imaging Management System (TIMS), which serve to replace paper-based records with electronic files for acquiring, storing, and processing of claims data

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

- Upgrading and enhancement of training systems

  VA's Training and Performance Support Systems (TPSS) is a multimedia, multi-method training tool that applies Instructional Systems Development (ISD) methodology to train and support employee performance of job tasks. These TPSS applications require technical updating to incorporate changes in laws, regulations, procedures, and benefit programs. In addition to regular software upgrades, a help desk for users is needed to make TPSS work effectively.

  VBA initiated its "Skills Certification" instrument in 2004. This tool aids VBA in assessing the knowledge base of Veterans Service Representatives. VBA intends to develop additional skills certification modules to test Rating Veterans Service Representatives, Decision Review Officers, Field Examiners, Pension Maintenance Center employees, and Education Veterans Claims Examiners.

- Accelerated implementation of Virtual Information Centers (VICs)

  By providing veterans regionalized telephone contact access from multiple offices within specified geographic locations, VA achieves greater efficiency and improved customer service. Accelerated deployment of VICs will more timely accomplish this beneficial effect.

Congress has reduced funding for VBA initiatives every year since 2001, from $82 million in FY 2001 to $23 million in FY 2006. The IB calls for restoration of funding for this purpose to the 2001 level, with a 5 percent adjustment for each year to cover inflation and increased demands upon the system. The IB therefore recommends that Congress provide $109.9 million for VBA initiatives in FY 2007.

To overcome the persistent and long-standing problem of large claims backlogs and consequent protracted delays in the delivery of crucial benefits to veterans and their families, VA must invest adequate resources in a long-term strategy to improve quality, proficiency, and efficiency. VA has neither maintained the necessary capacity to match and meet its claims

workload nor corrected systemic deficiencies that compound the problem of inadequate capacity. Rather than making headway and overcoming the chronic claims backlog and consequent protracted delays in claims disposition, VA has lost ground to the problem, with the backlog of pending claims growing substantially larger and benefit awards being delayed.

Historically, many underlying causes acted in concert to bring on this now intractable problem. These dynamics have been thoroughly detailed in several studies into the problem. Most of the causes can be directly or indirectly associated with inadequate resources. The problem was triggered primarily, and is now perpetuated, by insufficient resources.

Insufficient resources are the result of misplaced priorities, in which the agenda is to reduce spending on veterans' programs despite a need for greater resources to meet a growing workload in a time of war and a need for added resources to overcome the deficiencies and failures of the past. Instead of requesting the additional resources needed, the President has sought and Congress has provided fewer resources. Recent budgets have sought reductions in fulltime employees for VBA. Such reductions in staffing are clearly at odds with the realities of VA's workload and its failure to improve quality and make gains against the claims backlog. During congressional hearings, VA is forced to defend a budget that it knows is inadequate.

The priorities and goals of the immediate political strategy are at odds with the need for a long-term strategy by VA to fulfill its mission and the nation's moral obligation to disabled veterans in an effective manner. VA must have a long-term strategy focused principally on attaining quality and not merely achieving production numbers. It must have adequate resources, and it must invest them in that long-term strategy rather than reactively targeting them to short-term, temporary, and superficial gains. Only then can the claims backlog really be overcome. Only then will the system serve disabled veterans in a satisfactory fashion, in which their needs are addressed timely with the effects of disability alleviated by prompt delivery of benefits. Veterans who suffer disability from military service should not also have to needlessly suffer economic deprivation because of the inefficiency of their government.

Adequate staffing is essential to any strategy to get claims processing and backlogs under control. The IB recommends 10,820 FTE for Compensation and Pension Service (C&P). During FY 2004 and FY 2005, the total number of compensation, pension, and burial claims received in C&P increased by 9 percent, from 735,275 at the beginning of FY 2003 to 801,960 at the end of FY 2005. This represents an average annual growth rate in claims of 4.5 percent. During this same period, the number of pending claims requiring rating decisions increased by more than 33 percent. (As the Undersecretary for Benefits has stated, "[c]laims that require a disability rating determination are the primary workload component because they are the most difficult, time consuming, and resource intensive.") With an aging veterans' population and ongoing hostilities in Iraq and Afghanistan, no reason exists to believe that growth rate will decline during FY 2006 and FY 2007. With a 9 percent increase over the FY 2005 number of claims, VA can expect 874,136 claims for C&P in FY 2007. Moreover, legislation requiring VA to invite veterans in six states to request review of past claims decisions and ratings in their cases and to conduct outreach to invite new claims from other veterans in these states will add substantially to the expected increased workload. It is projected that, of the approximately 325,000 veterans receiving disability compensation and the additional estimated 50,000 who will

be invited to file new claims, 15 percent will seek new or increased benefits, resulting in an estimated 56,000 additional claims. Given past claims processing times, much of this workload will carry over into FY 2007, making the new total more than 930,000 claims in FY 2007.

In its budget submission for FY 2006, VA projected production based on an output of 109 claims per direct program FTE. The Independent Budget Veterans Service Organizations have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, resulting in compromised quality, higher error and appeal rates, and even more overload on 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. In response to survey questions from VA's Office of Inspector General, nearly half of the adjudicators responding admitted that many claims are decided without adequate record development. They saw an incongruity between their objectives of making legally correct and factually substantiated decisions and management objectives of maximizing decision output to meet production standards and reduce backlogs. Nearly half reported that it is generally or very difficult to meet production standards without sacrificing quality. Fifty-seven percent reported difficulty meeting production standards if they make sure they have sufficient evidence for rating each case and thoroughly review the evidence. Most attributed VA's inability to make timely and high quality decisions to insufficient staff. They indicated that adjudicator training had not been a high priority in VA.

To allow for more time to be invested in training, we believe it prudent to recommend staffing levels based on an output of 100 cases per year for each direct program FTE. With an estimated 930,000 claims in FY 2007, that would require 9,300 direct program FTE. With the FY 2006 level of 1,520 support FTE added, this would require C&P to be authorized 10,820 total FTE for FY 2007.

To meet its ongoing workload demands and to implement the important new initiatives the VA Vocational Rehabilitation and Employment Task Force recommended, VR&E needs increased staffing. As a part of its strategy to enhance accountability and efficiency, the Task Force recommended creation and training of 200 new staff positions for this purpose. Other new initiatives recommended by the Task Force also require an investment of personnel resources. With its increased reliance on contract services, VR&E also needs approximately 50 additional FTE for management and oversight of contract counselors and employment service providers.

As it has with its other benefit programs, VA has been striving to provide more timely and efficient service to its claimants for education benefits. Though the workload (number of applications and recurring certifications, etc.) increased by 11 percent during FY 2004 and FY 2005, direct program FTE were reduced from 708 at the end of FY 2003 to 675 at the end of FY 2005. Based on experience during FY 2004 and FY 2005, it is very conservatively estimated that the workload will increase by 5.5 percent in FY 2007. VA must increase staffing to meet the existing and added workload, or service to veterans seeking educational benefits will decline. Based on the number of direct program FTE at the end of FY 2003 in relation to the workload at that time, VBA must increase direct program staffing in its Education Service in FY 2007 to 873 FTE, 149 more direct program FTE than authorized for FY 2006. With the addition of the 160

support FTE as currently authorized, Education Service should be provided 1,033 total FTE for FY 2007.

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 accomplish 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. The IB makes a number of recommendations to adjust rates and improve the benefit programs administered by VBA. Some of those recommendations are:

- 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 on policies of Veterans' Mortgage Life Insurance

- legislation to restore protections for veterans' benefits against awards to third parties in divorce actions

We invite the Committee's attention to the section of the IB addressing the Benefit Programs for details on these and other IB recommendations for improvement.

Another important component of our system of veterans' benefits is the right to appeal VA's benefits decisions to an independent court. The IB includes recommendations to improve the processes of judicial review in veterans' benefits matters. Again, we invite the Committee's attention to the IB for the details of these recommendations. In addition, the IB recommends that Congress enact legislation to authorize and fund construction of a courthouse and justice center for the United States Court of Appeals for Veterans Claims.

A continuing major concern is adequate funding for veterans' medical care. Because the Administration typically seeks funding substantially below the amount necessary to maintain medical services for veterans and because discretionary appropriations have continually fallen short of what is needed, the IB supports legislation to fund veterans' medical care under a mandatory account. Ranking Member Lane Evans introduced H.R. 515 for that purpose. His bill has 127 cosponsors, of which 10 cosponsors are members of this Committee. We urge the Chairman to schedule a hearing on this bill.

Because of the timing of this hearing, we were unable to include our views on the President's budget in conjunction with our own recommendations as we have historically done. For the benefit of the Committee, we will therefore provide a written supplement to our testimony to address the President's budget.

In preparing the IB, the four partners draw upon their extensive experience with the workings of veterans' programs, their firsthand knowledge of the needs of America's veterans, and the information gained from their continual monitoring of workloads and demands upon, as well as the performance of, the veterans' benefits system. Historically, this Committee has acted favorably on many of our recommendations to improve services to veterans and their families, and we hope you will give our recommendations full and serious consideration again this year.

STATEMENT OF

CARL BLAKE

SENIOR ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE INDEPENDENT BUDGET

AND THE DEPARTMENT OF VETERANS' AFFAIRS BUDGET

FOR FISCAL YEAR 2007

FEBRUARY 8, 2006

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) health care system for FY 2007.

We are proud that this will mark the 20th year that PVA, along with AMVETS, Disabled American Veterans and Veterans of Foreign Wars, have presented *The Independent Budget*, a comprehensive budget and policy document that represents the true funding needs of the Department of Veterans Affairs. *The Independent Budget* uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year, the document is endorsed by 60 veterans' service organizations, and medical and health care advocacy groups.

We are deeply disappointed that we were not given adequate time to properly analyze and comment on the President's Budget Request for the coming fiscal year prior to this hearing. We believe that it is essential that we have an opportunity to examine policy initiatives and recommendations to provide our insight into how veterans will be affected. With this is mind, we will provide recommendations that we believe will most affectively address the needs of the VA health care system.

Last year proved to be perhaps the most unique year ever in the debate over the VA budget. The VA was forced to admit that it did not have the resources necessary to meet the demands being placed on its health care system. Congress was forced to react quickly and decisively to address this situation. These events served to validate the recommendations made every year, by *The Independent Budget.*

Unfortunately, despite these actions, the VA still faces the real possibility that it will receive inadequate resources in future budgets and the resources they receive will be provided after the

start of the new fiscal year. These factors continue to place enormous stress on the system and will leave the VA struggling to provide the care that veterans have earned and deserve.

The Administration requested $27.8 billion for veterans' health care for FY 2006, a mere $110 million more than funding for FY 2005. This request represented an increase of only 0.4 percent despite the fact that in the past the VA has testified that it requires 13 percent to 14 percent just to meet the demands of inflation and mandatory salary increases.

Once again the President's recommendation attempted to use budget gimmicks, major cuts in long-term care programs, and higher out-of-pocket costs for veterans to cover for its lack of appropriated dollars. The budget request sought to require veterans in Category 7 and 8 to pay a $250 enrollment fee in order to access the health care system each year. The request also included a recommendation to increase prescription drug co-payments by more than double, from $7 to $15, for a 30 day supply. The VA originally estimated that these fees could result in more than 213,000 veterans disenrolling. Overall, more than a million veterans in Categories 7 and 8 would have been affected by these proposals. Fortunately, Congress recognized that these policies were untenable and soundly rejected them.

Faced with growing federal budget deficits, these proposals were part of a concerted effort to save money and reduce discretionary spending in all federal programs, including VA health care. We were deeply concerned with the budget control legislation that was considered by Congress last session that would have placed spending caps on all discretionary programs. These caps would have meant real cuts in funding. Such cuts would likely force the VA to further restrict

enrollment of new veterans seeking access to the system, and could mean staff cuts which would result in longer waiting times for veterans.

Shockingly, the VA acknowledged in June 2005, that it was facing a shortfall of approximately $1.0 billion for veterans' health care funding for FY 2005. During a hearing conducted by this Committee to examine models used to forecast funding needed to provide health care, the VA Under Secretary for Health, Jonathan Perlin, MD, stated that because of flaws with its health care model VA would be transferring approximately $1 billion from other health care accounts in order to continue to meet demand. During subsequent hearings, the Secretary of Veterans Affairs, James Nicholson, explained that the VA was forced to transfer approximately $600 million from operations and non-recurring maintenance and approximately $400 million in funds that were originally made available for transfer for FY 2006 funding. In the end, the VA was provided an additional $1.5 billion through an emergency supplemental.

Part of the reason for the shortfall was the result of the VA underestimating the growth rate of demand on the system. The VA had assumed a growth rate of approximately 2.3 percent when actually the growth rate was closer to 5.2 percent. *The Independent Budget* for FY 2006 projected a growth rate of approximately 5 percent, for close to the true growth rate on the system. Furthermore, VA assumed that only about 23,500 veterans of the global war on terrorism would access the VA for health care services when in fact the total number was closer to 103,000 veterans.

One of the most important points to come out of this process was validation of the recommendations made by *The Independent Budget*. During a press conference held by Chairman Buyer (R-IN), Representative James Walsh (R-NY), Chairman of the House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs, and Secretary Nicholson, Chairman Buyer stated that balanced against other health care models, the *IB's* "best guess was as accurate as I've seen." For being no more than just a "guess," *The Independent Budget* was right on the mark.

For FY 2007, *The Independent Budget* recommends $32.4 billion for VA health care, an increase of $3.7 billion over the FY 2006 appropriation. Unfortunately, the FY 2006 "Military Quality of Life and Veterans' Affairs" appropriations bill was not approved until November 18, 2005. The bill provided approximately $28.7 billion for VA medical care. Although the appropriation provided a significant increase over the Budget Request, it still fell short of the actual resources needed to continue to provide timely, quality care to veterans.

The medical care appropriation includes three separate accounts—Medical Services, Medical Administration, and Medical Facilities—that comprise the total VA health care funding level. For FY 2007, *The Independent Budget* recommends approximately $26.0 billion for Medical Services, an increase of $3.5 billion over the FY 2006 appropriation. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate.....$23,350,760,000
Increase in Patient Workload.....$1,470,817,000
Increase in FTE.....$118,886,000
Policy Initiatives.....$1,050,000,000
Total FY 2007 Medical Services.....$25,990,463,000

In order to develop our current services estimate, we used the Obligations by Object in the President's Budget to set the framework for our recommendation. We believe this method allows us to apply more accurate inflation rates to specific accounts within the overall account. Our inflation rates are based on five-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 6.3 percent increase in workload. The policy initiatives include $500 million for improvement of mental health and long term care services, $250 million for funding the fourth mission, and $300 million to support centralized prosthetics funding. In previous testimony, the VA testified that it is already spending more than $250 million per year on homeland security, emergency preparedness, and fourth mission requirements.

For Medical Administration, the *IB* recommends approximately $2.9 billion. The FY 2006 appropriations bill separated $1.2 billion from this account to create a new Information Technology (IT) account. The new IT account is established as part of General Operating Expenses (GOE). Our recommendation reflects this money being excluded from the Medical Administration account as well. We do recommend approximately $1.3 billion to be included in the GOE account for IT for FY 2007. If the IT funds are added back into the *IB's* recommendation, the Medical Administration recommendation would then be approximately $4.2 billion and the total Medical Care recommendation would be $33.6 billion. Finally, for Medical Facilities the *IB* recommends approximately $3.5 billion

Our health care recommendation does not include additional money to provide for the health care needs of Category 8 veterans being denied enrollment into the system. Despite our clear desire to have the VA health care system open to these veterans, Congress and the Administration have shown little desire to overturn this policy decision. The VA estimates that a total of over 1,000,000 Category 8 veterans will have been denied enrollment into the VA health care system by FY 2007. Assuming a utilization rate of 20 percent, we believe that it would take approximately $684 million to meet the health care needs of these veterans, if the system were reopened. We believe that the system should be reopened to these veterans and this money appropriated on top of our medical care recommendation for this purpose.

For Medical and Prosthetic Research, *The Independent Budget* is recommending $460 million. This represents a $48 million increase over the FY 2006 appropriated amount. Research is a vital part of veterans' health care, and an essential mission for our national health care system. VA research has been grossly underfunded in comparison to the growth rate of other federal research initiatives. We call on Congress to finally correct this oversight.

In order to address the problem of adequate resources provided in a timely manner, *The Independent Budget* has proposed that funding for veterans' health care be removed from the discretionary budget process and made mandatory. The budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of not only how much money it is going to get, but, equally important, when it is going to get it. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient

clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they need them. Making veterans health care funding mandatory would not create a new entitlement, rather, it would change the manner of health care funding, removing the VA from the vagaries of the appropriations process. Until this proposal becomes law, however, Congress and the Administration must ensure that VA is fully funded through the current process. We look forward to working with this Committee in order to begin the process of moving a bill through the House, and the Senate, as soon as possible.

Health care delayed is health care denied. If the health care system cannot get the funds it needs when it needs those funds the resulting situation only fuels efforts to deny more veterans health care and charge veterans even more for the health care they receive. It is easy to forget, that the people who are ultimately affected by wrangling over the budget are the men and women who have served and sacrificed so much for this nation. We hope that you will consider these men and women when you develop your budget views and estimates, and we ask that you join us in adopting the recommendations of *The Independent Budget*.

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

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

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

Fiscal Year 2006

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $252,000 (estimated).

Fiscal Year 2005

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $245,350.

Paralyzed Veterans of America Outdoor Recreation Heritage Fund – Department of Defense – $1,000,000.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $228,000.

William Carl Blake
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Carl Blake is the Senior Associate Legislative Director with Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for federal legislation and government relations, as well as budget analysis and appropriations. He represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, and the Office of Personnel Management. In addition, he represents PVA on issues such as homeless veterans and disabled veterans' employment as well as coordinates issues with other Veterans Service Organizations.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998. He received the National Organization of the Ladies Auxiliary to the Veterans of Foreign Wars of the United States Award for Excellence in the Environmental Engineering Sequence.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the United States Army. He was assigned to the 1st Brigade of the 82nd Airborne Division at Fort Bragg, North Carolina. Carl was retired from the military in October 2000 due to a service-connected disability.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.

STATEMENT OF

DENNIS M. CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA's CONSTRUCTION BUDGET REQUEST FOR FISCAL YEAR 2007

WASHINGTON, D.C. FEBRUARY 8, 2006

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 U.S. (VFW), this nation's largest combat veterans organization, I would like to thank you for the opportunity to testify today on the Fiscal Year 2007 budget for the Department of Veterans Affairs (VA).

Today, I am not just representing the VFW, but also the Independent Budget (IB). The IB is a partnership of four veterans' service organizations, AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the VFW. For today's hearing, the VFW's testimony will be limited to VA's construction programs.

The VA construction budget includes major construction, minor construction, grants for construction of state extended-care facilities, and grants for state veterans' cemeteries. Over the last few years, the construction budget has been overshadowed by the Capital Assets Realignment for Enhanced Services (CARES) process. CARES, which aims to reorganize the VA health care system to properly plan for the future, and, in turn, realize improved health care service for veterans, has been a long and difficult process.

We will continue to support CARES as long as VA returns to its primary emphasis and intent: the "ES" portion of CARES. We accept that locations and missions of some VA facilities may need to change to improve veterans' access, to allow more resources to be devoted to medical care rather than to the maintenance of old buildings, and to accommodate more modern methods of health-care delivery. Accordingly, we concur with VA's plans to proceed with the feasibility studies of the remaining 18 facilities contained in the Secretary's decision document. We note that those processes are moving forward on the local level with establishment of local advisory committees and public

hearings, allowing the veterans, who are stakeholders in this complex process, to have a voice. We support this transparent approach to public policy, and intend to remain active in it.

In July 2004, the previous VA Secretary testified before the Subcommittee on Health of the House Veterans' Affairs Committee. He stated 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."

Using that as a baseline, and accounting for the 18 CARES-related projects being assessed, the IB calls for $860 million to be allocated for CARES projects. We must, however, keep in mind that as projects advance and as ground is broken, funding levels will need to be increased dramatically.

Over the last few years, the funding for major construction has ebbed. This moratorium was caused by the planning of the CARES process. There was much political resistance to funding any projects before the planning process took place. Now that it has occurred, it is time to move forward, and advance this important plan.

Delays cost money. With the rate of construction inflation roughly 9% nationwide (and regionally as high as 35% in some parts of the South), pushing these projects further into the future will only increase the amount of money Congress will need to provide to maintain this nation's commitment to veterans' health care.

Under the major construction account, we are calling for a total investment of $1.447 billion, which includes the CARES funding outlined above:

Construction, Major Appropriation
FY 2007 IB Recommendation
(Dollars in thousands)

CARES	$860,000
Architectural Master Plans Program	100,000
Historic Preservation Grant Program	25,000
Seismic	285,000
Advanced Planning Fund (VHA)	43,000
Asbestos Abatement	6,000
Claims Analyses	3,000
Judgment Fund	10,000
Hazardous Waste	3,000
NCA	89,000
Design Fund	6,000
Advanced Planning Fund	11,000
Staff Offices	6,000
Total, Major Construction	**$1,447,000**

Of particular importance on that list is the funding for seismic corrections. Currently, 890 of VA's 5,300 buildings have been deemed at "significant" seismic risk, and 73 VHA buildings are at "exceptionally high risk" of catastrophic collapse or major damage. We understand that the list of major construction priorities that VA has provided to Congress includes the seven facilities most at risk of damage. Accordingly, this will increase VA's need for construction funding. This is a chance

to be proactive and fix a problem before the health and safety of VA's patients and workers is further compromised.
We also call for funding for an architectural master plan. Without this plan, the benefits of CARES will be jeopardized by hasty and shortsighted construction planning. Currently VA plans construction in a reactive manner—i.e., first funding the project then fitting it on the site. Furthermore, there is no planning process that addresses multiple projects; each project is planned individually. "Big picture" design is critical so that a succession of small projects don't "paint" the facility into the proverbial corner. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. The development of master plans will prevent shortsighted construction that restricts, rather than expands, future options. As the cost of construction rises with inflation, the importance of optimal planning becomes paramount.

We believe that architectural master planning will also provide a mechanism to address the three critical programs that the CARES study omitted. Specifically, these are long-term care, severe mental illness, and domiciliary care. These programs should be addressed as quickly as possible.

For Minor Construction, VFW and the IB are calling for $505 million in funding:

Construction, Minor Appropriation
FY 2007 Recommendation
(Dollars in thousands)

CARES/Non-CARES	$392,000
NCA	32,000
VBA	38,000
Staff	6,000
Advanced Planning Fund	35,000
Inspector General	2,000
Total, Minor Construction	**$505,000**

The funds for minor construction comprise construction projects costing less than $7 million. This appropriation includes funding for the National Cemetery Administration, the Veterans Benefits Administration, and the Inspector General.

As you prepare your views and estimates, and as the entire Congress begins the budget process, there are a few other issues we feel you should keep in mind.

With the reticence over the last few years to provide construction funding, the amount appropriated for maintenance has lagged far behind what has been needed. Price-Waterhouse, following standard industry practices, has recommended that VA spend at least 2-4% of the value of its building for nonrecurring maintenance. These small projects, such as replacing a roof or improving the fire alarm system, are necessary for the safety of patients, but also to maintain the integrity of the building so that it is viable for its entire lifespan. Accordingly, VA should spend no less than $1.6 billion for nonrecurring maintenance in FY 2007.

Further, because maintenance comes out the medical care account, not the construction budget, much of the funding for the last few years has been used to provide medical care. VA needs to cover

deferred maintenance. In fact, according to VA's own assessment, which is conducted on three-year cycles, the investment necessary to bring all facilities currently rated "D" or "F" up to an acceptable level is $4.9 billion. There should not be a choice between fixing a roof and buying medical supplies. It is Congress' job to properly allocate funding for both.

It is also important that VA recapitalize their infrastructure beyond nonrecurring maintenance. Properly reinvesting in facilities extends their useable life, and saves costs over the long run. Both Price-Waterhouse and the American Society of Hospital Engineers say that a 35 to 50-year recapitalization rate is required for VA facilities. Of note, most hospitals rely on a 25-year or less rate of recapitalization. VA traditionally has a historically low rate of recapitalization. From FY 1996-2001, for example, it was just a paltry 0.64% of VA's total plant replacement value. To overcome this shortfall, a minimum of 5-8% investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Congress must ensure that VA has adequate funding to ensure the life of its infrastructure.

Before I conclude, there is one more important issue I would like to raise. Last year's disastrous storms in the Gulf Coast region resulted in the total destruction of the Gulfport VA Medical Center, near-destruction of the New Orleans VA Medical Center, and major damage to other VA facilities in the region. Understand that we have the deepest sympathies for the veterans and VA staff in the Gulf Coast region, but we urge Congress not to allow a diversion of funds VA needs to revamp infrastructure nationwide. The Gulf emergency must be managed with a special allocation outside VA's regular construction and medical care appropriations. It would be patently unfair to delay other projects for lack of funds necessitated by reallocation of available funds to the Gulf Coast region.

Mr. Chairman, FY 2006 has presented major challenges for VA, Congress, and veterans. The unprecedented request for multiple emergency supplementals in 2005 to provide necessary funding for a VA that was rapidly running out of money is a step that none of us want to see again. That is why it is so vitally important that we get things right the first time this year. What we learned last year is that no matter how sophisticated a model one uses to forecast health care, it must account for real word situations and be adaptable to account for any emerging developments.

We thank you for allowing us to testify today, and we would be happy to answer any questions that you or the committee may have.

STATEMENT OF
STEVE ROBERTSON, DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON THE FISCAL YEAR 2007 BUDGETARY RECOMMENDATIONS
OF THE AMERICAN LEGION

FOR THE DEPARTMENT OF VETERANS AFFAIRS

FEBRUARY 8, 2006

Mr. Chairman and Members of the Committee:

This written statement was due to the Committee on February 6, 2006, the same day that the President's budget request was released. The American Legion did not have time to do a thorough analysis and provide appropriate comments; therefore, we request permission to "revise and extend remarks" for the record of this written statement.

On September 20, 2005, The American Legion's newly elected National Commander, Tom Bock presented the views of its 2.7 million members on issues under the jurisdiction of your Committee. At the conclusion of The American Legion's 87th National Convention in Honolulu, Hawaii, over 3,100 delegates adopted 42 organizational resolutions with 36 having legislative intent. These organizational mandates will add to the legislative portfolio of The American Legion for the remainder of the 109th Congress.

As Legionnaires gathered at the National Convention to once again determine the path of the nation's largest veterans' service organization, it was with respect for those who have worn the uniform before us, friendship for those with whom we served and admiration for those who currently defend the freedoms of this great nation. Each generation of America's veterans has earned the right to quality health care and transitional programs available through the Department of Veterans Affairs (VA). The American Legion will continue to work with this Committee and your colleagues in the Senate to ensure that VA is indeed capable of providing "...care for him who shall have borne the battle and for his widow and his orphan."

The American Legion applauds the President's recent letter to the Speaker addressing the $1.225 billion earmarked as "emergency spending" in the FY 2006 VA medical care budget. Clearly, The American Legion supports this decision and appreciates this Committee's efforts in securing additional funding for both the FY 2005 and FY 2006 budgets. These additional dollars replaced funds swapped between other accounts to meet the medical care shortfall. The American Legion believes VA will now see an end to "hiring freezes," no delays in non-recurring maintenance, reductions in medical equipment backlogs, and other "management efficiencies."

With that in mind and on behalf of The American Legion, I reiterate the following budgetary recommendations for VA's discretionary funding in FY 2007:

BUDGET PROPOSALS FOR SELECTED DISCRETIONARY PROGRAMS FOR VA IN FISCAL YEAR 2007

VETERANS HEALTH ADMINISTRATION

($ MILLIONS)	FISCAL YEAR 2006 VA REQ	FISCAL YEAR 2006 TAL	FISCAL YEAR 2006 APPR	FISCAL YEAR 2007 TAL
MEDICAL CARE INCLUDING:				
MEDICAL SERVICES	21972	23279	21322	24768
MEDICAL ADMINISTRATION	4518	4756	2858	5057
MEDICAL FACILITIES	3298	3465	3298	3675
EMERGENCY APPROPRIATIONS			1225	
INFORMATION TECHNOLOGY			1214	
MEDICAL CARE TOTAL	**29788**	**31500**	**29917**	**33500**
MEDICAL CARE COLLECTIONS*				**2100**
MEDICAL AND PROSTHETICS RESEARCH	**438**	**447**	**412**	**469**
GENERAL OPERATING EXPENSES	**1200**	**1800**	**1411**	**1900**
MAJOR CONSTRUCTION/CARES	**353**	**327**	**607**	**343**
CARES DEDICATED FUNDING		**1000**		**1000**
MINOR CONSTRUCTION/CARES	**160**	**261**	**199**	**274**
STATE HOMES CONSTRUCTION	**32**	**124**	**85**	**250**

NATIONAL CEMETERY ADMINISTRATION

($ MILLIONS)	FISCAL YEAR 2006 VA REQ	FISCAL YEAR 2006 TAL	FISCAL YEAR 2006 APPR	FISCAL YEAR 2007 TAL
NCA OPERATIONS	**156**	**274**	**156**	**174**
STATE VETERANS CEMETERIES	**32**	**42**	**32**	**44**

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

MANDATORY FUNDING FOR VETERANS HEALTH CARE

A new generation of young Americans is once again 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 the freedom, liberty and security of us all. Also like those who fought before them, today's veterans deserve the due respect of a grateful nation when they return home.

Unfortunately, without urgent changes in health care funding, new veterans will soon discover their battles are not over. They will be forced to fight for the life of a health care system that was designed specifically for their unique needs. Just as the veterans of the 20th century did, they will be forced to fight for the care each one is eligible to receive.

The American Legion continues to believe that the solution to the Veterans Health Administration (VHA) recurring fiscal difficulties will only be achieved when its funding becomes a mandatory spending item. Funding for VA health care currently falls under discretionary spending within the Federal budget. VA's health care budget competes with other agencies and programs for Federal dollars each year. The funding requirements of health care for service-disabled veterans are not guaranteed under discretionary spending. VA's ability to treat veterans with service-connected injuries is dependent upon discretionary funding approval from Congress each year.

Under mandatory funding, VA health care would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care benefits of enrolled veterans.

The American Legion is pleased to support legislation pending in the 109th Congress that would establish a system of capitation-based funding for VHA by combining the total enrolled veteran population with the number of non-veterans who received services from VHA, then dividing that number into 120 percent of the current VHA budget or to another amount, depending on the bill. This baseline per-capita amount is then adjusted for medical inflation each year and is multiplied by the veteran and non-veteran population for the prior fiscal year to arrive at a total budget for VHA for each succeeding fiscal year. This new funding system would provide the bulk of VHA's Medical Services funding, except funding of the State Extended Care Facilities Construction Grant Program, which would be separately authorized, and third-party reimbursements. Annual funding would be without fiscal year limitation, meaning that any savings VHA realized in a fiscal year would be retained rather than returned to the Treasury, providing VHA with incentives to develop efficiencies and creating a pool of funds for enhanced services, needed capital improvements, expanded research and development and other purposes.

The Veterans Health Administration is now struggling to maintain its global preeminence in 21st century health care with funding methods that were developed in the 19th century. No other modern health care organization could be expected to survive under such a system. The American Legion believes that health care rationing for veterans must end. It is time to guarantee health care funding for all veterans.

MEDICAL CARE COLLECTIONS FUND

The Balanced Budget Act of 1997, Public Law 105-33, established the VA Medical Care

Collections Fund (MCCF), requiring that amounts collected or recovered from third party payers after June 30, 1997 be deposited into this fund. The MCCF is a depository for collections from third-party insurance, outpatient prescription co-payments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the government. In fiscal year 2004, VHA collected $1.7 billion, a significant increase over the $540 million collected in fiscal year 2001. The fiscal year 2005 budget estimate projects $1.9 billion in MCCF collections and the VA fiscal year 2006 budget request called for $2.1 billion to supplement appropriations, a 10.8 percent increase over fiscal year 2005. VA's ability to capture these funds is critical to its ability to provide quality and timely care to veterans.

Government Accountability Office (GAO) reports have described continuing problems in VHA's ability to capture insurance data in a timely and correct manner and raised concerns about VHA's ability to maximize its third-party collections. At three medical centers visited, GAO found inability to verify insurance, accepting partial payment as full, inconsistent compliance with collections follow-up, insufficient documentation by VA physicians, insufficient automation and a shortage of qualified billing coders were key deficiencies contributing to the shortfalls. VA should implement all available remedies to maximize its collections of accounts receivable.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF treasury account, but remain within VHA and are used as operating funds. When developing the agency's budget proposal, the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect on VISNs and VAMCs. Offsetting estimated MCCF funds largely defeats the purpose of realigning VHA's financial model to more closely approximate the private sector. The American Legion opposes offsetting annual VA discretionary funding by the MCCF recovery.

MEDICARE

As do all other citizens, veterans pay into the Medicare system without choice throughout their working lives. A portion of each earned dollar is allocated to the Medicare Trust Fund and although veterans must pay into the Medicare system they cannot use their Medicare benefits to reimburse allowable treatment and services received in VA health care facilities. VA, unlike the Department of Defense or Indian Health Services, cannot bill Medicare for the treatment of allowable Medicare eligible veterans' nonservice-connected medical conditions. This prohibition constitutes a multibillion dollar annual subsidy to the Medicare Trust Fund. The American Legion does not agree with this policy and supports Medicare reimbursement for VHA for the allowable treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES

VA's Capital Asset Realignment for Enhanced Service (CARES) has entered into the final steps of the process - implementation and integration. The CARES decision released in May 2004 directed VHA to conduct 18 feasibility studies at those health care delivery sites where final decisions could not be made due to inaccurate and incomplete information. The 18 studies fall into two broad categories: 1) studies of sites where no specific decisions have been made to date for the delivery of health care, i.e., do we decide to merge these facilities or not; and 2) studies of

sites where the Secretary's decision defines the health care solution to be implemented, i.e., how to best use or re-use the campus as a capital planning decision. VHA contracted Pricewaterhouse Cooper (PwC) to identify and determine the best approach to provide veterans with health care services equal to or better than is currently provided and evaluate in terms of access, quality, and cost effectiveness, while maximizing any potential re-use of all or portions of the current real property inventory. The entire process was scheduled for 13 months with a completion date of no later than February 2006.

One of the components of the CARES Phase II process was stakeholder input. In order to ensure the concept was not lost during the ongoing studies, Local Advisory Panels (LAPs) were set up at each of the study sites. The membership of the LAPs consist of key stakeholders including community leaders, veterans groups, VA affiliated medical schools and VA representation. The LAPs are to hold four public meetings to gather and share stakeholder input during the yearlong studies. Ideally, PwC and LAPs will work together to develop options that PwC will eventually present to the Secretary. The American Legion was concerned when the first meetings had to be pushed back from March to the end of April. This could only mean that the final decision was going to be delayed. VA was already behind their established timeline. When the meetings were finally held, The American Legion was present at every single one. We will ensure our presence at all of LAPs throughout the process. The American Legion intends to hold accountable those who are entrusted to provide the best health care services to the most deserving population – the nation's veterans.

The implementation of the CARES decision promises to be long. VA has estimated that it will require $1 billion per year for the next six years, with continuing substantial infrastructure investments into the future. The American Legion is opposed to CARES funding coming out of the discretionary medical care account. The American Legion believes the CARES implementation must occur in the context of a fully utilized VA health care system. It must take into consideration VA's role in emergency preparedness, organizational capacity for services such as long-term care and Homeland Security. Further, there must be continued oversight of the integration of the CARES process into the strategic planning process. Without that oversight, plans and promised services may be overlooked.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

Major Construction

Over the past several years, The American Legion has testified on the inadequacy of funding for VA's major and minor construction programs. This inadequacy has become even more apparent in light of the congressionally imposed moratorium on construction funding during the CARES process. The American Legion is both relieved and encouraged to see that the first two years worth of VA designated high-priority projects include critically needed seismic corrections to nine vulnerable structures in California and Puerto Rico. The American Legion has consistently expressed its concern about veterans being treated in unsafe facilities. There are over 60 patient care and other related use buildings in danger of collapse or heavy damage in the event of an earthquake. The sorely needed seismic corrections, along with the necessary ambulatory care and patient safety projects, will require a significant increase in funding to address VHA's current major construction requirements. We believe these designated seismic projects, other seismic corrections and life safety upgrades, should be dealt with first on an emergency basis.

VA's list of priority projects for fiscal years 2004 (18 projects) and 2005 (12 projects) will cost an estimated $1.85 billion and $635 million, respectively. Of this, $1 billion is from major construction and CARES appropriations, including $400 million in transfer authority from medical care accounts. The American Legion opposes the use of medical care appropriations for construction and urges Congress to separately and fully fund these projects.

The American Legion recommends $343 Million for Major Construction and a separate $1 billion for the implementation of the CARES recommendations in FY 2007.

Minor Construction

VA's minor construction program has likewise suffered significant neglect over the past several years. The requirement to maintain the infrastructure of VA's buildings is no small task. When combined with the added cost of the CARES program recommendations and the request for minor infrastructure upgrades in several research facilities, it is easy to see that a major increase over the previous funding level is crucial. We question the transfer of prior-year minor construction funds into CARES. During our site visits to all VHA medical centers over the past three years, we noted a recurrent theme in which facilities managers are routinely forced to divert funds from other priorities to repair roofs, replace boilers and upgrade utilities and life safety and other critical systems. The American Legion believes that these funds should be used for the purposes for which they were intended and that the "transfer authority" does not include monies designated for patient care.

The American Legion recommends $274 million for Minor Construction in FY 2007.

THE AGING OF AMERICA'S VETERANS

A landmark July 1984 study, Caring for the Older Veteran, predicted that a "wave" of elderly World War II and Korean Conflict veterans would occur some 20 years ahead of the elderly in the general U.S. population and had the potential to overwhelm the VA Long Term Care (LTC) system if not properly planned for. The most recent available data from VA, 2000 Census-based VETPOP2001Adjusted, show there were 25.6 million veterans in 2002. Of that number, 9.76 million, or 37 percent are aged 65 or older. According to the 2003 National Survey of Veteran Enrollees' Health and Reliance on VA enrolled in VA health care 14 percent of the veteran population was under the age of 45, 39 percent were between the ages of 45 and 64, and 47 percent of veterans were 65 years or older. Compared to the 2001 Survey, in which the age distribution was 21 percent, 41 percent and 39 percent, respectively, it is clear that the "demographic imperative" predicted by the 1984 study is now upon us.

The study cited an "imminent need to provide a coherent and comprehensive approach to long-term care for veterans." Twenty–one years hence, the coherent and comprehensive approach called for has yet to materialize. The American Legion supports a requirement to mandate that VA publish a Long Term Care Strategic Plan.

The Veterans Millennium Health Care and Benefits Act of 1999 provided VA authority to act on these projections. Based on an "aging in place" continuum of care model, VA was mandated to begin providing a variety of non-institutional services to aging veterans, including; home–based primary care, contract home health care, adult day health care, homemaker and home health aides, respite care, telehealth and geriatric evaluation and management.

On March 29, 2002, GAO issued a report that stated that nearly two years after The Millennium Act's passage, VA had not implemented its response to the requirements that all eligible veterans be offered adult day health care, respite care and geriatric evaluation. At the time of GAO's inquiry, access to these services was "far from universal." While VA served about one-third of its 3rd Quarter 2001 LTC workload (23,205 out of an Average Daily Census of 68,238) in non-institutional settings, VA only spent 8 percent of its LTC budget on these services. Additionally, VA had not even issued final regulations for non-institutional care, but was implementing the services by issuing internal policy directives, according to GAO. Of 140 VAMCs, only 100 or 71 percent were offering adult day health care in non-institutional settings.

By May 22, 2003, over one year later, GAO testified before the House Veterans' Affairs Subcommittee on Health that things had not improved and that veterans' access to non-institutional LTC was still limited by service gaps and facility restrictions. GAO's assessment showed that for four of the six services, the majority of facilities either did not offer the service or did not provide access to all veterans living in the geographic service area. GAO summed up the problem nicely when it testified that "[f]aced with competing priorities and little guidance from headquarters, field officials have chosen to use available resources to address other priorities."

In the area of nursing home care, VA is equally recalcitrant in implementing the mandates of the Millennium Act. The Act required VA to maintain its in-house Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001, 11,969 in 2002 and 12,339 beds in 2003. VHA estimates it had 11,000 beds in 2004 and projects only 8,500 beds for fiscal year 2005. VA claims that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act. Providing adequate inpatient LTC capacity is good policy and good medicine. The American Legion opposes attempts to repeal 38 U.S.C. § 1710B(b).

The American Legion believes that VA should take its responsibility to America's aging veterans much more seriously and provide the quality of care mandated by Congress. Congress should do its part and provide adequate funding to VA to implement its mandates.

State Extended Care Facility Construction Grants Program

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans Homes (SVHs) and contracts with public and private nursing homes. The reason for this is obvious; for fiscal year 2004 VA paid a per diem of $59.48 for each veteran it places in SVHs, compared to the $354.00 VA said it cost in FY 2002 to maintain a veteran for one day in its own NHCUs.

Under the provisions of title 38, U.S.C., VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 109 SVHs in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. Grants for Construction of State Extended Care Facilities provide funding for 65 percent of the total cost of building new veterans homes. Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative health care provider to the VA system. The American Legion opposes attempts to place moratoria on new SVH construction grants and .find the $85 million appropriated in H.R. 2528 for fiscal year 2006 unacceptable. State authorizing legislation has been enacted and state

funds have been committed. The West Los Angeles State Veterans Home, alone, is a $125 million project. Delaying this and other projects will result in cost overruns from increasing building materials costs and may lead states to cancel these much–needed facilities.

The American Legion supports increasing the amount of authorized per diem payments to just 50 percent for nursing home and domiciliary care provided to veterans in State Veterans Homes. The American Legion also supports the provision of prescription drugs and over-the-counter medications to State Homes Aid and Attendance patients, along with the payment of authorized per diem to State Veterans Homes. Additionally, VA should allow for full reimbursement of nursing home care to 70 percent service-connected veterans or higher, if the veteran resides in a State Veterans Home.

The American Legion recommends $250 Million for the State Extended Care Facility Construction Grants Program in FY 2007.

MEDICAL SCHOOL AFFILIATIONS

VHA and its medical school affiliates have enjoyed a long-standing and exemplary relationship for nearly 60 years that continues to thrive and evolve to the present day. Currently, there are 126 accredited medical schools in the United States. Of these, 107 have formal affiliation agreements with VA Medical Centers (VAMCs). More than 30,000 medical residents and 22,000 medical students receive a portion of their medical training in VA facilities annually. VA estimates that 70 percent of its physician workforce has university appointments. At some medical schools, 95 percent of medical staff at affiliated VAMCs has dual appointments.

VHA conducts the largest coordinated education and training program for health care professions in the nation and medical school affiliations allow VA to train new health professionals to meet the health care needs of veterans and the nation. Medical school affiliations have been a major factor in VA's ability to recruit and retain high quality physicians and to provide veterans access to the most advanced medical technology and cutting edge research; VHA research has made countless contributions to improve the quality of life for veterans and the general population.

The American Legion affirms its strong commitment and support for the mutually beneficial affiliations between VHA and the medical schools of this nation.

MEDICAL AND PROSTHETICS RESEARCH

VA's Medical and Prosthetic Research Service has a history of productivity in advancing medical knowledge and improving health care not only for veterans, but all Americans. VA research has led to the creation of the cardiac pacemaker, nicotine patch, and the Computerized Axial Tomography (CAT) scan, as well as other medical breakthroughs. Most recently, VA research has shown that an experimental vaccine against shingles prevented about 51 percent of cases of shingles, a painful nerve and skin infection, and dramatically reduced its severity and complications in vaccinated persons who got shingles. Over 3800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects.

The American Legion supports adequate funding for VA research activities, including basic biomedical research as well as bench-to-bedside projects. Congress and the Administration should encourage acceleration in the development and initiation of needed research on conditions

that significantly affect veterans - such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others jointly with the Department of Defense (DoD), the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends $ 469 million for Medical and Prosthetics Research in FY 2007.

HOMELESS VETERANS

VA has estimated that there are at least 250,000 homeless veterans in America and approximately 500,000 veterans experience homelessness in a given year. Most homeless veterans are single men; however, the number of single women with children has drastically increased within the last few years. Homeless female veterans tend to be younger, are more likely to be married, and are less likely to be employed. They are also more likely to suffer from serious psychiatric illness.

Approximately 40 percent of homeless veterans suffer from mental illness and 80 percent have alcohol or other drug abuse problems. It cannot go unnoticed that the increase in homeless veterans coincides with the under-funding of VA health care, which resulted in the downsizing of inpatient mental health capabilities in VA hospitals across the country. Since 1996, VA has closed 64 percent of its psychiatric beds and 90 percent of its substance abuse beds. It is no surprise that many of these displaced patients end up in jail, or on the streets. The American Legion applauds VA's recent plan to restore a good portion of this capacity. The American Legion believes there should be a focus on the prevention of homelessness, not just measures to respond to it. Preventing it is the most important step to ending it.

The American Legion has a vision to assist in ending homelessness among veterans, by ensuring services are available to respond to veterans and their families in need before they experience homelessness. Towards that objective, The American Legion in partnership with the National Coalition for Homeless Veterans created a Homeless Veterans Task Force in the fall of 2002. The mission of the Task Force is to develop and implement solutions to end homelessness among veterans through collaborating with government agencies, homeless providers and other veteran service organizations. In the last two years, 16 homeless veterans workshops were conducted during The American Legion National Leadership Conferences, National Convention and Mid-Winter Conferences. Currently, there are 51 Homeless Veterans Chairpersons within The American Legion who act as liaison to federal, state and community homeless agencies and monitor fundraising, volunteerism, advocacy and homeless prevention activities within participating American Legion Departments. The American Legion Homeless Veterans Outreach Award is presented to the Department that made the greatest effort to end veteran homelessness within their area. At this year's National Convention, the Department of Indiana was presented this award.

The current Administration has vowed to end the scourge of homelessness within ten years. The clock is running on this commitment, yet words far exceed deeds. While less than nine percent of the nation's population are veterans, 34 percent of the nation's homeless are veterans and of those 75 percent are wartime veterans.

Homelessness in America is a travesty. Veterans' homelessness is a national disgrace. Left

unattended and forgotten, these men and women, who once proudly wore the uniforms of this nation's armed forces and defended her shores, are now wandering streets in desperate need of medical and psychiatric attention and financial support. While there have been great strides in ending homelessness among America's veterans, there is much more that needs to be done. We must not forget them. The American Legion supports funding that will lead to the goal of ending homelessness in the next ten years.

Homeless Providers Grant and Per Diem Program Reauthorization

In 1992, VA was given authority to establish the Homeless Providers Grant and per Diem Program under the Homeless Veterans Comprehensive Services Programs Act of 1992, P.L. 102-590. The Grant and Per Diem Program is offered annually (as funding permits) by the VA to fund community agencies providing service to homeless veterans.

The American Legion strongly supports changing the grant and Per Diem Program to be funded on a five-year period instead of annually. The American Legion also supports a funding level increased to the $200 million level annually.

NATIONAL CEMETERY ADMINISTRATION

The National Cemetery Administration (NCA) is charged with meeting the interment needs of the nation's veterans and their eligible dependents. NCA is striving to meet its accessibility goal of 90 percent of all veterans living within 75 miles of open national or state veterans cemeteries. There are approximately 14,200 acres within established installations in NCA. Just over half are undeveloped and, with available gravesites in developed acreage, have the potential to provide more than 3.6 million gravesites. More than 301,050 full-casket gravesites, 58,500 in-ground gravesites for cremated remains, and 37,900 columbarium niches are available in already developed acreage in our 120 national cemeteries.

National Cemetery Expansion

The NCA's budget proposal totaled $459 million and 1,566 FTE for fiscal year 2006. Of the total outlay projected for FY 2006, $170.6 million is for burial benefits, $156 million is for National Cemetery operations and maintenance. The FY 2006 outlay proposal earmarks $90.3 million for major and minor construction. This reflects the cemetery construction mandated by The Veterans Millennium Health Care and Benefits Act, P.L. 106-117, which required NCA to establish six new National Cemeteries. The first, Fort Sill, opened in 2001 under the fast-track program, while the remaining five – Atlanta, Detroit, South Florida, Pittsburgh and Sacramento – are in various stages of development.

The American Legion supported P.L. 108-109, the National Cemetery Expansion Act of 2003 authorizing VA to establish new national cemeteries to serve veterans in the areas of: Bakersfield, Calif.; Birmingham, Ala.; Jacksonville, Fla.; Sarasota County, Fla.; southeastern Pennsylvania; and Columbia-Greenville, S.C. All six areas have veteran populations exceeding 170,000, which is the threshold VA has established for new national cemeteries.

Congress must 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 by locating cemeteries within 75 miles of 90 percent of eligible veterans.

National Shrine Commitment

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding; however, adequate funding is key to maintaining this very important commitment. At the rate that Congress is funding this work, it will take twenty-eight years to complete. The American Legion supports NCA's goal of completing the National Shrine Commitment in five 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.

The American Legion recommends $174 million for the National Cemetery Administration in FY 2007.

State Cemetery Construction Grants Program

The FY 2006 budget requested $32 million for State Veterans Cemetery Grant Program. This is "no-year money" and so any monies not spent in the previous fiscal year can be carried over into the next fiscal year. 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. Currently there are 61 operating state cemeteries in 32 states. In FY 2004, NCA supported State cemeteries provided more than 19,000 interments. NCA currently has 43 active applications for grants to build new state cemeteries and expand existing ones.

Since NCA concentrates its construction resources on large metropolitan areas, it is unlikely that new national cemeteries will be constructed in all states. Therefore, individual states are encouraged to pursue applications for the State Cemetery Grants Program. Fiscal commitment from the state is essential to keep the operation of the cemetery on track. NCA estimates it takes about $300,000 a year to operate a state cemetery.

The American Legion recommends $47 million for the State Cemetery Grants Program in FY 2007.

DEPARTMENT OF LABOR

Veterans' Employment and Training Service

The American Legion's position regarding VETS is that it should remain a national program with Federal oversight and accountability. The mission of VETS is to promote the economic security of America's veterans. This stated mission is executed by assisting veterans in finding meaningful employment. The American Legion views the VETS program as one of the best-kept secrets in the Federal government. It is comprised of many dedicated individuals who struggle to maintain a quality program without substantial increases in both funding and staffing.

Annually, DoD discharges approximately 250,000 service members. Recently separated service personnel are likely to seek immediate employment or continue their formal or vocational education. 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.

The American Legion believes staffing levels for Disabled Veterans' Outreach Program (DVOP) specialists and Local Veterans' Employment Representatives (LVERs) should match the needs of the veteran community in each state and not be based solely on the fiscal needs of the state government. Such services will continue to be crucial as today's active duty service members, especially those returning from combat in Iraq and Afghanistan, transition into the civilian world. Education and vocational training and employment opportunities will enable these veterans to succeed in their future endeavors. Adequate funding will allow the programs to increase staffing to provide comprehensive case management job assistance to disabled and other eligible veterans.

Title 38 U.S.C. § 4103A requires that all DVOP specialists shall be qualified veterans and that preference be given to qualified disabled veterans in appointment to DVOP specialist positions. 38 U.S.C. § 4104(a)(4) states:

> "[I]n the appointment of local veterans' employment representatives on or after July 1, 1988, preference shall be given to qualified eligible veterans or eligible persons. Preference shall be accorded first to qualified service-connected disabled veterans; then, if no such disabled veteran is available, to qualified eligible veterans; and, if no such eligible veteran is available, then to qualified eligible persons."

The American Legion believes that the military experience is essential to understanding the unique needs of the veteran and that all LVERs, as well as all DVOPs, should be veterans.

The American Legion recommends a funding level of $342 million for the Veterans' Employment and Training Service in FY 2007.

CONCLUSION

Thank you for the opportunity for The American Legion to reiterate its budget recommendations for FY 2007. Unfortunately, due to the scheduling of this hearing, The American Legion was unable to make appropriate comments specifically on the President's budget request for FY 2007. The American Legion will submit thorough views and estimates "for the record" following this hearing.

Clearly, The American Legion remains deeply concerned with VA medical funding in recent years. Repeatedly, the President advanced seriously flawed legislative initiatives that undermined the "thanks of a grateful nation." Fortunately, Congress joined the veterans' community in rejecting them. The American Legion will continue to oppose any "enrollment fees" targeted towards a selected group of veterans with the goal of discouraging enrollment or that does not guarantee timely access to quality health care in return.

The American Legion has joined with eight other veterans' service organizations in calling for an immediate fix of the broken annual Federal appropriations process that is budget driven rather than demand driven. In recent years, the Office of Management and Budget's budgetary recommendations to Congress fell well short of the mark. Congress, not OMB, is responsible for providing adequate funding for VA medical care. We do not see lengthy discussions on the "right amount" for funding Social Security benefits, Medicare, Veterans' Compensation and Pension, TRICARE for Life or even your salaries as Members of Congress because they are scored as mandatory funding items and, therefore, an entitlement – funding that is guaranteed.

If an entitlement is a statement of national priority, where should the care and treatment of veterans rank among Federal spending programs?

The American Legion respectfully requests a future Committee hearing on evaluating the best funding methodology for VA medical care. This hearing would also address alternative revenue streams to complement annual Federal appropriations.

Mr. Chairman, that concludes my testimony.

Vietnam Veterans of America

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

TESTIMONY

OF

Vietnam Veterans of America

Submitted By

Rick Weidman
Director of Government Relations

Before the

Committee on Veteran's Affairs
United States House of Representatives

Regarding

The Department of Veterans Affairs
Fiscal Year 07 Budget Request

February 8, 2006

Chairman Buyer, Ranking Member Evans and Members of the Committee, I appreciate the opportunity to come before you today to share Vietnam Veterans of America's views on the fiscal year 2007 budget.

Most of our comments in this statement will concentrate on health care for veterans, as that is the largest and most pressing issue in terms of the magnitude of the need for additional resources. While we comment briefly on the Veterans Benefits Administration (VBA), I draw your attention to the fact that Vietnam Veterans of America (VVA) has endorsed the Independent Budget of the Veterans Service Organizations (IBVSO) although some of our recommended estimates are higher than in that document. VVA is in general accord with the premises of the IBVSO, and the majority of their conclusions. Where we diverge will be clear from our statement below, and there will be more specifics in statements to be delivered to the Committee later this week for the specific hearings in the Subcommittees next week.

Veterans Health Administration

Unfortunately, we are not able to comment in detail on the President's budget submission, as it was not available to the veterans' service organizations before 12:00 noon on Monday, February 6, 2006. However, VVA has just completed an analysis of fiscal needs for 2007 and would like to share some of these key findings.

VA needs a significant infusion of funds in fiscal year 2007—about $6 billion more than its fiscal year 2006 funding level—to compensate for years of flat-lined or inadequate funding at a time when there have been huge increases in veterans' demand and health care inflation. Since VA is compelled to live within its constrained annual increases, Congress must find a way to restore the baseline for its medical care business line. I will discuss options VVA believes are appropriate later.

All veterans must be allowed access to their health care system. VVA calls for the immediate reinstatement of Priority 8 veterans' eligibility for enrollment. Further, veterans must not be subjected to enrollment fees or increased co-payments in order to receive care. VA must be properly funded to allow this to occur.

VA needs more people—about 25,000 more full-time employees—to carry out the responsibilities of its health care system, particularly if it is to once again open its doors to all eligible veterans. If VA had had its way in eliminating some of the Priority 7 and 8 veterans, it would have excluded 1.1 million veterans in fiscal year 2006. Thanks to the help of Congress, including many on this Committee, many of these veterans probably remain enrolled and use VA services—there will likely be about 8 million enrolled and about 5.4 million veterans who use VA health care services in fiscal year 2006. If VA lifted its ban on enrolling new Priority 8 veterans, it will increase these numbers to about 8.4 million enrollees and about 5.9 million users. This is about a 9% increase in utilization, including new use by some veterans—such as new Operations Iraqi Freedom and Enduring Freedom veterans—considered "high priority."

VA must address its current waiting times—according to recent VA statistics about 50,000 veterans can presently be expected to wait more than 6 months for care its increases in demand and expected changes in the intensity of service delivery. It must restore and enhance long-term care services for veterans. Many of newest veterans require dental care of the already overburdened and less than fully modernized dental system, too.

VA must ensure that it has adequate mental health services, not only to meet its current veteran patients' needs, but also to meet the needs of troops returning from Operations Iraqi Freedom and Enduring Freedom. Estimates of the needs of these troops vary, but all are high—from 17-30% may have post-traumatic stress disorder or some other post-deployment issues that require clinical care. In addition to the full range of services for PTSD treatment, a wide range of mental health services must be available to meet these new veterans' needs—from family counseling to substance use disorder treatment to homelessness interventions. In addition, those returning with traumatic brain injuries will result in the need for both significant counseling for the veteran (and the veteran's family) as well as physiological care

Increasing staff levels at the VA Medical Centers to adjust for the intensity of services are necessary and, in fact, was one of the factors cited in the Office of Management and Budget's request for emergency funds. The largest populations of current users are now Vietnam era veterans—there are 8.1 million of us according to VA statistics. Most Vietnam era veterans are between fifty and sixty years old, and age range in which many chronic diseases, some the byproducts of our military experience, are manifested. About 10 million veterans are more than 65 years old—a time when health care utilization is at its peak. VA health care users are also a group—particularly now that potentially wealthier and healthier veterans continue to be prohibited from enrolling—who are more difficult to treat than the general veteran population because of co-morbidities, poverty and social isolation.

These demographics also make the case for rebuilding the once robust long-term care system in the VA. In our view, long-term care includes a range of services from interim rehabilitative care to non-institutional long-term care (such as home and respite care and adult day care), to custodial care which, unless there is considerable improvement in a veteran's health status, should be available throughout the remainder of that veteran's life. Long-term care policy remains a difficult issue to address. VVA will stipulate that VA's oft-cited refrain, "No one wants to live in a nursing home," is true, but unfortunately for some there is no other humane option. Also, unfortunately for America's frailest veterans, VA does not value the role it has played in offering custodial care to those who need it. Every recent budget submission from the Administration has sought to curtail VA's role in providing long-term care. It is not interested in preserving its beds for this mission and sought to eliminate 3,200 long-term care employees in fiscal year 2006. It is now reviewing the law that prohibits it from discharging the most highly service-disabled veterans without their consent.

In FY 2006, the Administration also proposed offloading its role in paying for care for many of the veterans receiving care in state nursing homes. State nursing home directors told Congress that the proposal would cause about 80% of the state homes to close effectively putting to rest a successful partnership between the states and the federal government that has existed for more than 100 years. We want to thank this Committee for its role in helping to shelve these proposals—hopefully for the indefinite future. The emergency funding in fiscal year 2006 sought from VA also requested $600 million for long-term care, perhaps indicating that Congressional pushback may have led the Administration to reconsider its proposals. We hope they do not re-emerge in fiscal year 2007 and that this Committee will remain steadfast in its support of the state homes and the prohibition of eliminating nursing home capacity and treatment mandates for the severely service-connected.

VVA projects that inflation and increased utilization will cost the VA about $1.8 billion in fiscal year 2007. These costs include inflation for pharmaceutical drugs, durable medical equipment and contracted services; the increases for these items are likely to exceed general inflation.

We want to thank Congressman Evans for his joint request with Senator Akaka for the Government Accountability Office's recent report "Limited Support for VA's Efficiency Savings." Looking at per capita costs for VA compared to the general population and Medicare enrollees, there can be no doubt that VA is an efficient provider. In fact, resources have become far too spare in an environment with costs that are often increasing at double the rate of non-medical items and in which users have almost doubled in the last decade. According to GAOs report, there was never a basis for the efficiencies VA claimed to find in fiscal years 2003 and 2004 the President was simply unwilling to request the funds that were necessary to support veterans' growing demand. This sham, now uncovered, must not be allowed to continue in fiscal year 2007.

In the last few years, VA has spent millions of dollars on a plan to restructure the VA health care system's capital assets. There was extensive study, although some of us believed it was flawed because a civilian health care formula and not a veteran's health care formula was employed. Even with the absence of mental health and long-term care in its models—the report called for about $6 billion to be invested in the system, VVA believes this indicates the magnitude of the problem of a crumbling infrastructure for the most part built in the 1940s and 50s.

The promises of CARES seem far from fulfillment as medical facilities coffers continue to be robbed to pay for medical services operations. It must be disheartening for the hard-working and dedicated employees of VA to compare the state of many of their facilities to those in the community. Some of VA's hospitals are barely maintaining accreditation because they cannot meet privacy and access standards because of overcrowding. VA has delayed vital capital equipment purchases and non-recurring maintenance projects in order to fund veterans' health care. This must cease. Dilapidated and over-crowded facilities are symbolic to veterans of the lack of commitment the federal government has to those who have served or would serve their

nation. We must do better. Congress should include at least $1.5 billion for medical facilities in fiscal year 2007.

If Congress enacts an appropriation that provides for these basic adjustments—what we consider an adequate budget for VA in fiscal year 2007—it should then seriously consider how it intends to fund VA in the future. VVA is a member of the Partnership for Veterans' Health Care Budget Reform and believes that assured funding is the best and most straightforward response to the funding dilemma the Administration and Congress confront every fiscal year.

Assured funding means a budget that grows with the beneficiary population and medical inflation and is provided to VA automatically each fiscal year. It would create a funding stream that is predictable and timely, aiding the efforts of VA planners and managers. It would ensure funding for those the Administration and Congress agreed should be served. We would hope this would include all honorably discharged veterans who choose to seek care from the VA.

VVA is in the process of finalizing an updated version of our White Paper on Health Care Funding for All Veterans. This document will fully justify our continued call for major budget reform and explain how vital it is to the sustenance of the unique health care resource that has been created for America's veterans. Mr. Chairman, we respectfully ask that you hold hearings on this important subject, and we hope in this fiscal year we can once again see some bipartisan progress in achieving this important goal.

VVA will also have additional specifics that we will share with you in our statement for the Subcommittee on Health hearing next week. These will include report language that we urge you request be included with the appropriations bill.

Veterans Benefits Administration

VVA believes that there is much more that can be done with the funding for the Veterans Benefits Administration (VBA) to achieve better training, supervision, and greater accountability using existing legal means. Having said that, VVA still believes that there are not enough adjudicators in the Compensation & Pension system, and that as many as 300 FTE are needed in addition to those they have recently hired.

Further, VVA strongly believes that the VA Vocational Rehabilitation system is grossly understaffed, particularly in rural areas: Consider that 60% (when considering the National Guard and the Reserves as well as the active duty troops) of those serving in Operation Iraqi Freedom and Operation Enduring Freedom are from rural areas. We need much better coverage of those areas.

Further, we need the right people with the right skills in these vocational rehabilitation jobs who will concentrate on helping veterans, particularly disabled veterans, obtain and sustain meaningful employment at a living wage. Although we are certainly not

suggesting that we do away with service-connected compensation, or reduce it from what is already a low base, but we owe those who serve more.

We clearly cannot rely on the state work force development agencies to get the job done for veterans, particularly disabled veterans and returning servicemembers, despite the often-heroic actions of staffers (who just keep trying, no matter how little encouragement they often receive from management). There is simply no means within that system to ensure that the veterans staff are doing their job, that the rest of the staff at the one-stop centers are doing their job, or that the Jobs for Veterans Act is being properly implemented at the state and local level. So, that is largely because the Act has not been properly implemented at the national level. Therefore, we need to concentrate at the moment on something we can effect, and seek to have the VA Vocational Rehabilitation system do a much better job helping disabled veterans find and keep decent jobs. This will take additional staff, in addition to further proper training, as well as more effective supervision and greater means of accountability.

Mr. Chairman, this concludes our written comments. Again, VVA thanks you for the opportunity to present our views to you on this vital issue of resources. I will be happy to answer any questions you or your distinguished colleagues may have.

VIETNAM VETERANS OF AMERICA
Funding Statement
February 8, 2006

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
Director of Government Relations
Vietnam Veterans of America.
(301) 585-4000, extension 127

RICHARD WEIDMAN

Richard F. "Rick" Weidman serves as Director of Government Relations on the National Staff of Vietnam Veterans of America. As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam War, including service with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Service Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo (NY) as statewide director of veterans' employment & training (State Veterans Programs Administrator) for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans (NCHV), and served at various times on the VA Read adjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities - Subcommittee on Disabled Veterans, Advisory Committee on veterans' entrepreneurship at the Small Business Administration, and numerous other advocacy posts in veteran affairs. He currently serves as Chairman of the Task Force for Veterans Entrepreneurship (TFVE), which has become the principal collective voice for veteran and disabled veteran business owners.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veterans affairs. He attended Colgate University (B.A., (1967), and did graduate study at the University of Vermont.

He is married and has four children.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
February 10, 2006

The Honorable Steve Buyer
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

During the hearing on the Department of Veterans Affairs (VA) budget, Congresswoman Berkley suggested that my office had not been responsive to a call from her. Upon examination, that does not seem to be the case, and I have so informed her by the enclosed letter.

Would you please include this letter in the record of the hearing so that it accurately reflects the situation?

VA makes every effort to be responsive to Members of Congress and their staffs. We do this at multiple levels—from staff in our Hill liaison offices, in the Office of Congressional and Legislative Affairs, and in other offices within the Administrations to staff in my own office.

Sincerely yours,

R. James Nicholson

Enclosure

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
February 10, 2006

Commemorating 75 Years of Service

The Honorable Shelley Berkley
U.S. House of Representatives
Washington, DC 20515

Dear Congresswoman Berkley:

I was concerned about your comment at the Department of Veterans Affairs (VA) budget hearing suggesting that I did not respond to a call you had made to my office. As I mentioned, I was unaware of any such call. Indeed, upon returning to the office, I queried my immediate staff, and they had no record or recollection of your call. I also inquired of our Executive Secretariat. Staff there answers the telephones in the evening, after normal duty hours. They also have no record of your call.

I do want you to know that I take your position as a Member of Congress and a member of the Veterans' Affairs Committee seriously. I can assure you that, had I known of your call, I would have responded to you with alacrity.

On Friday, February 3, 2006, VA's General Counsel, Tim McClain, called and spoke directly with Ms. Shannon Von Feldon of your staff regarding the situation with construction funding in Las Vegas for fiscal year 2007. Mr. McClain also made calls to the offices of the other members of the Nevada delegation, including Senators Reid and Ensign, and to the staff directors of VA's authorizing oversight committees.

On Tuesday, February 7, 2006, at approximately 11:30 a.m., I received a call from Senator Ensign. He inquired about the reasons for the increase in project cost and the fiscal year 2007 construction budget. As I stated, I never received a call from you or your office. At approximately 3 p.m. on that day, Mr. McClain received a call from Ms. Von Feldon. At the time, Mr. McClain was in a meeting with me. Upon return to his office at 5:30 p.m., he called Ms. Von Feldon and answered her questions regarding the breakdown of increased costs for the project. I do not consider this to be an unreasonable response time on the part of my staff.

Because I take this matter seriously, and because I would not wish the record to stand with the implication that my office had not responded to you or your office when you called, I am taking the liberty of sending a copy of this letter to Chairman Buyer and asking that it be made a part of the hearing record.

Sincerely yours,

R. James Nicholson

Claims to FTE Ratios (4)
Sorted by Combined Ratio of Rating Claims and Appeals to Employees

	Pending Rating Issues End of FY 2005	Pending Appeals End of FY 2005	Service Center FTE End of FY 2005	Ratio of Rating Claims to FTE	Combined Ratio of Rating Claims and Appeals to FTE (Total number of claims and appeals for each regional office employee)
Washington Regional Office	1,139	154	37.0	30.8	34.9
Fargo VAMROC	1,155	165	35.9	32.2	36.8
Salt Lake City Regional Office	2,287	258	67.5	33.9	37.7
Manila Regional Office	1,782	988	69.0	25.8	40.1
Jackson Regional Office	2,816	1,643	110.8	25.4	40.2
Sioux Falls VAMROC	1,293	73	32.0	40.4	42.7
Manchester Regional Office	1,021	403	32.6	31.3	43.7
Muskogee Regional Office	5,378	1,665	159.0	33.8	44.3
Boise Regional Office	1,558	452	44.0	35.4	45.7
San Juan Regional Office	2,703	1,865	99.1	27.3	46.1
Columbia Regional Office	5,248	2,092	156.7	33.5	46.8
White River Junction VAMROC	768	93	18.0	42.7	47.8
Lincoln Regional Office	2,578	792	68.4	37.7	49.3
St. Paul Regional Office	4,669	722	106.1	44.0	50.8
Milwaukee Regional Office	4,095	1,832	116.0	35.3	51.1
Hartford Regional Office	1,722	651	44.9	38.4	52.9
Philadelphia Regional Office	6,047	2,409	155.7	38.8	54.3
Little Rock Regional Office	3,979	1,720	99.5	40.0	57.3
Providence Regional Office	1,270	849	37.0	34.3	57.3
Nashville Regional Office	7,349	3,342	181.1	40.6	59
Phoenix Regional Office	7,199	1,515	147.0	49.0	59.3
Togus VAMROC	2,843	525	54.0	52.6	62.4
St. Louis Regional Office	6,762	3,184	159.1	42.5	62.5
St. Petersburg Regional Office	23,151	6,269	464.5	49.8	63.3
Waco Regional Office	16,564	6,986	369.5	44.8	63.72
Fort Harrison VAMROC	1,633	470	32.9	49.6	63.9
Winston-Salem Regional Office	17,639	3,811	327.7	53.8	65.5
Seattle Regional Office	8,572	3,274	179.8	47.7	65.9
New Orleans Regional Office	7,006	2,795	147.3	47.6	66.5
USA	346,292	60,699	3,260.2	50.8	67.2
Albuquerque Regional Office	3,626	1,053	68.8	52.7	68
Indianapolis Regional Office	4,751	2,530	106.8	44.5	68.2
Oakland Regional Office	10,426	3,295	200.5	52.0	68.4
Roanoke Regional Office	10,526	2,277	183.9	57.2	69.6
San Diego Regional Office	7,810	2,150	142.5	54.8	69.9
Denver Regional Office	6,861	2,008	125.1	54.8	70.9
Wichita VAMROC	3,631	736	61.4	59.1	71.1
New York Regional Office	8,002	1,444	132.6	60.3	71.2
Pittsburgh Regional Office	5,544	925	90.1	61.5	71.8
Reno Regional Office	3,678	849	62.9	58.5	72
Detroit Regional Office	7,993	1,752	133.7	59.8	72.9
Anchorage VAMROC	1,542	290	25.0	61.7	73.3
Newark Regional Office	3,828	1,746	74.6	51.3	74.7
Buffalo Regional Office	5,428	1,460	90.9	59.7	75.8
Baltimore Regional Office	5,570	1,192	88.8	62.7	76.1
Atlanta Regional Office	12,838	3,795	217.2	59.1	76.6
Wilmington VAMROC	996	411	18.0	55.3	78.2
Honolulu VAMROC	2,734	725	43.9	62.3	78.8
Los Angeles Regional Office	9,836	3,987	174.5	56.4	79.2
Cleveland Regional Office	12,574	2,793	193.4	65.0	79.5
Louisville Regional Office	6,857	3,526	123.5	55.5	84.1
Chicago Regional Office	10,953	2,201	153.1	71.5	85.9
Huntington Regional Office	3,792	2,100	68.2	55.6	86.4
Houston Regional Office	19,125	6,286	281.8	67.9	90.2
Boston Regional Office	5,294	1,586	74.5	71.1	92.3
Des Moines Regional Office	4,191	1,329	57.8	72.5	95.5
Portland Regional Office	7,023	3,351	108.2	64.9	95.9
Montgomery Regional Office	10,637	4,902	158.5	67.1	98

Data Prepared by the Office of Field Operations
January 20, 2005

Section C5 (v1)
Enrollment Suspension and Disenrollment Policy

The enrollment projection model has the built-in capacity to project the impact of changes in enrollment policy involving the suspension and/or disenrollment of specified priority levels on a specified date. This feature enables VHA to evaluate the impact of future policy changes as they are proposed.

In certain conceivable enrollment policy scenarios, changes in enrollment policy for one priority level can temporarily or permanently affect enrollment in another priority level. For example, if new enrollment in Priority Level 7 is suspended, new enrollment in Priority Level 5 will increase during the first year of suspension. This occurs since a portion of the suspended Priority Level 7 veterans are assumed to become eligible and enroll for the first time as Priority Level 5. Without a suspension policy, those veterans would have enrolled as Priority Level 7. When providing projection data related to scenarios involving these features, projections for all priority levels are produced for VA in order to avoid ambiguity.

The enrollment projection model contains a sub-model to determine the effects of enrollment policy changes. This sub-model expands the standard categorization of veterans from Enrolled and Not Enrolled to

- Enrolled,
- Applied but Not Eligible or Un-Enrolled,
- and Not Enrolled.

By specifically tracking those who apply for enrollment, but are denied (e.g., Priority Levels 8e and 8g in MEF), as well as those who are un-enrolled, the effects of subsequent priority transitions and geographic migrations are readily incorporated. Presumably, those who have been un-enrolled or denied eligibility to enroll will be very likely to enroll in the future if their eligibility status changes. Therefore, the model is currently designed to assume that all un-enrolled veterans, and all veterans who applied but were ineligible will immediately enroll if at any time in the future their eligibility status changes.

This report and all of the associated databases and summary reports were produced for the internal use of the Department of Veterans Affairs. If any portion of this report or the associated databases is released, reference must be made to the entire report. If this report or associated databases are released to parties outside the government, Milliman, Inc. does not accept liability to any such third party.

Model Limitations

The analyses in this report rely in part on data and other listings provided by various personnel at VA. That data has been reviewed for reasonableness and compared to past data submissions and other information, when possible. The information has not been audited by Milliman for accuracy. If the data or other listings are inaccurate or incomplete, this analysis may also be inaccurate or incomplete.

Some of the information in this analysis is based on modeling assumptions and historic data. Estimates presented in this report will only be accurate if future experience exactly replicates those data and assumptions used in this analysis. Actual experience will likely vary from this analysis to a degree for a number of reasons. In addition, many of the modeling variables are assumed to be constant over time. Therefore, emerging experience should be continually monitored to detect whether expectations based on this analysis are appropriate over time.

The results contained in this report are projections. It is impossible to determine how world events will unfold. Those events that impact the economy and the use of the nation's military may have a profound impact on enrollment and expenditure projections into the future. The analysis has not attempted to present results for events where data is not yet available to consider their impacts on enrollment and expenditures. It is important that actual enrollment and costs be monitored and the projections updated regularly based on this changing environment.

This report and all of the associated databases and summary reports were produced for the internal use of the Department of Veterans Affairs If any portion of this report or the associated databases is released, reference must be made to the entire report If this report or associated databases are released to parties outside the government, Milliman, Inc. does not accept liability to any such third party.

Attachment 3

Priority 8 Veterans Denied Enrollment
Due to January 17, 2003 Enrollment Decision

State	Fiscal Year[1] 2003	2004 Cumulative[2]	2005 Cumulative[3]
AK	233	406	578
AL	1,755	3,732	5,004
AR	1,737	3,596	4,983
AZ	2,119	4,095	5,835
CA	6,967	13,407	17,378
CO	1,153	2,611	3,599
CT	989	2,048	2,651
DC	59	125	164
DE	274	598	877
FL	8,834	20,292	27,465
GA	2,539	5,170	7,062
HI	293	512	710
IA	1,764	3,697	4,762
ID	483	1,100	1,608
IL	3,005	6,317	8,944
IN	2,285	4,301	5,700
KS	1,052	2,165	2,878
KY	1,640	3,280	4,506
LA	1,665	3,399	4,893
MA	1,445	2,680	3,509
MD	1,143	2,158	3,051
ME	588	1,785	2,403
MI	2,175	4,243	5,942
MN	1,655	4,124	5,319
MO	2,118	4,027	5,552
MS	1,672	3,277	4,308
MT	697	1,484	1,956
NC	3,536	7,580	10,405
ND	345	750	927
NE	675	1,506	1,991
NH	444	1,049	1,434
NJ	1,870	3,503	4,808
NM	612	1,367	1,851
NV	541	1,445	2,111
NY	3,258	6,635	9,357
OH	3,269	6,827	9,764
OK	1,437	2,883	4,013
OR	1,557	2,995	4,162
PA	5,385	9,926	13,262
RI	466	878	1,045
SC	1,968	3,972	5,964
SD	350	902	1,201
TN	1,898	4,196	6,165
TX	6,829	13,834	19,204
UT	514	1,005	1,361
VA	1,897	3,839	5,459
VT	261	528	751
WA	1,446	3,096	4,584
WI	2,394	5,163	6,622
WV	922	1,862	2,550
WY	268	565	777
Other/ Unknown	747	1,484	1,852
Total	93,228	192,419	263,257

[1] Totals are cummulative and do not include enrollees who were initially denied enrollment and subsequently enrolled in an eligible priority.
[2] Does not include ineligible enrollees who died prior to FY 2004.
[3] Does not include ineligible enrollees who died prior to FY 2005.
Data Source: End of Year Enrollment Files (sep03,sep04,sep05)

Attachment 1
Enrollment Priority Groups Health Care Fact Sheet

Department of Veterans Affairs

VA Health Care Enrollment Priority Groups

Enrollment Priority 1
- Veterans with service-connected disabilities rated 50% or more disabling

Enrollment Priority 2
- Veterans with service-connected disabilities rated 30% or 40% disabling

Enrollment Priority 3
- Veterans who are former POWs
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Enrollment Priority 4
- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

Enrollment Priority 5
- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Enrollment Priority 6
- World War I veterans
- Mexican Border War veterans
- Compensable 0% service-connected veterans
- Veterans solely seeking care for disorders associated with:
  - exposure to herbicides while serving in Vietnam; or
  - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  - for disorders associated with service in the Gulf War;
  - for illness possibly related to participation in Project 112/SHAD; or
  - for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998

Enrollment Priority 7
Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and income below the HUD geographic index
- Subpriority a: Noncompensable 0% service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans not included in Subpriority a above
- Subpriority g: Nonservice-connected veterans not included in Subpriority c above

Enrollment Priority 8
Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and the HUD geographic index
- Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003

Additional Information:
The term service-connected means, with respect to a condition or disability, that VA has determined that the condition or disability was incurred in or aggravated by military service. Some veterans may have to agree to pay copayments to be placed in certain priority groups.

Questions for the Record
Chairman, Ranking Democratic Member Lane Evans
House Committee on Veterans' Affairs

January 13, 2006

Pre-Hearing Questions in Preparation for the Committee's Consideration of the President's Budget for Fiscal Year 2007

Question 1: Please provide for fiscal years 2004 through 2005, the number of claims processed in each regional office in each year for each separate program: compensation (provide separate data concerning the number of claims involving 8 or more issues and 7 issues or less); dependency and indemnity compensation (DIC); disability pension; pension based upon age, death pension, and: in each RPO, the number of education claims processed, claims, pending and average length of time to complete processing of claim.

Response: See attached spreadsheet.

Question 2: Please provide for each regional office and the Appeals Management Center the number of remanded appeals pending as of September 30, 2005, the date the Notice of Disagreement was filed the date of each remand by the Board of Veterans Appeals and the current status of the claim.

Response: Two separate spreadsheets are provided for the regional offices and for the Appeals Management Center with the requested information about the number of remanded appeals pending as of September 30, 2005, the date the notice of disagreement was filed, and the date of each remand by the Board of Veterans' Appeals.

We are not able to provide the current status of the claims since this requires review of more than 18,000 individual records that comprise the remanded appeals pending at the regional offices and the Appeals Management Center.

Question 3: Please provide the methodology and rationale for allocating resources to the six regional offices with the highest ration of pending claims to full time employee (FTEE) and the six regional offices with the lowest ratio of pending claims to FTEE. Please include data on the number and type of FTEE at these offices, the number of pending claims and pending appeals for each such regional office as of the end of Fiscal Year 2005 and the total number of new claims (by type compensation, pension, DIC, death pension) for each such office in Fiscal Year 2005.

Response: Our resource allocation model does not allocate staffing based on pending work or on the ratio of pending work to staffing levels. The model allocates staffing levels based on four factors: 1) volume of incoming claims work, including compensation and pension claims, telephone inquiries, and non-rating claims; 2) accuracy of completed work; 3) performance on appeals measures; and 4) performance on timeliness measures. To minimize large variations in staffing allocations from year to year, the model employs a two-year average for each of these factors.

The volume of incoming claims is given the greatest weight as the most important factor driving staffing requirements. The use of accuracy and timeliness measures provides a level of accountability for both employee productivity and the quality of service delivery. The appeals factor is derived from both output and timeliness measures and assesses the effectiveness of appellate workload management.

The resource allocation model considers the impact of workload and performance in determining regional office staffing levels. However, it is not viewed as an absolute standard for final staffing decisions. Veterans Benefit Administration (VBA) leaders use the model as a guide, but then make some adjustments for special circumstances or unique missions performed by a regional office. To assist regional offices experiencing workload difficulties, we broker claims that are ready for a decision to designated resource centers and to offices with higher capacity to finalize claims.

The attachment provides data on pending inventories and on-board staffing levels for all regional offices as of the end of fiscal year 2005. Data on claims receipts by benefit type is also provided.

Question 4a: Please provide data concerning the number of claims received from veterans who served in the theater of operations for Operation Enduring Freedom and Operation Iraqi Freedom and their survivors and the disposition (grant, denial) of such claims for compensation, pension, DIC and death pension. Additionally, please provide the number of education claims filed under Chapter 1607 or the REAP program.

Response: Department of Veterans Affairs (VA) identifies Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) returning service members through data sharing with Department of Defense. The most recent information we have identifies returning OEF/OIF service members discharged through November 30, 2005. We matched this information with our disability compensation and pension benefits information systems. We identified 75,162 veterans with a service-connected disability (0 percent to 100 percent) or receiving pension benefits; 9,740 veterans whose claims have been denied; and 38,854 veterans with

pending disability claims. It is important to recognize that many veterans with service in the Afghanistan and Iraq theaters also served during a prior period. Our data systems do not collect information that would allow us to determine which of these veterans claimed service-connected disabilities as a result of service in OEF/OIF. We do not currently stratify the match to count survivors under the death pension or dependency and indemnity compensation (DIC) programs.

Question 4b: Additionally, please provide the number of education claims filed under Chapter 1607 or the REAP program.

Response: As of January 14, 2006, the number of REAP applications received was 10,283.

Question 5: Please provide information concerning the number of FTEE assigned to the Board of Veterans Appeals and the Group 7 staff assigned to represent the Secretary at the Board and the ration of staff to pending appeals at the Board and the Court respectively.

Response: The Board of Veterans Appeals (Board) is authorized 434 full time employee (FTE) in fiscal 2006. On January 24, 2006, 40,981 appeals were pending before the Board. The number of appeals pending before the Board includes the number of appeals physically at the Board (32,535) plus those appeals still in the field that the field offices have identified as ready for a Board hearing (8,446). Accordingly, the ratio of staff to pending appeals at the Board is 1 to 94.

There are 95 FTE currently assigned to Professional Staff Group VII (PSG VII), the Veterans Court Litigation Group.

During fiscal 2005, PSG VII received a total of 4,364 new cases. That number was comprised of 3,322 new appeals from Board of Veterans' Appeals decisions, 135 new petitions for extraordinary relief, and 907 new applications for attorney fees under the Equal Access to Justice Act.

On October 1, 2005, the start of fiscal 2006, there were 3,531 pending appeals at PSG VII. By "pending appeal", we refer to cases assigned to PSG VII in which the dispositive pleading on behalf of the Secretary had yet to be filed with the Veterans Court. Accordingly, the ratio of staff (95) to pending cases (3,531) is approximately 1 to 37.

Question 6: Please provide a list of the number of cases in which the Secretary requested more than one extension of time for the same specific filing (such as record on appeal, brief or motion) in the Untied States Court of Appeals for Veterans Claims for cases which were filed in fiscal year 2005.

Response: Owing to limitations in our computerized case-tracking system, we are unable to provide a list of cases in which the Secretary of Veterans Affairs requested more than one extension of time for the same specific filing during fiscal 2005. Nonetheless, we offer the following data that represents more generally the number of extension motions filed by PSG VII on behalf of the Secretary.

For illustrative purposes, there are three critical stages in the litigation process that consume the most of the Secretary's time. These stages are: designation of the record; transmission of the record; and briefing. In fiscal 2005, PSG VII filed 2,459 designations of the record, and 1,239 extension motions for the purpose of designating the record. During the same period, PSG VII filed 2,034 transmissions of the record, and 471 extension motions for the purpose of transmitting the record. Finally, PSG VII filed 906 briefs in fiscal 2005, and 1,740 extension motions for the purpose of briefing the case.

Given the Committee's interest in the subject of extension motions, it is worth noting that under the Veterans Court's Rules of Practice and Procedure, the total time for filing a pleading cannot be extended for longer than 45 days. Hence, even if two or more extension motions were filed respecting a particular pleading (such as record on appeal, brief, or motion), the total amount of extension time cannot exceed 45 days.

Question 7: Please provide an update on the Hines BDN succession/staffing plan, including the number of FTEE and contractors assigned to specific BDN on-going functions and specific VETSNET functions.

Response: The Hines succession plan includes retention bonuses for key personnel (reviewed yearly), hiring and training additional personnel, and use of contractors. Inherent to the succession plan is simplifying the technical environment for BDN, streamlining batch processing, and keeping changes to the system to a minimum. In 2005, 144 FTE were assigned to BDN and 95 FTE to VETSNET. In 2005, two BDN COBOL programmers were replaced with contractors, and we added a career intern. All VETSNET contracts are fixed–price with specified deliverables, and the contractors provide a range of resources. VETSNET contractors include 25-30 developers and 10-15 testers.

Question 8: Please provide an update to the National Cemetery Administration's strategic plan concerning national cemetery repair and maintenance efforts, including costs for activities completed in Fiscal Year 2005 and cost estimates for activities anticipated for Fiscal Year 2006.

Response: The National Cemetery Administration (NCA) is using a multi-faceted strategy to address cemetery maintenance and repair needs. In August 2002, as required under the Veterans Millennium Health Care and Benefits Act, Public Law Number 106-117, section 613 (1999), we forwarded to Congress a

report entitled "Volume 2, National Shrine Commitment", which provides a comprehensive assessment of VA's national cemeteries. The report identified the need for 928 repair projects at an estimated cost of $280 million to ensure a dignified and respectful setting appropriate for each national cemetery. NCA is using the information and data provided in the report to plan and accomplish the repairs needed at each cemetery. Through fiscal year (FY) 2005, NCA has completed work on 208 projects, and initiated work on additional projects, with an estimated cost of $88 million.

NCA has also developed additional performance metrics that will be used to improve the appearance of its national cemeteries. Baseline data was collected in 2004 for three new performance measures designed to assess the condition of individual gravesites, including the cleanliness and proper alignment of headstones and markers. With this baseline data, NCA has identified the gap between current performance and the strategic goal for each measure.

Approximately 36 percent of the discretionary budget for burial programs is used for the maintenance of national cemeteries as national shrines. This includes mowing and trimming, routine maintenance as well as repair projects to improve cemetery appearance. The FY 2006 budget includes $96 million for national cemetery maintenance. This includes $20 million, for gravesite renovation and infrastructure repairs.

The report includes an extensive database of condition assessment information. This data is used in the planning process to assist in prioritizing repair projects over a multi-year period. NCA evaluates the problem categories and the severity of problems within each category. Data from NCA's Annual Survey of Satisfaction with National Cemeteries is also used to factor in the viewpoint of veterans and their families when determining project priorities.

Repairs to address long-standing deferred maintenance needs are addressed in a variety of ways. Gravesite renovation projects to raise, realign and clean headstones and markers and to repair sunken graves will continue to be a high priority in allocating operational resources. Infrastructure improvements to buildings, roads, irrigation systems and historic structures are addressed with capital expenditures through the major and minor construction programs. In addition, cemetery staff will be used to complete some repairs.

NCA has also established an Organizational Assessment and Improvement Program to ensure regular and consistent assessment of performance against established standards. Each national cemetery will be evaluated through site visits conducted on a cyclical basis. In addition, NCA will develop and evaluate new innovations and equipment to make the most effective use of resources in meeting cemetery maintenance needs.

Question 9: Please provide data concerning the State Cemetery Grant Program, including the number of grants awarded in fiscal year 2005, total grant amounts, average grant amounts, and award locations.

Response: In FY 2005, VA provided $36.1 million for grants associated with 13 projects to establish, expand, or improve state veterans cemeteries. The average grant award was $2.8 million. Grant funding was provided at the following locations:

Wrightstown, New Jersey ($6.1 million - Cemetery Improvements)
Ft. Harrison, Montana ($85,000 - Cemetery Improvements)
Knoxville, Tennessee ($97,000 - Cemetery Improvements)
Mandan, North Dakota ($3.1 million - Cemetery Improvements/Expansion)
Springfield, Missouri ($844,000 - Cemetery Improvements)
Agawam, Massachusetts ($4.8 million - Cemetery Expansion)
Wrightstown, New Jersey ($99,000 - Cemetery Improvements)
Mission, Texas ($8.7 million - New Cemetery)
Amelia, Virginia ($26,000 - Cemetery Improvements)
Shreveport, Louisiana ($5.6 million - New Cemetery)
Boulder City, Nevada ($4.8 million - Cemetery Expansion)
Quincy, Illinois ($100,000 - Cemetery Improvements)
Northern Mariana Islands ($1.7 million - New Cemetery)

Question 10: Please provide the total amount of expenditures for the Ocwen contract for property management for each fiscal year since the contract was signed, separately indicating the payments made to Ocwen and the amounts attributable to oversight by Department staff. Separately identify any additional payments requested and made since the contract was negotiated, the basis for the same and any penalties imposed.

Response: In FY 2003, VA paid Ocwen $5,974,009. This represents phase-in costs that were part of awarding the contract.

VA paid Ocwen $648,394 in FY 2004 and $21,312,598 in FY 2005. The contract does not have a specified fiscal year cost. Rather, costs are calculated based on a rate per property managed and sold. Ocwen receives a partial fee up front and the remainder when the property is sold. Since the average holding time is approximately ten months, costs overlap fiscal years.

Oversight costs are approximately $1.8 million per year.

VA has negotiated but has not finalized a modification to the contract to pay Ocwen a monthly fee for properties leased to disaster victims approved by FEMA.

No penalties have been imposed on Ocwen to date.

Question 11: For each of last 3 fiscal years, please provide the total amount paid to contractors providing services under the VR&E program, total number of contractors providing such services and the general nature of such services. Additionally, please identify the top 5 (total amount paid) Regional Offices that engage in VR&E contract services.

Response: The following table provides the total amount paid to contractors under the Vocational Rehabilitation and Employment Program and the number of contractors providing services for the last three fiscal years.

The categories of services are:

- Educational/Vocational Counseling – provided to service members and recently discharged veterans
- Case Management - Chapter 31 vocational assessments and routine case management services
- Special Rehabilitation Services - Independent Living evaluations, specialized placement assistance, and other assessments.

Fiscal Year	Fund Type	Number of Contractors	Total Contract Payment Amount
2005	ED/VOC	89	$5,642,441
2005	Case Management	256	$6,678,016
2005	Special Rehabilitative Svcs.	881	$14,184,551
2004	ED/VOC	99	$5,402,984
2004	Case Management	220	$7,340,458
2004	Special Rehabilitative Svcs.	855	$10,094,053
2003	ED/VOC	98	$4,316,729
2003	Case Management	315	$8,719,506
2003	Special Rehabilitative Svcs.	830	$4,467,078

The top five regional offices that engage in VR&E contract services and the amounts paid for the last 3 three fiscal years are listed below:

Fiscal Year	Regional Office	Total Contract Payment Amount
2005	San Diego	$3,032,462
	Washington	$2,251,481
	Phoenix	$2,248,788
	Oakland	$1,841,715
	Atlanta	$1,343,666
2004	San Diego	$3,086,251
	Washington	$2,480,560
	Phoenix	$1,666,443
	Oakland	$1,659,860
	Seattle	$1,163,663
2003	San Diego	$2,320,137
	Washington	$1,851,807
	Denver	$1,222,426
	Phoenix	$1,003,486
	Oakland	$934,764

	FY 2004						FY 2005					
	Orig Comp >7 Issues (EP010)	Orig Comp <8 Issues (EP110)	Reopened Disability (EP020)	Future Exams (EP310)	Hospital Reviews (EP320)	DIC (EP140)	Orig Comp >7 Issues (EP010)	Orig Comp <8 Issues (EP110)	Reopened Disability (EP020)	Future Exams (EP310)	Hospital Reviews (EP320)	DIC (EP140)
USA	30,622	139,182	401,489	13,533	6,940	27,191	40,056	157,498	431,031	17,682	7,280	27,740
Baltimore	725	2,130	5,641	341	19	322	736	2,027	5,299	470	47	311
Boston	77	1,705	6,260	154	359	362	107	1,183	4,236	193	660	343
Buffalo	394	2,367	5,985	164	28	309	420	2,222	5,668	384	14	304
Cleveland	386	3,914	11,263	271	20	819	400	4,003	10,838	243	58	728
Detroit	203	3,526	9,242	309	66	610	264	3,750	9,590	597	82	651
Hartford	93	757	2,250	60	57	107	145	949	2,557	89	46	117
Indianapolis	172	3,042	6,507	246	17	321	208	3,254	7,635	228	15	381
Manchester	59	431	1,698	138	125	93	65	512	1,581	108	154	123
New York	154	2,365	8,044	148	229	484	243	2,557	8,936	173	481	441
Newark	95	1,370	4,391	118	61	216	158	1,265	3,880	80	75	244
Philadelphia	299	3,128	9,078	372	23	1,553	393	3,554	10,599	560	39	1,728
Pittsburgh	203	1,510	4,408	124	16	362	333	1,767	4,941	191	10	400
Providence	70	806	2,712	140	96	165	66	716	2,441	245	44	146
Togus	160	1,061	3,390	112	190	137	157	1,163	3,154	61	200	145
White River J	35	377	1,276	58	26	77	49	367	1,104	99	26	55
Wilmington	102	438	1,067	74	15	64	107	421	1,149	74	10	61
Atlanta	1,000	4,938	13,186	334	9	844	1,484	5,444	14,392	589	101	796
Columbia	570	2,941	9,817	442	65	573	744	3,224	10,878	605	23	588
Huntington	93	1,133	4,881	146	206	235	120	1,270	4,999	137	172	243
Jackson	258	1,553	6,004	409	113	451	308	1,748	6,366	304	138	505
Louisville	943	3,064	6,566	292	490	454	1,150	4,120	7,078	232	207	517
Montgomery	477	2,547	8,952	257	92	733	810	3,265	10,606	261	23	824
Nashville	878	4,048	11,237	615	119	790	1,114	4,347	12,419	392	74	814
Roanoke	2,693	3,713	9,456	589	200	681	2,279	4,686	12,807	807	319	863
San Juan	44	675	3,785	110	5	202	175	952	4,394	217	15	208
St. Petersburg	2,409	8,934	30,404	1,276	80	2,019	3,043	9,354	27,433	1,462	126	1,664
Washington	561	423	693	14	20	45	476	376	721	34	9	44
Winston-Salem	2,215	6,425	18,272	401	273	1,011	4,090	7,367	15,964	919	290	954
Chicago	574	3,060	7,306	209	261	365	797	3,877	8,842	325	216	473
Des Moines	86	1,185	2,805	99	230	185	156	1,512	3,347	61	126	200
Fargo	118	885	2,140	125	3	105	190	1,079	2,170	229	1	93
Houston	1,695	4,230	15,564	397	32	977	2,502	5,838	18,865	609	152	1,038
Lincoln	277	2,128	3,594	176	246	150	474	2,595	4,398	290	277	182
Little Rock	325	1,581	6,045	187	76	395	387	1,947	7,158	266	82	461
Milwaukee	177	2,483	7,699	232	585	360	184	2,738	8,467	281	616	333
Muskogee	886	3,449	11,056	213	7	717	1,057	3,468	12,211	351	0	830
New Orleans	353	2,236	8,940	317	20	475	357	2,287	8,207	340	5	482

	FY 2004						FY 2005					
	Orig Comp >7 Issues (EP010)	Orig Comp <8 Issues (EP110)	Reopened Disability (EP020)	Future Exams (EP310)	Hospital Reviews (EP320)	DIC (EP140)	Orig Comp >7 Issues (EP010)	Orig Comp <8 Issues (EP110)	Reopened Disability (EP020)	Future Exams (EP310)	Hospital Reviews (EP320)	DIC (EP140)
Sioux Falls	56	590	1,915	107	78	72	110	841	2,181	108	82	103
St. Louis	534	4,286	8,745	153	214	476	592	4,339	9,378	187	115	495
St. Paul	114	3,221	7,826	333	383	297	200	4,161	7,977	425	145	345
Waco	1,771	7,245	21,076	537	108	1,426	2,455	8,752	24,762	609	77	1,396
Wichita	186	1,212	2,808	94	240	216	243	1,781	4,131	172	361	229
Albuquerque	256	1,242	5,059	75	147	240	289	1,365	5,090	95	62	308
Anchorage	247	504	1,700	126	13	42	261	410	1,185	139	6	50
Boise	155	815	2,573	132	68	124	195	1,027	2,825	199	80	104
Denver	1,036	2,110	6,024	255	325	388	1,230	3,213	8,006	420	354	417
Fort Harrison	115	728	2,112	80	30	84	137	936	2,703	118	31	88
Honolulu	246	1,222	3,072	110	31	211	253	1,214	3,067	147	73	216
Los Angeles	464	3,351	9,071	145	63	573	766	4,250	10,717	264	160	584
Manila	56	679	4,811	36	20	1,933	76	530	5,498	27	21	1,638
Oakland	508	5,388	14,558	308	18	844	813	5,978	14,731	395	42	840
Phoenix	695	2,705	9,643	253	15	617	1,001	2,903	10,113	370	79	619
Portland	267	2,396	7,115	177	273	441	364	2,505	7,031	117	211	381
Reno	266	1,279	3,825	154	8	257	269	1,140	3,925	170	3	244
Salt Lake City	185	828	2,476	177	194	93	1,440	1,514	2,338	211	214	95
San Diego	1,970	4,959	6,814	180	26	445	2,367	4,806	7,649	240	6	524
Seattle	1,636	3,864	8,652	432	207	644	1,247	4,629	12,394	766	225	774

Claims to FTE Ratios

	Pending Rating Issues End of FY 2005	Pending Appeals End of FY 2005	Service Center FTE End of FY 2005	Ratio of Rating Claims to FTE	Combined Ratio of Rating Claims and Appeals to FTE
USA	346,292	111,696	6,812.3	50.8	67.2
Albuquerque Regional Office	3,626	1,053	68.8	52.7	68.0
Anchorage VAMROC	1,542	290	25.0	61.7	73.3
Atlanta Regional Office	12,838	3,795	217.2	59.1	76.6
Baltimore Regional Office	5,570	1,192	88.8	62.7	76.1
Boise Regional Office	1,558	452	44.0	35.4	45.7
Boston Regional Office	5,294	1,586	74.5	71.1	92.3
Buffalo Regional Office	5,428	1,460	90.9	59.7	75.8
Chicago Regional Office	10,953	2,201	153.1	71.5	85.9
Cleveland Regional Office	12,574	2,793	193.4	65.0	79.5
Columbia Regional Office	5,248	2,092	156.7	33.5	46.8
Denver Regional Office	6,861	2,008	125.1	54.8	70.9
Des Moines Regional Office	4,191	1,329	57.8	72.5	95.5
Detroit Regional Office	7,993	1,752	133.7	59.8	72.9
Fargo VAMROC	1,155	165	35.9	32.2	36.8
Fort Harrison VAMROC	1,633	470	32.9	49.6	63.9
Hartford Regional Office	1,722	651	44.9	38.4	52.9
Honolulu VAMROC	2,734	725	43.9	62.3	78.8
Houston Regional Office	19,125	6,286	281.8	67.9	90.2
Huntington Regional Office	3,792	2,100	68.2	55.6	86.4
Indianapolis Regional Office	4,751	2,530	106.8	44.5	68.2
Jackson Regional Office	2,816	1,643	110.8	25.4	40.2
Lincoln Regional Office	2,578	792	68.4	37.7	49.3
Little Rock Regional Office	3,979	1,720	99.5	40.0	57.3
Los Angeles Regional Office	9,836	3,987	174.5	56.4	79.2
Louisville Regional Office	6,857	3,526	123.5	55.5	84.1
Manchester Regional Office	1,021	403	32.6	31.3	43.7
Manila Regional Office	1,782	988	69.0	25.8	40.1
Milwaukee Regional Office	4,095	1,832	116.0	35.3	51.1
Montgomery Regional Office	10,637	4,902	158.5	67.1	98.0
Muskogee Regional Office	5,378	1,665	159.0	33.8	44.3
Nashville Regional Office	7,349	3,342	181.1	40.6	59.0
New Orleans Regional Office	7,006	2,795	147.3	47.6	66.5
New York Regional Office	8,002	1,444	132.6	60.3	71.2
Newark Regional Office	3,828	1,746	74.6	51.3	74.7
Oakland Regional Office	10,426	3,295	200.5	52.0	68.4
Philadelphia Regional Office	6,047	2,409	155.7	38.8	54.3
Phoenix Regional Office	7,199	1,515	147.0	49.0	59.3
Pittsburgh Regional Office	5,544	925	90.1	61.5	71.8
Portland Regional Office	7,023	3,351	108.2	64.9	95.9
Providence Regional Office	1,270	849	37.0	34.3	57.3
Reno Regional Office	3,678	849	62.9	58.5	72.0
Roanoke Regional Office	10,526	2,277	183.9	57.2	69.6
Salt Lake City Regional Office	2,287	258	67.5	33.9	37.7
San Diego Regional Office	7,810	2,150	142.5	54.8	69.9
San Juan Regional Office	2,703	1,865	99.1	27.3	46.1
Seattle Regional Office	8,572	3,274	179.8	47.7	65.9
Sioux Falls VAMROC	1,293	73	32.0	40.4	42.7
St. Louis Regional Office	6,762	3,184	159.1	42.5	62.5
St. Paul Regional Office	4,669	722	106.1	44.0	50.8
St. Petersburg Regional Office	23,151	6,269	464.5	49.8	63.3
Togus VAMROC	2,843	525	54.0	52.6	62.4
Waco Regional Office	16,564	6,986	369.5	44.8	63.7
Washington Regional Office	1,139	154	37.0	30.8	34.9
White River Junction VAMROC	768	93	18.0	42.7	47.8
Wichita VAMROC	3,631	736	61.4	59.1	71.1
Wilmington VAMROC	996	411	18.0	55.3	78.2
Winston-Salem Regional Office	17,639	3,811	327.7	53.8	65.5

Prepared by the Office of Field Operations
January 20, 2005

Questions for the Record
Chairman, Ranking Democratic Member Lane Evans
House Committee on Veterans' Affairs

Pre-hearing Questions for VA Budget for Fiscal Year 2007

Question 1: According to VA enrollment data, 263,257 veterans filed 10-10EZ forms to apply for enrollment in FY 2005 but VA determined that these veterans had incomes above the national mean threshold and low-income geographic index. Therefore VA denied them enrollment under the continuing January 2003 enrollment decision.

a. Please provide the total number of veterans who filed 10-10EZ forms in FY 2004 and who the VA determined were new Priority 8 veterans and subject to the continuing January 2003 enrollment decision. Please provide a breakdown of this total number by state, District of Columbia and territories.

   Response: It is important to note that 263,257 represent the cumulative total number of veterans from January 2003 thru the end of fiscal year (FY) 2005 denied enrollment due to the January 17, 2003 enrollment decision. Attachment 1, Department of Veterans Affairs (VA) Health Care Enrollment Priority Group fact sheet, provides definitions for each of the Enrollment Priority Groups.

   Attachment 2 provides the number of veterans who applied and were assigned to Priority Groups 8e and 8g during FY 2004 (112,524) and FY 2005 (94,638). These figures exclude those veterans who initially were assigned as Priorities 8e/g, but then were later reassigned to a higher priority group (Priorities 1 – 8c) during the fiscal year or did not appear in the respective end of fiscal year enrollment file.

b. Please provide the cumulative total number of veterans who filed 10-10EZ forms from January 2003 through December 2005 and who the VA determined were new Priority 8 veterans and subject to the continuing January 2003 enrollment decision. Please provide a breakdown of this cumulative total number by state, District of Columbia and territories.

   Response: Attachment 3 provides the cumulative number of veterans who applied and were assigned to Priority Groups 8e and 8g during FY 2003 (93,228), FY 2004 (192,419), and FY 2005 (263,257). These figures exclude those veterans who initially were assigned as Priorities 8e/g, but then were later reassigned to a higher priority group (Priorities 1-8c) during the period (FY 2003 - 2005). These figures also exclude approximately 4,100 veterans who either died during FY 2003 - 2004 or do not appear in subsequent enrollment files.

c. Please provide the total number of veterans who the VA estimates will be denied enrollment in FY 2006 due to the continuing January 2003 enrollment decision. Please provide a breakdown of this estimated total number by state, District of Columbia and territories.

Response: VA does not have information on the number of veterans who would be denied enrollment in FY 2006 due to the continuing January 2003 enrollment decision. However, VA estimates that if the enrollment decision was suspended, approximately 273,000 veterans who would currently be classified as Priority 8e or 8g would seek benefits from VA in FY 2006. Attachment 4 provides the breakdown by state, District of Columbia and territories.

d. Please provide the total number of veterans who the VA estimates will be denied enrollment in FY 2007 due to the continuing January 2003 enrollment decision. Please provide a breakdown of this estimated total number by state, District of Columbia and territories.

Response: VA does not have information on the number of veterans who would be denied enrollment in FY 2007 due to the continuing January 2003 enrollment decision. However, VA estimates that if the enrollment decision was suspended, 242,000 veterans who would currently be classified as Priority 8e or 8g would seek benefits from VA in FY 2007. Attachment 4 provides the breakdown by state, District of Columbia and territories.

Question 2a: Please provide a copy of the 2005 report of the Special Committee on Post-Traumatic Stress Disorder. The committee's report was due to Congress May 1, 2005.

Response: We anticipate the final report from the Special Committee on Post-Traumatic Stress Disorder (PTSD), along with the Under Secretary's comments, to be released later in February.

Question 2b: Please identify any initiatives or recommendations of the committee that do not receive full funding in the FY 2007 budget request.

Response: VA is unable to respond to specific recommendations for mental health initiatives made by the PTSD Advisory Committee until the subject report and the Under Secretary for Health's responses have been cleared by the Department.

Question 3: Please provide a copy of the Ninth Annual Report to the Under Secretary for Health Department of Veterans Affairs submitted by the Committee on Care of Veterans with Serious Mental Illness. The committee's report was due to Congress June 1, 2005.

Response: The 9th Annual Report developed by the Committee on the Care of Veterans with Serious Mental Illness (SMI), was significantly delayed. Partly in response to this delay, the SMI Committee membership and leadership was recently updated. A revised report is anticipated in the next two months.

Question 3b: Please identify any initiatives or recommendations of the committee that do not receive full funding in the FY 2007 budget request.

Response: VA is unable to respond to specific recommendations for mental health initiatives made by the SMI Committee until the committee's report has been received and reviewed by the Under Secretary for Health.

Question 4: Please provide a copy of the 2005 Advisory Committee Report on Minority Veterans. The advisory committee's report was due September 1, 2005.

Response: Enclosed is the 2005 Annual Report of the Advisory Committee on Minority Veterans. The report provides an assessment of the Department of Veterans Affairs (VA) administration of programs, services and benefits affecting minority veterans.

Question 5: After nine months of pilot programs, the Army is implementing the Post-Deployment Health Reassessment (PDHRA) program. Please describe VA's participation in the PDHRA program. How much has VA budgeted for FY 2007 for staff, administrative support and any other related expenses for the PDHRA program?

Response: VA has actively participated with the Army's Reserve Component Post-Deployment Health Reassessment (PDHRA) Pilot beginning in November 2005. The PDHRA On-Site Pilot projects took place with Army Reserve soldiers in Michigan and Army National Guard soldiers in Arkansas. A total of 1,063 soldiers were screened. The PDHRA Call Center Pilot project took place in Minnesota. There were 132 Army Reserve soldiers screened. A total of 1,195 soldiers completed the PDHRA, resulting in 578 being referred to VA for health care services. On January 19, 2006, the Army shifted from the pilot phase to the full implementation phase of the PDHRA. VA is working with the Army and with other military services in providing follow-up evaluation and treatment to Reserve Component servicemembers referred from PDHRA screening initiatives. The FY 2007 budget does not include any additional resources for the PDHRA program. VA will prepare and finalize its preliminary FY 2007 PDHRA budget projections once it receives the Department of Defense (DoD) Reserve Component PDHRA projections for FY 2007. Both Departments have agreed to revisit estimates on a regular basis due to very preliminary nature of the pilot data and the evolving nature of the program.

Question 6: How many OIF/OEF veterans does VA estimate will need mental health services in FY 2007? Please describe in detail how the Administration's budget request for FY 2007 reflects increased demand for mental health services and other services for Operations Iraqi and Enduring Freedom veterans.

Response: Projections of the number of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans that will need mental health services in FY 2007 would need to consider a number of uncontrollable variables. For example, 1) DoD is unable to provide data on the anticipated rate or pattern of discharge of troops; 2) VA cannot assume that the pattern of illness would be similar in troops discharged in the later phases of the conflict (e.g., Would one expect higher rates of mental illness in troops that are redeployed several times?); 3) VA cannot assume that the pattern of use of VA health care services (vs. use of Vet Center services, private health care options, employer health plans) would be similar for troops discharged in the later phases of the conflict.

From FY 2002 through the fourth quarter of FY 2005, 36,893 OEF/OIF veterans who sought VA medical care received a diagnosis of a possible mental disorder. With the limitations above clearly stated, a reasonable assumption is that there will be at least a 20 percent increase in separating veterans seeking VA health care and that rates of diagnosis of a possible mental health disorder will remain the same. For example, with PTSD, that would lead to an approximate prediction of an additional 2,900 cases of PTSD in FY 2006, increasing the total to 17,971, and another increase of 3,480 in FY 2007 for a total of 20,871.

The President's Budget Request for FY 2007 includes a request for $3.2 billion for mental health programs, to cover psychiatric residential rehabilitation treatment, psychiatric inpatient and outpatient, and mental health initiatives. This is an increase of $339 million over the FY 2006 estimate and reflects increased demand for mental health services and other services for OEF/OIF veterans. These funds will cover many initiatives including, but not limited, to the following -

VA plans on continuing to screen Iraq and Afghanistan veterans who come to VA health care facilities with a standard set of questions designed to identify potential problems in areas of PTSD, depression and substance use disorders. This will help us set the stage for determining if returning veterans are properly diagnosed in order to get proper treatment for their problems.

VA has committed resources that are specific to expanding PTSD programs and personnel, and plans on continuing such programs into 2007. VA has 108 specialized PTSD Clinical Teams (PCT) as well as over 160 special PTSD programs that are ongoing at this time. We are ensuring that there is expertise in every VA medical center in every network. And VA continues initiatives to ensure that community based outpatient clinics have mental health expertise.

The planning of three new Centers of Excellence for mental health and PTSD is ongoing. As directed by the FY 2006 Conference Report 109-305, there was a December 2005 designation of three new centers of excellence in Waco (Texas), San Diego (California), and Canandaigua (New York) devoted to advancing the understanding and care of mental health illness. When established these Centers will join the existing VA entities that focus on mental health aspects of war including the

National Center for PTSD and the Mental Illness Research Education and Clinical Care (MIRECC) on Post Deployment mental health. A specific report on the new Centers of Excellence is due to Congress in May 2006.

Department of Veterans Affairs

Attachment 1
Enrollment Priority Groups Health Care Fact Sheet

VA Health Care Enrollment Priority Groups

Enrollment Priority 1
- Veterans with service-connected disabilities rated 50% or more disabling

Enrollment Priority 2
- Veterans with service-connected disabilities rated 30% or 40% disabling

Enrollment Priority 3
- Veterans who are former POWs
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Enrollment Priority 4
- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

Enrollment Priority 5
- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Enrollment Priority 6
- World War I veterans
- Mexican Border War veterans
- Compensable 0% service-connected veterans
- Veterans solely seeking care for disorders associated with:
  - exposure to herbicides while serving in Vietnam; or
  - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  - for disorders associated with service in the Gulf War;
  - for illness possibly related to participation in Project 112/SHAD; or
  - for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998

Enrollment Priority 7
Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and income below the HUD geographic index
- Subpriority a: Noncompensable 0% service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans not included in Subpriority a above
- Subpriority g: Nonservice-connected veterans not included in Subpriority c above

Enrollment Priority 8
Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and the HUD geographic index
- Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Nonservice-connected veterans applying for enrollment after January 16, 2003

Additional Information:
The term service-connected means, with respect to a condition or disability, that VA has determined that the condition or disability was incurred in or aggravated by military service. Some veterans may have to agree to pay copayments to be placed in certain priority groups.

Priority 8e/g Veterans as of End of Fiscal Year for FY 2004 and FY 2005

State	Fiscal Year 2004	Fiscal Year 2005
AL	2,251	1,913
AK	255	244
AZ	2,373	2,074
AR	2,105	1,806
CA	7,351	5,798
CO	1,655	1,303
CT	1,222	911
DE	370	339
DC	76	64
FL	12,173	9,592
GA	3,082	2,554
HI	267	262
ID	689	631
IL	3,727	3,306
IN	2,364	1,874
IA	2,098	1,514
KS	1,227	947
KY	1,876	1,650
LA	2,016	1,972
ME	1,288	869
MD	1,198	1,156
MA	1,449	1,112
MI	2,461	2,200
MN	2,703	1,754
MS	1,833	1,410
MO	2,307	2,026
MT	863	674
NE	903	299
NV	947	818
NH	655	476
NJ	1,959	1,744
NM	849	683
NY	3,871	3,689
NC	4,556	3,520
ND	450	337
OH	4,074	3,797
OK	1,664	1,466
OR	1,702	1,524
PA	5,152	4,488
RI	479	261
SC	2,237	2,383
SD	600	434
TN	2,599	2,417
TX	8,061	7,045
UT	553	489
VT	286	272
VA	2,260	2,145
WA	1,860	1,787
WV	1,090	979
WI	3,066	2,060
WY	336	273
PR	314	403
Other/Overseas	722	894
Total	112,524	94,638

Veterans who applied during and were assigned to Priorities 8e/g at the end of FY 2004 and FY 2005 (separately). These figures exclude Priorities 8e/g veterans who were reassigned to a higher priority (Priorities 1 – 8c) during the fiscal year or did not appear in the respective end of fiscal year enrollment file.

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Priority 8 Veterans Denied Enrollment
Due to January 17, 2003 Enrollment Decision

State	Fiscal Year[1] 2003	2004 Cumulative[2]	2005 Cumulative[3]
AK	233	406	578
AL	1,755	3,732	5,004
AR	1,737	3,596	4,983
AZ	2,119	4,095	5,835
CA	6,967	13,407	17,378
CO	1,153	2,611	3,599
CT	989	2,048	2,651
DC	59	125	164
DE	274	598	877
FL	8,834	20,292	27,465
GA	2,539	5,170	7,062
HI	293	512	710
IA	1,764	3,697	4,762
ID	483	1,100	1,608
IL	3,005	6,317	8,944
IN	2,285	4,301	5,700
KS	1,052	2,165	2,878
KY	1,640	3,280	4,506
LA	1,665	3,399	4,893
MA	1,445	2,680	3,509
MD	1,143	2,158	3,051
ME	588	1,785	2,403
MI	2,175	4,243	5,942
MN	1,655	4,124	5,319
MO	2,118	4,027	5,552
MS	1,672	3,277	4,308
MT	697	1,484	1,956
NC	3,536	7,580	10,405
ND	345	750	927
NE	675	1,506	1,991
NH	444	1,049	1,434
NJ	1,870	3,503	4,808
NM	612	1,367	1,851
NV	541	1,445	2,111
NY	3,258	6,635	9,357
OH	3,269	6,827	9,764
OK	1,437	2,883	4,013
OR	1,557	2,995	4,162
PA	5,385	9,926	13,262
RI	466	878	1,045
SC	1,968	3,972	5,964
SD	350	902	1,201
TN	1,898	4,196	6,165
TX	6,829	13,834	19,204
UT	514	1,005	1,361
VA	1,897	3,839	5,459
VT	261	528	751
WA	1,446	3,096	4,584
WI	2,394	5,163	6,622
WV	922	1,862	2,550
WY	268	565	777
Other/ Unknown	747	1,484	1,852
Total	93,228	192,419	263,257

[1] Totals are cummulative and do not include enrollees who were initially denied enrollment and subsequently enrolled in an eligible priority.
[2] Does not include ineligible enrollees who died prior to FY 2004.
[3] Does not include ineligible enrollees who died prior to FY 2005.
Data Source: End of Year Enrollment Files (sep03,sep04,sep05)

Estimated Impact of Suspension
New Priority 8 Enrollment
For FY 2006 and FY 2007

State	Fiscal Year 2006	Fiscal Year 2007
AL	4,425	4,006
AK	537	502
AZ	8,065	7,259
AR	4,349	3,864
CA	21,832	19,191
CO	2,918	2,676
CT	3,333	2,847
DE	809	733
DC	210	193
FL	29,836	26,101
GA	6,859	6,303
HI	1,363	1,217
ID	1,486	1,361
IL	9,892	8,540
IN	6,743	5,890
IA	3,551	3,096
KS	4,153	3,555
KY	4,512	4,010
LA	4,477	3,950
ME	2,165	1,869
MD	3,643	3,270
MA	4,230	3,687
MI	5,940	5,239
MN	5,743	4,958
MS	3,655	3,263
MO	6,575	5,765
MT	1,651	1,461
NE	1,741	1,536
NV	3,332	3,041
NH	1,510	1,322
NJ	5,997	5,192
NM	1,604	1,499
NY	11,018	9,619
NC	9,552	8,544
ND	1,108	952
OH	10,134	8,908
OK	4,065	3,648
OR	3,161	2,891
PA	14,151	12,089
RI	1,005	846
SC	5,172	4,712
SD	1,199	1,041
TN	5,368	4,882
TX	18,314	16,498
UT	1,549	1,397
VT	794	705
VA	5,937	5,462
WA	3,828	3,548
WV	2,078	1,877
WI	6,071	5,274
WY	936	840
PR	679	656
Other/Overseas	97	92
Total	273,353	241,876

Estimates are for the number of Priority 8 veterans who would have been expected to apply for enrollment in fiscal year.

Questions for the Record
Ranking Democratic Member, Health Subcommittee Michael Michaud
House Committee on Veterans Affairs

Pre-hearing Questions for VA Budget for Fiscal Year 2007

Question 1a: According to VA enrollment data, 2,403 Maine veterans applied for enrollment in FY 2005 but VA determined that these veterans had incomes above the national means threshold and low-income geographic index and therefore VA denied them enrollment. Please provide the median income of these Maine veterans?

Response: It is important to note that 2,403 represents the total number of Maine veterans who have been impacted by the enrollment restriction on new Priority 8 applicants since January 17, 2003, through the end of fiscal year (FY) 2005. In FY 2005, 869 Maine veterans who applied for enrollment were determined to be Priority 8 and thereby denied enrollment. Currently, Department of Veterans Affairs (VA) is unable to produce a meaningful median income of this group since, by law, these veterans are only required to agree to make applicable copayments; they are not required to provide income information.

Question 1b: Please provide the total number of Maine veterans who applied for enrollment since January 2003 through December 2005 who VA determined to be new Priority 8 veterans, and therefore VA denied them enrollment.

Response: VA enrollment records show that from January 17, 2003 through the end of FY 2005, 2,403 Maine veterans were denied enrollment due to the restriction for new Priority 8 veterans.

Question 2a: The CARES commission decision of February 2004 recommends new Community Based Outpatient Clinics in Maine. The Secretary's CARES decision of May 2004 for VISN 1 targeted news sites for VA care in Maine.

a. What is the specific timeline for opening the CBOC in the Lewiston-Auburn area of Maine?
b. What is the specific timeline for opening the access point of care in Houlton, Maine?
c. What is the specific timeline for opening the access point of care in Dover-Foxcroft, Maine?

Response: The need for providing VA healthcare in the Cumberland County, Houlton and Dover-Foxcroft areas has been acknowledged. The opening of a community Based outpatient clinic (CBOC) in the Cumberland County area and outreach clinics in Houlton, and Dover-Foxcroft have been planned in accordance with the Secretary's 2004 Capital Asset Realignment for Enhanced Services (CARES) decision. These sites are targeted for priority implementation by FY 2012.

Question 2b: If the response is that the VA will open the clinics and access points by FY 2012, please explain in detail the specific reasons why the access points and CBOC will not be open sooner.

Response: Timelines are dependent on the availability of funding from year to year. VA remains committed to the CARES process for the coordination and prioritization of capital enhancements, including CBOCs based on system requirements and available resources.

Question 3: Does the FY 2007 budget provide additional funding for VISN 1 to open the Lewiston-Auburn CBOC by the end of FY 2007? If yes, how much and do these funds come from the Togus VA Medical Center's budget or the VISN budget? If not, please explain in detail how the VA will meet the projected needs of veterans in the Lewiston-Auburn area in FY 2007.

Response: Once the VA's FY 2007 appropriation is finalized, a specific allocation to Veterans Integrated Service Network (VISN) 1 can be developed to respond to an additional CBOC.

Question 4: What is the amount of funds the Togus Maine VAMC is budgeted to receive for FY 06 operations?

Response:

TOGUS FUNDING FOR FY 2006 AS OF 1/31/2006

GENERAL PURPOSE (INCLUDING CONSOLIDATED MAIL-OUT PHARMACY)	136,615,701
TRAVEL	125,868
INFORMATION TECHNOLOGY (PAY)	1,299,994
MEDICAL CARE COLLECTIONS FUND	14,784,435
SHARING GOAL	131,308
TENANT SUPPORT	725,895
TOTAL GENERAL PURPOSE	**153,683,201**
PROSTHETICS	7,900,000
INFORMATION TECHNOLOGY APPROPRIATION (NON-PAY)	808,458
SPECIFIC PURPOSE	12,839,359
TOTAL FUNDING	**175,231,018**

Does not include Capital resources

Question 5: What is the amount of funds the Togus Maine VAMC would need in FY 2006 to maintain the FY 2005 level of services and FTEE levels without using any reserve funds or converting any non-recurring maintenance funds into operating expense funds?

Response: The Togus Maine VA Medical Center (VAMC) will maintain existing services and assigned FY 2005 full time employee (FTE) level in FY 2006 within currently available resources.

Question 6: Given the continuing number of wounded servicemembers who have sustained traumatic injuries, which have resulted in amputations, blindness and traumatic brain injuries, please describe the increase for FY 2007 over FY 2006, if any, in funding for a) prosthetics research, b) prosthetics, c) blind rehabilitation and d) mental health programs targeted towards recently separated service personnel.

Response to 6A Prosthetics Research: The President's Budget Request for FY 2007 includes $399 million in direct appropriations to support VA's medical and prosthetic research program. This amount will fund more than 2,000 high-priority research projects to expand knowledge in areas critical to veterans' health care needs. VA projects $74.9 million will be devoted to research related to a general category of amputation and prosthetics, including research related to acute and traumatic injuries, sensory loss, central nervous system injury and associated disorders, and degenerative diseases of bones and joints that can be generally classified as amputation and prosthetics research. This is an increase over the FY 2006 projection of $68.2 million.

Response to 6B Prosthetics: VA's medical care request includes $1.4 billion for FY 2007 ($160 million over the 2006 level) to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. The Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans returning from combat are provided state of the art devices that VA purchases.

VA will spend $20 million dollars each year specifically to meet the needs of the critically injured veterans returning from the Iraq war, who will require intensive medical care from VA throughout their lifetime. These patient groups include amputees, spinal cord injures, traumatic brain injures, hearing and visual impairments, and other conditions. This is an integrated effort that includes other patient care services groups such as Research and Development, Physical Medicine & Prosthetics and Sensory Aids.

Response to 6C Blind Rehabilitation: The limited number of recently separated service members who carry a diagnosis of legally blind also carry other medical diagnoses. VA has not tracked data on the specific population of recently separated service members who require blind rehabilitation service, therefore, funding information specific to this group is not available. However, for the overall Blind Rehabilitation program, the President's Budget Request for FY 2007 includes $81.6 million for FY 2007, an increase over $76 million in FY 2006.

Response to 6D Mental Health Programs: The President's Budget Request for FY 2007 includes a request for $3.2 billion for mental health programs, to cover psychiatric residential rehabilitation treatment, psychiatric inpatient and outpatient, and mental health initiatives. This is an increase of $339 million over the FY 2006 estimate and reflects increased demand for mental health services and other services for OEF/OIF veterans.

Question 7: Please describe, in detail, the FY 2007 budget request for VA programs to address the unique challenges of access to high quality care that face rural veterans. Are there any new initiatives the Secretary would recommend to assist in expanding access for rural veterans?

Response: VA has taken, and will continue to take steps to implement several new initiatives that provide for special consideration for veterans living in rural areas include but are not limited to the following:

- Community-Based Outpatient Clinics (CBOCs) – CBOC's assist in improving access to care for veterans in rural areas. VA's current policy for the planning and activation of CBOCs ensures that new CBOCs meet VA's goal to improve access by current users by placing them in those areas where users travel significant distances or experience excessive travel time to access care. VHA Networks will be encouraged to plan for the establishment of additional CBOCs or to expand services at existing CBOCs, where there is demonstrated need and within the context of available resources. An additional 43 potential CBOCs have been identified for consideration in 2007, pending operational funding, Secretarial approval, and Congressional notification.

- Care Coordination and Home Telehealth – Care coordination involves telehealth which enables the provison of services to rural and remote areas in CBOCs and Vet centers. In FY 2006, marked expansions will take place in tele-retinal screening for diabetic retinopathy and telemental health. Home telehealth enables non-institutional care to take place beyond the usual 20 to 40 mile restriction faced by homecare providers. VA plans on continuing to expand the use of care coordination and home telehealth in FY 2007 to meet the needs of veterans in rural areas.

- Veterans Rural Access Hospital Directive – This directive provides guidance to the field on the proper means of providing access to veterans in rural areas. There are environments where the demand supports small inpatient bed capacity. This is challenging especially in rural areas where professional service support may be limited. The directive specifies that:

    - These facilities must be part of a larger network of health care and clinical practice policies must ensure that identified support staff possesses the skills necessary to provide post-anesthesia/post-operative care.

- A VA facility with less than 25 medical or surgical inpatient beds is assessed annually to ensure that quality of care and availability of support services are maintained.

If care is not available at the VA and the care required is emergent, fee care is authorized. If not an emergency, then the VISN will refer the veteran to a tertiary care facility within the VISN or to a nearby VISN.

Post-hearing Questions from the Honorable Steve Buyer
Before the House Committee on Veterans Affairs
Hearing on the Department of Veterans Affairs
Budget for Fiscal Year 2007
February 8, 2006

1. Is the Department continuing to pursue a proposal to standardize self monitoring blood glucose equipment through a single national contract, even though the FY 2006 VA Appropriations Act specifically prohibits VA from replacing the current system by which VISNs select and contract for blood glucose testing supplies and monitoring equipment?

Response: No, the Department of Veterans Affairs (VA) is not pursuing a proposal to standardize self monitoring blood glucose equipment through a single national contract.

2. Have you provided clear communication to all of the VISN directors as to the status of the Department's proposal to standardize self monitoring blood glucose equipment through a single national contract? If not, I would ask that you provide written notification to each VISN Director reaffirming the continuation of the current process for selecting diabetes monitoring equipment.

Response: VA has provided clear communication to VA Central Office pharmacy program managers and VISN Formulary Leaders regarding the prohibition to pursue standardization contracting shortly after the FY 2006 Appropriations Bill was signed. Follow-up written notification will also be sent to each VISN Director.

3. During recent visits by both myself and the Committee staff, we have received reports that there have been problems in transferring complete medical information from Bethesda Naval Medical Center and Walter Reed Army Medical Center to the VA Polytrauma units for soldiers injured during OIF/OEF. What is the current status on the transfer of medical records for these patients?

Response: To provide a seamless transition as service members move from the Department of Defense (DoD) to VA, VA is coordinating with DOD to ensure information on the service members who will be transitioning to VA for care and benefits, particularly those who are severely injured in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). On June 29, 2005, DoD and VA signed a Memorandum of Understanding (MOU) for the purpose of sharing data between DoD and VA. The Departments have made significant progress in sharing pertinent health information as service members and veterans are transferred from Military Treatment Facilities to VA Medical Centers. VA's

Polytrauma Rehabilitation Centers are establishing read only access to electronic medical information at Walter Reed and Bethesda. VA staff has and continues to train clinicians to access and utilize this information. While this is a major accomplishment, some limitations still remain. DoD is in the final stages of implementing a fully electronic medical record. As this process nears completion we continue to increase the level of medical information that can be shared electronically. VA's Polytrauma Rehabilitation Centers have initiated monthly video-teleconferences with the treatment teams at Walter Reed Army Medical Center and Bethesda National Naval Medical Center. This has proven to be an effective means of communicating information that is not typically documented in the medical record.

From an Information Technology (IT) standpoint, VA and DoD have made significant progress toward achieving interoperability of available electronic medical information. In 2002, VA and DoD implemented the Federal Health Information Exchange (FHIE). FHIE supports the one-way transfer of all clinically pertinent electronic data from the DoD Composite Health Care System (CHCS) to clinicians from the Veterans Health Administration (VHA) and to benefits workers from the Veterans Benefits Administration (VBA). Upon a service member's separation or retirement from DoD, DoD sends that service member's data to a shared secure FHIE repository where the data are available for viewing by VA personnel using the VA Computerized Patient Record System (CPRS). FHIE is operational at all VA medical centers and facilities.

To date, DoD has transferred records approximately 3.3 million unique service members to the shared FHIE repository. Of this 3.3 million, over 2 million have registered to receive medical treatment or benefits from VA. FHIE data available for viewing by VA include outpatient pharmacy, laboratory, radiology reports, consults, admission, disposition and transfer data, and diagnostic coding data from the standard ambulatory data record.

Using FHIE, VA also has access to military pre- and post-deployment health assessment data from DoD Forms 2795 and 2796. DoD has transmitted more than 515,000 pre- and post-deployment health assessments on over 266,000 separated service members. DoD continues to send monthly transmissions of these data to VA as more members separate or retire. These assessment data provide useful information to VA clinicians including information about exposures and other stressors related to deployments. In March 2006, DoD completed an initial load of over 700,000 pre-and post-deployment health assessments for demobilized National Guard and Reservists. VA and DoD are now working together to ensure that National Guard and Reserve data also are collected and included in the monthly transmissions.

In addition to the one-way transfer of electronic medical data through FHIE, VA and DoD have developed the capability to share electronic medical records bi-directionally to use in the care of shared patients. The VA/DoD Bidirectional

Health Information Exchange (BHIE) automatically match patient identities for active DoD military service members and their dependents with their electronic health records at VA facilities. It also supports the real-time bidirectional exchange of outpatient pharmacy data, allergy information, lab results, and radiology reports. BHIE data is available at eight DoD host sites. These DoD sites include locations that receive large numbers of Operation Enduring Freedom and Operation Iraqi Freedom combat veterans, such as the Walter Reed Army Medical Center, the Bethesda National Naval Medical Center, and the Landstuhl Army Medical Center. DoD data from these host sites are available at every VA site of care, and staff at those DoD facilities has full access to this information from every VA facility.

Both FHIE and BHIE provide interoperability of data through existing health information systems for VA and DoD. VA and DoD are now migrating these technologies to next-generation health information systems and implementing a plan to share data between those systems. The first release of this interface, known as "CHDR," will support interoperability between the DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR) and will allow VA and DoD to conduct drug-drug and drug-allergy interaction checking between VA and DoD pharmacy systems. In January 2006, the Departments completed formalized interagency testing and conducted a successful demonstration using the production version of CHDR for VA and Military Health System IT leadership. The Departments are now working closely with an interagency staff in El Paso, Texas, to complete CHDR production testing in a patient care environment between the William Beaumont Army Medical Center and the VA El Paso Healthcare System no later than July 2006.

VA is working closely with DoD to expand the scope of clinical information that is shared. Recently, the Departments initiated a pilot to explore the feasibility of sharing scanned paper records to provide VA electronic access to clinical data that was not previously available in electronic format. VA and DoD also are closely collaborating on the development of next generation imaging technology that will facilitate the sharing of radiological images between DoD and VA.

4. What steps do you plan to take to hold VA employees more accountable for the quality of services furnished to veterans?

Response: In 2002, a Department-level work group was tasked with reviewing VA's pass-fail appraisal program to ensure it aligned with VA strategic goals, and supported the President's Management Agenda. Based on that review, the work group recommended that all of VA convert from its pass-fail program to a 5-level appraisal program, and re-implement performance awards based on ratings of record. The Secretary accepted the work group's recommendations and our non-bargaining unit employees began transitioning to the new program in late 2003. After negotiating the implementation and transition procedures with our

unions, VA's last bargaining unit employees were brought into the 5-level program effective March 1, 2006.

The new appraisal and awards programs are intended to adequately distinguish between levels of individual performance, deal more effectively with poor performers, and better reward our top performers.

5. What percentage of the claims staff at the regional offices is in training status?

Response: VBA considers both Veterans Service Representatives (VSRs) and Rating Veterans Service Representatives (RVSRs) to be in training status for the first two years in their position. As of December 2005, VBA had 1,618 RVSRs, 369 of whom were in training status (23%); and 3,116 VSRs, 976 of whom were in training status (31%). We expect the percentage of employees in training status to increase in fiscal year 2006 as we continue to hire.

6. The budget proposes an additional 89 FTEE for pension claims. How does that backlog compare with pending disability claims?

Response: As of February 28, 2006 the total pension workload in inventory was 115,800. Of this total, 25,000 were rating-related pension claims, 17,500 were initial death pension claims, and the remaining 73,300 were cases where pension maintenance actions were required. By comparison, VBA's pending inventory of rating-related compensation claims was just over 343,500 as of the same date.

However, VBA generally makes no distinction between rating-related pension and compensation claims when reporting our current inventory. Instead, we bundle all rating-related actions into one total, since original pension work is not processed separately from compensation work in a VBA regional office. Both compensation and pension claims are included in our count of total pending rating-related claims, as well as our measure for timeliness and accuracy, and are generally processed by the same employees.

Pension maintenance activities are not part of the rating-related workload, and are processed at one of three Pension Maintenance Centers (PMCs) located in St. Paul, Philadelphia, and Milwaukee. These centers process benefit adjustments due to income and dependency changes, process annual income matches, and process requests for waivers from pension-related benefit overpayments.

7. How do you plan to balance the competing objectives of timeliness and quality of decisions in the adjudication process? Do you view timeliness objectives and quality objectives as competing interests?

Response: Quality and timeliness are both essential elements of claims processing. We do not view them as competing interests. We emphasize the importance of each through training, performance expectations and standards, and oversight. The performance standards for all VSRs and RVSRs include both production and quality elements. The performance standards for regional office directors contain elements related to both timeliness and quality. The FY 2006 directors' standards call for achieving rating and authorization accuracy levels of 90 percent and 93 percent, respectively, and improvements in disability claims processing timeliness above their individual offices' performance in FY 2005.

On a daily basis, timeliness and quality measures are monitored at the regional office, area director, and VBA headquarters levels to identify and correct out-of-line situations. Daily reports showing national and regional office performance compared to organizational targets in timeliness and quality components are generated and shared at all levels. Area directors hold weekly performance discussions with regional offices to develop strategies for addressing areas of concern.

Supervisors conduct individual local quality reviews to provide immediate feedback and training to decision makers. The Systematic Technical Accuracy Review (STAR) program reviews thousands of claims annually, sufficient to provide a statistically valid quality assessment for each regional office. Findings of the STAR reviews are distributed through all levels of the organization for use in local and centralized training programs and in the development of training tools such as the Training and Performance Support System (TPSS). Additionally, the Under Secretary for Benefits has mandated the development of training plans that include at least 80 hours of training each year for all employees who work in claims processing. This emphasis on training results in a continually improving workforce that understands and is committed to providing timely and accurate service to veterans.

Post-hearing Questions from the Honorable Michael Turner Before the House Committee on Veterans Affairs Hearing on the Department of Veterans Affairs Budget for Fiscal Year 2007 February 8, 2006

Mr. Secretary – In the Department's FY 2007 budget submission, the Department projects that the average daily census will decrease from 11,151 to 11,100 in 2007 for nursing home care. As you are aware, particularly from visiting the nursing home during your tour of the Dayton VA Medical Center, nursing homes are a valuable resource for veterans, allowing them to receive quality care in a welcoming environment. Beyond 2007, can you provide me with your view as to whether the average daily census will decrease or increase, what role does this projection play in the long term care planning at the Department, and please describe the nature of the Department's commitment to these important facilities?

Response: VA provides long-term care in both nursing homes and in non-institutional care settings. The nursing home care is provided in three venues: VA owned and operated nursing homes community nursing homes, and state veterans homes, each with distinct veteran populations served and each with distinct admission and eligibility requirements. These services complement each other so that veterans' needs for nursing home care can be met to the greatest extent possible. VA continues to expand its non-institutional care which includes home and community-based care to support the wishes of most patients to receive care in the comfort and familiar setting of their home surrounded by their family.

VA's 2007 request includes over $4.3 billion for long-term care ($229 million more than the 2006 level). The patient and cost projections associated with long-term care have been checked to ensure that they represent our real need in this area. While we aim to expand all types of extended care services, we plan to increase the rate of growth of non-institutional care funding about twice as much as that for institutional care. With an emphasis on community-based and in-home care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live.

During 2007, we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census (ADC), to about 36,700. This represents a 14.4 percent increase above the level we expect to reach in 2006 and a 33.7 percent rise over 2005. This level of 36,700 ADC in 2007 will represent an increase of 85 percent over the 1998 level of 19,810 for non-institutional LTC. This will defined spectrum of care, including an array of home and community-based services, enables VA to honor veterans' preference for care and to provide services in the least restrictive setting, where services are

commensurate with a veteran's health status, functional status, and personal circumstances.

Currently, VA is meeting 100 percent of the need for veterans who have mandated eligibility for nursing home care as required by Public Law 106-117 and will continue to meet the demand for mandated nursing home care services. As indicated in the President's FY 2007 budget submission, VA will provide an ADC level of 11,100 in FY 2007. VA has increased the overall nursing home care for the three venues by 2 percent from the 1998 ADC level of 33,670 to 34,358.

For 2007 and beyond, VA's preliminary estimates show that the use of VA-sponsored nursing home care by veterans with mandatory eligibility for nursing home care will increase from approximately 9,300 ADC in FY 2007 to 11,000 in FY 2013. This is due to the significant increase in the number of veterans aged 85 and older. This estimate represents the portion of these veterans that VA estimates will choose to receive their care at a VA-sponsored facility (VA Nursing Home, State Veterans Home, or VA Community Contract Nursing Home). All these veterans do not seek care from a VA-sponsored facility because some of these veterans have other eligibilities (Medicare, Medicaid, private insurance), and some may prefer to seek care elsewhere if it is more conveniently located.

Department of Veterans Affairs (VA)
Response to Chairman Buyer's Inquiry Regarding VA's use of Energy Savings Performance Contracts (ESPC)

The Chairman of the House Committee on Veterans Affairs requested that VA provide its position on using energy services performance contracting (ESPC) in the following seven projects: VA medical centers (VAMC) in New Orleans and Denver; to-be-constructed VAMCs in Las Vegas and Orlando; outpatient clinic and regional office in Anchorage; spinal cord injury center in Syracuse; and electrical distribution system upgrade in Tampa. The following information addresses both these projects and VA's approach to energy conservation.

The referenced projects are being funded directly via current or requested appropriations. Direct appropriations are the most cost effective way to incorporate energy conservation measures. Hence, an ESPC-type approach is not needed for these projects. VA fully supports the use of ESPC in addressing energy conservation needs when direct capital appropriations are not available to make the needed improvements to VA's energy infrastructure.

Each of the facilities cited meets VA design standards, which have incorporated principles of energy conservation and sustainability for the past two decades. For example, building materials are specified to emphasize the use of recycled materials and other elements of sustainability. Life-cycle cost analysis for best value efficiency over the life of the building is required. During the design phase, consultants must submit energy conservation certificates of compliance with Department of Energy (DOE) regulations and demonstrate that building thermal envelopes meet Environmental Protection Agency's (EPA) Energy Star standards. Before VA takes over the building project, the construction contractor is required to certify the building's compliance with EPA and DOE requirements and train VA staff on efficient operation and maintenance of the building and its systems.

VA recently joined other federal agency signatories to a new Executive Memorandum of Understanding on high performance buildings at a kick-off meeting for a new high-level Sustainability and Stewardship Working Group. This new body will develop and coordinate sustainability policies and encourage proliferation of beneficial practices at the regional and local levels.

To further improve facility energy performance, VA formed a new Department-wide Energy Management Task Force in September 2005. Among other activities, the Task Force reaffirmed the energy investments program and policy that VA put in place in 2003, and determined the steps VA will take over the next several years to promote energy investments and meet the requirements of the Energy Policy Act of 2005. These steps include:

1. Completion of energy investment pilot program. An energy investment pilot program to test a competitive selection process for energy services

contractors is midway to completion in Veterans Integrated Service Networks (VISNs) 4, 21 and 22. The pilot in each VISN consists of the four stages called for in VA's energy investments policy: 1) energy assessments (audits) of facilities within the region; 2) identification, prioritization and selection of energy conservation measures to be implemented in the facilities; 3) competitive solicitation and source selection for conservation measure implementation; and 4) contractor negotiations and execution of an ESPC covering all selected conservation measures.

2. VISN-wide facility energy assessments. The Task Force identified six VISNs that constitute VA's current top priorities for implementing facility energy improvements (other than the pilot VISNs) – VISNs 2, 5, 10, 11, 15 and 18. Using the pilot program model, VA will group facilities within each of these VISNs and conduct coordinated energy assessments, identify and prioritize potential conservation measures, and "package" selected measures together in preparation for pursuing implementation via ESPC.

3. Development of a National Energy Business Center. The business office at VA's Cleveland Medical Center recently established a new center dedicated to serving the energy-related contracting needs of VA facilities around the country. Center staff has already updated the VA statement of work for energy assessments, and will this year be supporting the three pilot program VISNs along with the VISNs conducting coordinated facility energy assessments.

Follow-up Questions from the Honorable Lane Evans
Before the Committee on Veterans Affairs
Hearing on the Department of Veterans Affairs
Budget for Fiscal Year 2007
February 8, 2006

Legislative Proposals

1. In your fiscal year 2007 request for Medical Services, you subtract $796 million attributable to your legislative proposals from the $25.5 billion that you state you need (see "Appropriations Language," Fiscal Year 2007 Budget Submission, Medical Programs, Volume 1 of 4, p. 1-3, and p. 1-2, of the same volume):

Medical Care Budget Authority for the Three Appropriations
(dollars in thousands)

Medical Services $25,511,509
Appn. Prop. Legisl. Fees . . . . . $(795,509)
Medical Services Total $24,716,000

This $795 million figure is comprised of $251 million attributable to a decrease in obligations, and an increase in collections of $544 million. Using this $796 million figure provides you with a total request of $24.7 billion. Later in the same chart you provide for $2.8 billion in collections, and use these to increase your Budget Authority line. You budget submission states that your collections estimate is $2.3 billion, $2.8 billion including collections attributable to your legislative proposals. Hence, this $544 million seems to be counted twice: once to decrease your appropriations request and once again to increase your collections estimate. In fact, the chart entitled "Summary of Resource Increases/Decreases, Medical services (FY 2007 Budget Submission, Medical Programs, Volume 1 of 4, page 3-19) clearly shows, under source of funds, your request of $24,716,000,000 (reduced by the legislative proposals from $25,511,509,000) and collections of $2,832,778,000.

Please explain why the $544 million estimated from collections attributable to the Administration's legislative proposals re used to both reduce your appropriation request then to augment your collections estimate (used to bridge the gap between your appropriation request and your total obligations).

RESPONSE: The table below is an expansion of the Medical Care Budget Authority for the Three Appropriations chart (page 1-2) and reflects that the total need is for $25,511,509,000, before considering three legislative proposals. The

budget submission then proposes fee policies for the Congress to consider that would reduce that request by $795,509,000. With those policies we project that collections would increase by $544,425,000 and costs as a result of decreased utilization would be reduced by $251,084,000. If these proposals are enacted we would be able to collect $544,425,000 in collections to use toward direct patient care; therefore, we would not need that amount in appropriated funds. Additionally, because we expect fewer veterans to come into the system, we would not need $251,084,000 in appropriated funding. The sum of Appropriation Proposed Legislative Fees, Subtotals (Line 1) and Legislative Proposals Collections, Subtotal (Line 2) equal $251 million. Without acceptance of the policy proposals, VA requires the full $25,511,509,000 in direct appropriation.

	(Dollars in Thousands) 2007 Estimate	
Appropriation:		
Medical Services	**$25,511,509**	
Appropriation Proposed Legislative Fees:		
Assess Annual Enrollment Fee of $250 for all P7/8s	**($409,965)**	
Increase Pharmacy Co-Pay for P7/8s from $8 to $15	**($355,048)**	
MCCF – 3rd Party Offset of 1st Party Debt	**($30,496)**	
Appropriation Proposed Legislative Fees, Subtotal	($795,509)	Line 1
Medical Services Total	**$24,716,000**	
Medical Administration	**$3,177,000**	
Medical Facilities	**$3,569,000**	
Total Appropriations	**$31,462,000**	
MCCF Collections:		
Collections before Legislative Proposals	**$2,288,353**	
Legislative Proposals:		
3rd Party Offset of 1st Party Debt	**$30,496**	
Increase Pharmacy Co-Pay for P7/8s from $8 to $15	**$288,313**	
Assess Annual Enrollment Fee of $250 for all P7/8s	**$225,616**	
Legislative Proposals Collections, Subtotal	$544,425	Line 2
MCCF Collections, Total	**$2,832,778**	
Budget Authority	**$34,294,778**	

2. Your legislative proposals assume driving out more than 200,000 Priority 7 and 8 veterans from the VA. These proposals have been rejected in the past, and I believe we can expect them to be rejected once again.

Is your estimate of a decrease in obligations attributable to your legislative proposals, $251,084,000, sufficient to cover the costs of these veterans remaining in the VA?

RESPONSE: The FY 2007 budget includes three provisions that, if enacted, will be instrumental in helping VA meet its prime responsibility of providing health care to those veterans who need our medical services the most. The first provision is to implement an annual enrollment fee of $250 and the second is to increase the pharmacy co-payment from $8 to $15 for a 30-day supply of drugs; the third is to eliminate the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans. If these three legislative proposals are not enacted, VA would require an additional $795.5 million in direct appropriation to cover the inability to collect $544.4 million in revenues and to cover the $251.1 million required to pay for the veterans remaining in the system.

Purpose Clause

A GAO report issued in November finds that VA violated the Purpose Statute by using appropriated funds for non-authorized purposes and that VA must restore those funds. VA disputes the violation but may ultimately be required to restore the disputed funds to certain accounts. How does VA plan for this possibility? What effect would this have on your FY 2007 request?

RESPONSE: The Government Accountability Office (GAO) reviewed VA's funding of its competitive sourcing studies. GAO determined that VA violated the Purpose Statute by improperly funding certain cost studies using Veterans Health Administration (VHA) appropriations not specifically authorized for that use. GAO recommended that VA replace the VHA funds used with monies from other accounts, and that if no such funds were available VA should report to Congress a violation of the Anti-Deficiency Act. VA advised GAO that it disagreed with their conclusions and did not concur with the GAO recommendations. VA strongly disagrees with the interpretation of 38 U.S.C. § 8110(a)(5) that GAO's report rests upon an interpretation that makes sense only if one ignores its legislative history and the rest of title 38.

Carryover Funding

You estimate needing fewer appropriated dollars to meet your obligations in FY 2007 by counting a $442 million change in "Unobligated Balances." In light of your experience last year, when these balances proved illusory, what steps are you taking to request additional funding if they prove illusory once again this year?

REPONSE: VA does not anticipate requesting additional funding.

Please detail the source of this change in unobligated balances and the reason for being "unobligated."

RESPONSE: In 2005, $1.15 billion was carried over into 2006 partially due to receiving the $1.5 billion supplemental in late 2005. Of the $1.15 billion, $949 million was in Medical Services; $98 million was in Medical Administration; and $102 million in Medical Facilities. Of this $1.15 billion amount, $442 million is estimated to be carried over into FY 2007.

Board of Veterans Appeals

1. Please describe the specific impact on the Board of Veterans' Appeals' (the Board) ability to provide hearings at the local level on the decrease in travel funding for the Board?

RESPONSE: The Board's ability to provide hearings at the local level, particularly "Travel Board" hearings, will be unaffected by the change in requested funding for travel in Fiscal Year (FY) 2007. Travel funds are used primarily for visits of traveling Veterans Law Judges (VLJs) to field stations to conduct personal hearings, in addition to other limited types of travel for training and participation in VA program activities. The requested funds also provide for Board attorneys to accompany VLJs on Travel Board trips to VA regional offices to assist in conducting the hearings and to provide training and other assistance to regional office adjudication personnel. We have been able to reduce our request for travel funds by reducing the number of attorneys on each Travel Board trip from two to one, except for trips to the St. Petersburg and Waco regional offices. St. Petersburg and Waco are the two regional offices with the highest number of pending Travel Board requests. The attorneys are of particular assistance to these regional offices by providing training to their personnel and ensuring that pending hearing cases are properly prepared for BVA consideration. This will result in a lower expenditure of travel funds, but will not reduce the quality or the number of Travel Board hearings that we provide.

While the FY 2007 request for travel funding of $453,000 is below the estimated $545,000 provided in FY 2006, it is still above the FY 2005 actual budget level of $427,000. In FY 2005, within those budgetary constraints, the Board conducted a record high number of 5,220 Travel Board hearings, in addition to 2,618 videoconference hearings and 738 Central Office hearings.

2. Please describe in detail how the reduction in funding for transportation of things will impact the Board's work, given the increase in appeals to both the Board and the United States Court of Appeals for Veterans Claims (the Court) in fiscal years 2005 and the first quarter of 2006.

RESPONSE: We do not anticipate that the decrease in funding for the transportation of things will have an impact on the Board's ability to meet its mission. The funds requested cover shipping costs of hearing recordings to the

Board's transcription unit in Wilkes-Barre, Pennsylvania, as well as the costs of shipping claims folders and miscellaneous appeals documentation to and from VA regional offices, medical schools, VA medical centers, and other sources utilized to obtain outside medical opinions and other shipments relative to pending appeals.

Thus far, we have not seen a significant increase in the number of cases returned to the Board from the Court, despite the increase of Notices of Appeal (NOA) filed with the Court. Nor have we seen an unpredicted increase in appeals received at the Board from the regional offices. Even if such an increase in receipts were to occur, this would not involve significant additional cost to the Board for the transportation of things. The costs of transportation of the records in these cases, as well as for most cases remanded by the Board are not funded by the Board's budget. The cases sent to the Board by regional offices are generally mailed at no expense to the Board. Most of the records involving cases returned from the Court or remanded by the Board to the Appeals Management Center are transported locally within the District of Columbia by contract carrier. This expense is not funded by the Board's budget. While the Board incurs the expense for transportation of records in certain expedited cases and medical opinion requests, the Board expects to be able to contain these expenses within the FY 2007 budget request with no decrease in the level of service provided.

While the FY 2007 request of $40,000 is below that of the estimated $55,000 of FY 2006, it is greater than the $30,000 actually budgeted for this activity in FY 2005.

3. Please describe in detail what "other services" will be reduced or eliminated as the result of the decrease in that category from the current 2006 estimate of $2,127 to the proposed $1,204.

RESPONSE: The category of "other services" primarily includes contractual support for the BVA Research Center and other research services, service contracts for equipment maintenance, and tuition costs for executive development, legal, medical, professional, and other training.

In regard to research services, we have generated significant savings by renegotiating our contract with Westlaw to provide an approximate savings of $50,000 for online research services in FY 2007.

We plan to achieve additional savings in training costs in FY 2007 by providing increased "in-house" training and group, rather than individual, training. We plan to save by sending fewer employees for training outside the Board. Those employees who attend "outside" training will be expected to disseminate what they have learned to other employees. As a further cost saving measure, where training by an "outside" expert is required, whenever feasible, we will arrange to

have such training provided on site at the Board to a large group of employees. We believe this strategy will enable us to provide quality training within our requested budget. We have already begun implementation of this strategy in our current training for all our VLJs and staff counsel on writing clear, concise, coherent and correct decisions.

We do not plan to curtail contractual support assistance for our Research Center. However, we expect to realize savings by relying more heavily on online research whenever feasible, rather than replace or expand our collection of paper texts.

While the $1,204,000 request for FY 2007 is below the current estimate of $2,127,000 for FY 2006, it is still above the actual $1,168,000 budgeted in FY 2005.

4. Please describe the impact of the marked increase in appeals to the Court in fiscal years 2006 and 2007 on the workload and staffing needs of the Board.

RESPONSE: While there has been an increase in the number of NOAs filed with the Court in 2005 and so far in 2006, there has not been a significant increase in the number of cases returned by the Court to the Board. In FY 2004, 1033 cases were remanded to the Board from the Court. In FY 2005, that number increased only slightly to 1138. Nevertheless, it is reasonable to expect that a rise in the number of cases appealed to the Court will eventually result in an increase in the number of cases returned to the Board by the Court.

Cases returned to the Board from the Court are initially handled by our Office of Litigation Support. That Office is able to effectively process returning cases at the FY 2004 and FY 2005 levels with a staff of five full-time FTE, including one supervisory attorney. The processing includes verifying the power of attorney in the case, sending letters of notification to the appellant and the representative, processing new mail and evidence related to the appeal, and handling any associated motions. Following completion of these procedures, the case is sent to a VLJ for action appropriate with the Court's order.

An increase in the number of cases returning from the Court would add to the workload of our Office of Litigation Support and, in turn, to the workload of our VLJs and counsel. As a point of reference, in 2001 and 2003, the number of cases returned from the Court for Board action exceeded 2000. This was primarily due to a blanket remand of cases by the Court due to passage of the Veterans Claims Assistance Act of 2000. To deal with this increased workload, additional attorney and administrative staff were detailed to the Office of Litigation Support to assist in processing the incoming cases in an expeditious manner. This, of course, diverted these personnel from their regular duties.

If the number of cases returning from the Court were to markedly increase, we would likely respond as we have in the past so as to ensure that these cases are handled in an expeditious manner. This would likely divert resources from processing and deciding other cases on the docket that are not subject to the expeditious handling requirements of remands or cases advanced on the docket.

5. Please describe how remands from the Court and remands from the Board to regional offices or the Appeals Management Center are tracked to comply with the statutory requirement that such claims be expedited. What procedures and time periods are used to monitor compliance with this statute?

RESPONSE: The law requires that the Secretary shall take such actions as may be necessary to provide for the expeditious treatment by the Board of any claim that is remanded to the Secretary by the Court. 38 U.S.C. § 7112. The Board implemented this statutory requirement by amending 38 C.F.R. § 20.900, Order of consideration of appeals, to provide that expeditious treatment will be accorded to cases remanded by the Court "without regard to [their] place on the Board's docket." 38 C.F.R. § 20.900(d) (2005). BVA Chairman's Memorandum No. 01-98-28 (Sept. 8, 1998) and BVA Handbook, Part 8460 (Nov. 10, 1997) set forth procedures and time periods for expedited processing of Court remands.

The Court provides copies of its daily orders and opinions to VA's Office of the General Counsel, Professional Staff Group VII (Group VII) generally within two business days after their issuance. Group VII then forwards copies of the orders and opinions to the Board's Office of Litigation Support by daily messenger. The Office of Litigation Support first creates an electronic Court remand record on the Veterans Appeals Control and Locator System (VACOLS) within one business day of receipt of the order or opinion. If the claims folder has not yet been received at the Board, the Office of Litigation Support will request the claims folder from the Agency of Original Jurisdiction (AOJ) or from the Office of the General Counsel. AOJs are required to forward the cases to the Board by overnight mail, and Group VII forwards cases by the daily messenger.

Following receipt of the claims folder, the Office of Litigation Support reviews both the claims folder and VACOLS to ascertain the correct representative, if any. After clarifying issues of representation, and after the Court finalizes the appeal by issuing mandate, a "90-day letter" is sent to the appellant or the representative pursuant to Kutscherousky v. West, 12 Vet. App. 369 (1999). In Kutsherousky the Court held that an appellant is entitled to a 90-day period of time, following the mailing of post-remand notice by the Board, in which to submit evidence and argument without a showing of good cause under 38 C.F.R. § 20.1304. If the case is appealed to the U.S. Court of Appeals for the Federal Circuit (Federal Circuit), the Board will not send a 90-day letter, but will instead notify the appellant or representative that the Board cannot act on the remanded

matter until the Federal Circuit has ruled on the appeal and the Court has issued a mandate in the case (the mandate serves to transfer jurisdiction from the Court to the Board). There are currently two full-time paralegals assigned to the Office of Litigation Support, who are each required to prepare 25 "90-day" letters a week. The Board receives approximately 100 remand orders each month so, under normal workflow conditions, the paralegals are able to keep up with the incoming remands without developing a backlog.

If the appellant or representative requests an extension of time in which to respond to the "90-day letter," the Office of Litigation Support will administratively allow the first extension request for no more than 30 days. Additional extension requests will be treated as motions and forwarded to the Veterans Law Judge (VLJ) assigned to the matter for a ruling. 38 U.S.C.A. § 7102(a). Upon receipt of a response, or expiration of the 90-day period, the case will be forwarded either to a co-located veterans service organization for their review, if applicable, or directly to the VLJ to take appropriate action in the case.

The Chairman's Memorandum, supra, provides that "upon receipt of a Court-remanded case, the responsible [VLJ] will assign it without delay to a staff attorney for immediate review and preparation of a proposed action." If, however, the VLJ determines that an outside medical opinion is required prior to appellate disposition pursuant to 38 C.F.R. § 20.901, Board administrative personnel will monitor such opinion requests to ensure that they are completed within the 60-day time limit established for those requests.

To help ensure that expeditious treatment is provided to Court remands at the Board, an electronic report was created in VACOLS that tracks the location of Court remand cases at the Board, including the number of days that the case was at the Board. Once a case is assigned to a VLJ, the VLJ is expected to complete action on a Court remand case within 30 days of assignment. Periodic status checks on this process are completed to ensure that this goal is accomplished. Once the VLJ has completed his or her adjudication of the remand, the Board's administrative processing and dispatch of the case must be completed within two business days.

Cases remanded to the Appeals Management Center (AMC) from the Board of Veterans' Appeals (BVA) are initially processed in date of remand order and within 20 days of receipt at the AMC. Cases "advanced on the docket" by BVA in accordance with 38 CFR 20.900(c), and subsequently remanded to the AMC are given priority processing by the AMC. Priority processing is also given to all cases remanded to BVA by the Court of Appeals for Veterans Claims and subsequently remanded to the AMC, as well as, remand cases in which the appellant is a former POW, homeless, age 70 or older, terminally ill, or experiencing extreme financial hardship (e.g., bankruptcy, foreclosure/eviction).

Information Technology

1. What funding does VA anticipate will be needed for completion of VETSNET financial and accounting system in fiscal year 2007? Please provide a detailed description of the resources needed.

RESPONSE: VA is currently rebaselining the VETSNET program in response to the recommendations provided by Carnegie Mellon and is developing an integrated plan that will redefine when VETSNET completion is projected. The FY2006 IT Appropriation did not include resources to support VETSNET in VA's base IT budget and therefore funds are also not in the 2007 budget. VA is currently assessing the availability of other resources to determine the feasibility of realigning them to VETSNET.

2. Please provide a list of all contracts in effect during fiscal year 2005 and the first quarter of 2006 for VETSNET related activity. Please specify the name of the contractor; the date the original contract was let; the contract price; the type of contract; the expected completion date; the date, cost, and justification for any extensions, modifications or amendments to the contracts; and, a brief summary of the contracted work, including resources.

RESPONSE: See Attachment A.

3. VA's management of information technology (IT) has been spotlighted in the recent past due to a number of highly visible failures and problems. VA is changing its IT management structure to another system that it hopes will yield efficiencies. How are the up-front costs for this transfer of management systems being determined?

RESPONSE: The Department retained the services of Gartner to assist in determining the costs of implementing a Federated IT management model. This model will centralize the management of the operational and infrastructure aspects of information technology needed to provide benefits, deliver high quality health care, and provide final memorials to deserving veterans. Development aspects associated with information technology will be handled by those organizations best positioned to ensure final products actually meet requirements and enhance organizational performance—the Administrations and staff offices in VA that will benefit from the program. In both instances, fiduciary control will lie with VA's Chief Information Officer, leveraging the IT Systems Account to ensure scarce fiscal resources are expended for maximum benefit.

The Gartner review divided the implementation of the new organization into four phases: mobilization; foundation building; transition; and optimization. Overall, it is expected to take approximately 400 work days to move from the current state to a position where the IT enterprise is being optimized for value—in other words,

the significant task of enhancing the organization through this revised IT process will require work well into FY 2007. The Gartner review provided estimates to the Department for each of the four phases, along with an organizational artifact (a fifth element—Organizational Change Program) to track the progress. Outside contractor services will be obtained to assist with the implementation plan and execution.

In the first year, FY 2006, VA expects to complete the "Mobilization for Change" process and a good portion of the next phase, "Build Foundation," expending about $10,000,000 toward the effort. In FY 2007, the balance of the process will be completed and another $10,064,000 will be required. In arriving at these estimates, VA used the following figures:

FY 2006—	
Mobilize for Change	**$ 453,388**
Build Foundation (first portion)	**9,196,612**
Organization Change Program (first portion)	**350,000**
TOTAL	**$10,000,000**
FY 2007—	
Build Foundation (last portion)	**$ 1,651,745**
Execute Transition	**3,773,522**
Optimize for Value	**4,287,357**
Organization Change Program (last portion)	**351,436**
TOTAL	**$10,064,060**

Veterans Benefits Administration

1. VA regional offices which have been deemed poor performing are continuing to be challenged by the inability to replace staff, the consequent need to promote persons who may be less than qualified for the work they are responsible for and low employee morale. While some work may be brokered, veterans served by those offices cannot expect to receive timely and accurate decisions on their claims. What plan does VA have to improve the performance of such offices? Will any vacant positions be filled at poor performing offices in 2007?

RESPONSE: VBA analyzes the practices and performance of regional offices that consistently demonstrate high performance year after year in order to identify best practices that can be shared across the organization. As one example, VBA conducted a cycle-time study which involved analyzing each segment of the claims process in an effort to identify ways to reduce the overall processing time. The study initially focused on higher performing stations, observing and documenting best practices. The study then concentrated on

offices experiencing performance difficulties to compare and validate findings. The results of the cycle-time study were shared with all regional offices for use in improving performance.

VBA also calls on high-performing offices to provide instructors for centralized training sessions. These sessions are held throughout the year for specific groups of employees, including those newly hired, those recently promoted to first-line supervisory positions, and new division level managers. Additionally, senior leaders within the organization are asked to enter into structured mentoring relationships with employees selected for formal development programs, including VBA's Assistant Director Development Program and VA's Senior Executive Service Candidate Development Program. VBA further leverages the knowledge and skills of the top-performing offices by frequently looking to those offices for people who can fill leadership positions at other offices.

VBA does employ a strategy of shifting workload and resources to the highest performing regional offices. Over the last few years, VBA has emphasized a performance-based resource allocation methodology that provides additional resources to high-performing regional offices. Regional offices are evaluated in terms of their weighted share of workload receipts and their ability to meet and/or exceed operational performance indicators in accuracy, timeliness, appeals resolution, and appeals timeliness. By linking the resource allocation process to strategic performance measures, higher performing stations receive additional resources. This ensures VBA is reinforcing its commitment to the organizational mission.

Staffing at VA regional offices for fiscal year 2006 is dependent on the ceiling established by the resource allocation models for each business line, and made in cooperation with the four Area Directors. Offices that are under their ceilings will be allowed to add staff in consultation with their Area Director and the Office of Field Operations.

Regional Office Directors are ultimately accountable for the performance of their offices, and work closely with Area Directors to address performance concerns and develop action plans to mitigate those concerns. All levels of management monitor performance and staffing and adjust expectations and resources to meet demands.

2. Has VA conducted any recent studies to determine the continued value of the end product system used to evaluate performance? Given the increasing number of claims per issue, please indicate the continued rationale for weighing work accomplished in values of eight issues rather than the number of individual issues.

RESPONSE: VBA agrees that measuring issue by issue would be a desired enhancement in determining the hours required to complete claims. For instance, many single-issue claims (such as PTSD and radiation exposure) require extensive time-consuming development, research, and medical opinions, which might exceed even that needed for an eight or more issue case that did not include any complicated disabilities. However, our current Benefits Delivery Network limits our ability to make changes to our work management system at this time. We are looking at other methods for analyzing claimant issues using RBA 2000.

3. Has VA conducted any recent studies to validate the expected production levels for Veterans Service Representatives, Rating Veterans Service Representatives, and Decision Review Officers? If so, please provide copies of the executive summaries or similar summaries of any such studies if no executive summaries are available.

RESPONSE: VBA has completed two informal reviews of the national performance standards VA implemented for Rating Veterans Service Representatives (RVSRs) and Veterans Service Representatives (VSRs) in 2002. No executive summaries were provided.

The informal reviews led to a reexamination of the VSR position. A team was formed in Summer 2003 to reexamine the national standards for VSRs and make necessary changes or adjustments. The team utilized the results of the two informal reviews as well as other input in its reexamination of the national standards. The changes to the standards were implemented in October 2005. The goal of the revised standards is to more accurately give credit for work processed by the various teams under the Claims Process Improvement (CPI) structure in the Veterans Service Center. The revised standards break out work actions by team while still aligning with end products. The revised standards will be reviewed after six months of full implementation, and an analysis of the results will be done at that point to determine if adjustments are needed. VBA convened a team in February 2006 to review the existing standards and recommend changes to the national performance standards for RVSRs. The review team did not recommend any changes to the existing RVSR performance standards for FY2006.

VA implemented national performance standards for Decision Review Officers in January 2003. The DRO performance standards have not been revisited, and there is no current schedule for review.

4. Does VA plan to recommend any legislation to implement recommendations of the evaluations of the Dependency and Indemnity Compensation programs, the Pension and Death Pension Programs, or Life Insurance for Service-Disabled veterans? Please provide a brief

description of the advantages and disadvantage of the unimplemented recommendations from these evaluations.

RESPONSE:

Dependency and Indemnity Compensation and Pension and Death Pension programs

We are currently preparing our FY 2008 legislative proposals and are considering the recommendations from the evaluations of the Dependency and Indemnity Compensation and Pension and Death Pension Programs in connection with that effort. However, these proposals are still under development.

The advantages and disadvantages of the unimplemented recommendations are briefly summarized below.

Pension Recommendation 1. Congress should consider increasing the benefit payable under veteran and survivor pension to 185% of the poverty level to coincide with the Department of Agriculture methodology for fixing the limit in determining entitlement to food stamps.

This recommendation has been carefully considered. The current income limit for veterans entitled to non-service connected pension is already at the poverty threshold. Supplemental Security Income, the other large needs-based cash payment system, ties its income ceiling to the poverty threshold in the same manner as pension does. While the recommendation is to increase that rate to have it coincide with the eligibility level for food stamps, we note that food stamps are not a true income maintenance program. The findings of the study indicate that veterans receiving disability pension are actually better off than similarly situated elderly poor citizens. Virtually all are at or above the poverty threshold. Therefore, for veterans, the current benefit appears to be achieving congressional intent.

With respect to survivors' pension the recommendation made in this report is under internal review for further development. In general, as the study noted, the majority of such survivors are below the federal poverty threshold.

Pension Recommendation 3. VA should encourage pensioners to submit medical expenses throughout the year instead of its current policy of asking needy pensioners to submit accumulated UMEs at the end of the year. The income level of participating pensioners is too low to expect them to carry the costs of medical expenses until the end of the year.

VA has studied this recommendation. Claimants already have the right to submit UMEs at any time they wish. Monthly reporting would increase the potential for

error and overpayments while significantly increasing VA's workload and manpower needs without increasing the actual dollars paid.

DIC Recommendation 2. Provide lump-sum payments to DIC recipients in lieu of monthly payments.

VA has considered this recommendation and notes that such lump sum payments may assist survivors in achieving self-sufficiency more quickly following the veteran's death, but there are significant practical obstacles: ensuring survivors have the financial acumen to manage the payment; recouping erroneous payments; and significant short-term outlay costs.

Life Insurance for Service-Disabled Program

VA considered the recommendations from the evaluation regarding the Service-Disabled Veterans Insurance (SDVI) program in conjunction with other benefit changes to the life insurance programs. Since those recommendations were made, there have been two major pieces of VA insurance legislation that have significantly benefited disabled veterans.

The first is the Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program, which provides for payment of between $25,000 and $100,000 to servicemembers who are insured under Servicemembers' Group Life Insurance (SGLI) and suffer a qualifying loss due to a traumatic injury. As of December 1, 2005, all servicemembers who have SGLI are automatically covered by TSGLI. In addition, TSGLI benefits are payable retroactively to any member who suffered a qualifying loss due to a traumatic injury incurred in Operation Enduring Freedom or Operation Iraqi Freedom on or after October 7, 2001 and prior to December 1, 2005. The amount of the TSGLI benefit payable depends on the type and severity of the qualifying loss. The average payment to date is $70,000.

The second change is the 60 percent increase in the maximum amount of SGLI coverage, from $250,000 to $400,000, that went into effect September 1, 2005. Upon release from service, totally-disabled members with SGLI coverage can apply for a free one-year extension of their SGLI coverage, and thereafter can convert their SGLI to Veterans' Group Life Insurance (VGLI), subject to payment of VGLI premiums. Those vererans who are not totally disabled can convert their SGLI coverage to VGLI or to an individual commercial life insurance policy without evidence of good health, within 120 days of separation. This is an important and valuable benefit to a disabled veteran who might otherwise be uninsurable. The Insurance Service's ongoing one-on-one special outreach program to recently discharged veterans with military disability ratings of at least 50% helps to ensure that disabled veterans are informed of their eligibility regarding these conversion options.

The advantages and disadvantages of each of the three program evaluation recommendations are outlined below.

1. **Automatically provide S-DVI insurance to any newly eligible veteran with an opportunity for the veteran to opt out of the program.**

   Advantages: The advantage of providing automatic coverage to all those receiving new awards of service connection for a disability is that it has the potential to increase program participation, which is currently about 10 percent.

   Disadvantages: VA already notifies those veterans who are eligible for S-DVI coverage. Although we would expect the participation rate to increase somewhat if the S-DVI coverage were automatic, we would still expect only a relatively small number of veterans to keep the insurance.

   A. ***Customer Service Factors:*** A large majority of veterans who would be automatically enrolled will not want the insurance and will want the action reversed. The vast majority of newly discharged veterans are choosing to not apply for S-DVI. Issuing it automatically, would, in effect, be filling a "need" that does not exist. The S-DVI program is not the appropriate insurance program for every individual who receives service connection for a disability. Some do not want any insurance at all. Some get their insurance through their employer. Still others, particularly those with lower disability ratings, can find more affordable insurance in the commercial market. Individuals who are forced to request the reversal and the refund of premiums would be unhappy with the process. The large number of reversals and refunds would increase administrative costs.

   B. ***Increased mortality cost due to non-service connected conditions:*** As required by law, non-service-connected health problems can result in the denial of an application for S-DVI. With automatic enrollment, no underwriting of these conditions would be performed. The result would be acceptance of poor health risks based on nonservice-connected conditions. The government would, therefore, be subsidizing nonservice-connected conditions.

   C. ***Increased mortality costs:*** The survivors of all individuals who didn't want the insurance, but who die before the premium is refunded, will be due the full face amount of coverage, as the grace period for payment of premiums is 60 days. This would increase costs to the program.

2. **Increase the basic amount of S-DVI coverage.**

Advantages: The face amount of S-DVI would compare more favorably with the average commercial policy issued. It would be at a level that would cover over two years of lost income for the survivor of the average policyholder.

Disadvantages: Increasing the face amount of the current program without making changes to the program eligibility rules would be very costly. Under S-DVI, a veteran gets a new two-year period of eligibility for every new disability that is established as service connected. Many new eligibility periods are based on service connection of minor conditions. Many others are based on a natural progression of a previously established service-connected condition. For example, a veteran with service-connected diabetes may, 20 years later, receive service connection for loss of sight due to diabetes. The almost unlimited eligibility period creates a situation where there is an incentive for the submission of applications from seriously or terminally ill individuals, which further adds to the cost of the program. This makes the true nature of the program a cross between insurance and a death gratuity. The result is that the subsidy cost is very high relative to the amount of coverage provided. For any given subsidy level, the more expansive the eligibility period, the fewer financial resources will be available for increasing the face amount of coverage or reducing premiums.

The Veterans Group Life Insurance (VGLI) program has been providing comparable coverage for newly discharged veterans with service-connected disabilities since 1974. The monthly cost of $10,000 of 5-year renewable term insurance at higher ages for the two groups is compared below:

Program	Age 60	Age 65	Age 70
S-DVI	26.00	39.00	58.70
VGLI	11.25	15.00	22.50

The system of repeatedly reopened eligibility periods for S-DVI is much more liberal than the normal conditions of eligibility available to individuals applying for commercial insurance coverage. Individuals normally buy life insurance when they are younger, since their need for insurance is greater and they are still in good health. However, the median age of individuals purchasing S-DVI is about 58. Many S-DVI applicants had ample opportunity to obtain life insurance coverage during their younger years, when they were healthy and had no known conditions that would prevent them from buying insurance, but waited until they were older and had severe health problems before purchasing S-DVI.

3. Revise the mortality tables used for the S-DVI program.

The Program Evaluation noted that S-DVI premiums are based on the 1941 Commissioners Standard Ordinary (CSO) Table. The S-DVI program was intended to provide service-disabled veterans with the ability to purchase insurance coverage at "standard" premium rates. In 1951, when this program began, these premium rates were competitive with commercial insurance policy rates. However, mortality experience has improved substantially over the years. As a result, S-DVI premium rates are now much higher than commercial premium rates. The Program Evaluation recommended reducing premium rates to reflect the more recent mortality rates based on the 1980 Commissioners Standard Ordinary (CSO) Table. However, since the completion of the Program Evaluation, the National Association of Insurance Commissioners has published the 2001 CSO Table, which was jointly developed by the Society of Actuaries and the American Academy of Actuaries. This table reflects more recent mortality experience than the 1980 table. All new commercial life insurance products must comply with the 2001 CSO Table by January 1, 2009.

Advantage: Premiums would be lower for disabled veterans. The table below shows a comparison of the current (1941 CSO Table) and updated (2001 CSO Table) premium rates for a variety of ages for a Five-Year Term Plan or an Ordinary Life Plan in the S-DVI Program.

Comparison of Current S-DVI Premium Rates with 2001 CSO Table Updated Rates				
Monthly Premiums For $10,000 of Insurance				
	5 Year Term Plan		Ordinary Life Plan	
	Current	2001	Current	2001
AGE	Basis	Basis	Basis	Basis
20	$2.10	$.80	$11.10	$4.10
30	3.20	0.90	15.20	6.20
40	5.80	1.60	21.60	9.80
50	11.90	3.70	32.30	16.20
60	26.00	10.00	51.00	27.90
70	58.70	25.70	86.40	50.20

Disadvantage: The primary disadvantage of updating the mortality rates is the cost. In FY 2005, the S-DVI Program required an appropriation of $35.6 million. This funding is necessary because the premium income

does not cover the cost of insurance claims due to the high mortality rate of the disabled veterans in the program. By updating the CSO Mortality Table to reflect current mortality rates, policyholders would pay less for their coverage and the government would be required to pay more to bridge the larger gap between premium income and claims.

5. What direct and indirect costs have VA incurred as the result of making foreclosed home available for hurricanes Katrina and Rita survivors? How many homes have been utilized by the Federal Emergency Management Administration?

RESPONSE: VA has worked with FEMA to make VA's acquired property inventory available to victims of the Gulf hurricanes on a rental basis; however, VA has not hired any additional FTE to accomplish this. All efforts to coordinate with FEMA were absorbed with existing FTE resources. VA sent two employees to the Baton Rouge Joint Housing Solutions Center and one employee to a Town Hall meeting in Alabama at FEMA's request. Travel, lodging and per diem costs for these personnel were approximately $10,000. VA has negotiated a monthly fee with VA's property management contractor ; however, rents collected should offset the cost of that fee. VA will accrue additional property holding costs such as taxes, utilities, homeowner's association fees, and general maintenance of the properties held off the market. Alterations to VA Systems needed to address rentals to FEMA-certified evacuees were accomplished under VA's fixed price maintenance contract without specific additional cost. Some scheduled system enhancements are being rescheduled as a result.

Currently VA has 476 properties listed on a website as exclusively available to FEMA-certified evacuees. Each listing is available for 30 days; however, VA has continued to extend the listings in response to FEMA's extension of evacuee hotel benefits. VA has rented 58 of the listed properties to FEMA-certified evacuees as of February 28, 2006. Another 99 have expressed interest, and leases are being prepared.

6. During fiscal years 2004 and 2005, how many foreclosed home were made available to homeless providers? Please describe the procedure for making homeless providers aware of property and for making such homes available for their use.

RESPONSE: VA sold 13 discounted properties under the program during FYs 04 and 05. In past years, our outreach efforts to homeless providers were conducted by the Property Management Staff at each Regional Office. We recently contracted out the Property Management function and no longer have the staff to continue the outreach effort. To ensure homeless providers are made aware of available properties, LGY is currently working with the Director of Homeless Programs to develop a strategy for disseminating program information to the non-profit homeless provider community.

7. How many of the additional staff provided for in FY 2006 will be assigned to handle claims at VA regional offices?

RESPONSE: The FY 2006 budget contains 7,911 direct FTE in compensation, pension and burial. This represents a 364 FTE increase over FY 2005. All of these additional FTE will be assigned to handle claims at VA regional offices.

Seamless Transition

What specific actions has VBA taken to ensure a "Seamless Transition" for returning Iraqi servicemembers?

Response: The seamless transition process supports all transitioning servicemembers who, as a result of injury or illness, enter the disability process leading to medical separation or retirement. In order to assure that returning OEF/OIF veterans, especially those with serious disabilities, have their benefits processed and evaluated quickly and efficiently, VBA has provided directives to our Regional Offices to address urgent needs and benefits processing. In addition, VBA has taken the following actions.

Case Management

In 2003, VA began placing Veterans Service Representatives at key military treatment facilities (MTFs) where severely wounded servicemembers from OEF/OIF are frequently sent. Since March 2003, a VBA OEF/OIF representative has been assigned for each MTF. Full time staff is assigned to the Walter Reed Army Medical Center in D.C., and the Bethesda Naval Medical Center in Maryland. Similar teams work with patients and family members at other MTFs serving as key medical centers for seriously wounded returning troops: Eisenhower (Ft. Gordon, GA), Brooke (Ft. Sam Houston, TX) and Madigan (Tacoma, WA) *Army Medical Centers;* Evans (Ft. Carson, CO) and Darnall (Ft. Hood, TX) *Army Community Hospitals;* and Camp Pendleton and Balboa *Naval Hospitals* (CA).

VA benefits representatives provide information and assistance in applying for VA benefits. These VBA representatives are generally the first VA staff to meet with the veteran and family members. VBA coordinators also conduct itinerant service at all other major military treatment facilities. As of January 2006, over 8,400 hospitalized returning servicemembers have been assisted through this program at seven major MTFs. Since March 2003, each claim from a seriously disabled OEF/OIF veteran is case-managed for seamless and expeditious processing. In January 2004, an OEF/OIF mailbox was created for veterans who chose to e-mail inquiries to VA from the "Contact VA" option at VA Web sites. In FY 2005, 886 e-mails were received through that medium.

Transition Assistance Program (TAP) and Other Military Services Briefings
From FY 2005 through FY 2006 to date, VBA representatives conducted the following transition briefings and related personal interviews. These briefings include pre- and post-deployment briefings for Reserve and National Guard members, and those conducted overseas.

OVERALL BRIEFINGS

Fiscal Year	*Briefings*	*Attendees*	*Interviews*
2005	8,184	326,664	124,092
2006*	1,264	65,218	8,853

*through 12/31/05

Physical Evaluation Board (PEB)
The Department of Defense (DoD) provides VA with information on servicemembers who enter the PEB process. This information is received from DoD monthly. The servicemembers listed have sustained an injury or developed an illness that may preclude them from continuing on active duty and result in medical separation or retirement. VBA contacts the servicemembers to acknowledge that we understand they may be separating from the military soon and ensure that they are informed about potential VA benefits and services.

Letters to Inform Servicemembers/Veterans on Benefits
VA sends benefit information through general mailings to separating and retiring servicemembers including deactivated Reserve/Guard members.

- Using lists regularly provided by the Department of Defense, VA sends to returning OEF/OIF veterans letters from the Secretary with VA Pamphlet 21-00-1, *A Summary of VA Benefits*, and IB 10-1, *A Summary of VA Benefits for National Guard and Reserve Personnel.*
- VA sends to every veteran upon receipt of his or her DD 214 a "Welcome Home Package" which includes a letter from the Secretary, VA Pamphlet 21-00-1, *A Summary of VA Benefits, and VA Form 21-0501, Veterans Benefits Timetable.*
- A similar follow-up letter is sent to veterans at 6-months following discharge.

Additional Outreach to Guard and Reserve
In January 2006, DoD completed the hiring of 54 State Benefit Advisors (SBAs). These employees are located in the National Guard Adjutant General offices in U.S. States and Territories. They serve as a conduit through which local VA facilities will be provided unit demobilization information to ensure VA briefings and information are provided to all demobilizing Reserve/Guard members.

In February 2006, VBA collaborated in coordinating and conducting training for these National Guard SBAs at the VBA Training Academy in Baltimore. In addition to general training on VBA and VHA benefits, the SBAs were provided VA points of contact to coordinate the delivery of healthcare and benefit

information to both demobilized Reserve and Guard Units. All Regional Offices Directors were provided the list of National Guard SBAs and were directed to work closely with them in order to open communication and increase collaboration with National Guard and Reserve units at the local level.

How does VBA identify recent veterans at risk for homelessness who have claims pending and no source of income?

Response: Most often, claims from homeless veterans are initiated through our Homeless Veterans Outreach Program in place at each regional office. We also identify a veteran's status as homeless or at risk of homelessness when taking a compensation or pension claim. These claims are specifically labeled for priority processing, with a goal of completing them within 30 days. Claims are also identified for priority processing when homelessness or at risk for homelessness status is discovered during the claims process.

Loan Guaranty

Is VA/Loan Guaranty Service currently involved in any negotiations with respect to imposing any penalty or settlement agreement with a property management contractor for non-satisfactory performance of contract, or any other reason?

RESPONSE: The Loan Guaranty Service property management contractor, Ocwen Loan Servicing LLC, has received notification that VA intends to impose penalties for the 3rd and 4th quarter of FY 2005 and the 1st quarter of FY 2006. The penalties for non-satisfactory performance of contracts total approximately $1.59 million.

Efficiencies

1. The fiscal year 2007 budget submission reduces its total obligations request by a line item labeled "Efficiencies." (Book 1 of 4, p. 1-4). That line item shows that VA achieved actual efficiencies in fiscal year 2005 of $0 (zero) dollars or $1.290 billion below its forecast efficiency savings goal in the fiscal year 2005 budget submission. Presumably, this is in response to the findings in Government Accountability Office (GAO) report, GAO-06-359R, which found VA lacked a methodology for making health care management efficiency savings assumptions reflected in the President's budget requests for fiscal years 2003-2006 and, was unable to provide any support for those estimates.

a. What was the impact of projecting for savings of $1.29 billion in FY 2005, yet achieving no savings? What programs and services were impacted? How was this gap filled?

REPONSE: The GAO report cited above stated on page 12 that "*Although VA does not have a reliable basis for determining whether it has achieved its*

savings, it does not mean that new savings have not occurred". There were no programs or services to veterans that were adversely affected during FY 2005 as a result of resource shortfalls or any other reason. The President requested and Congress approved a $1.5 billion supplemental appropriation to cope with the shortfall that developed in FY 2005. Because of this, VA was able to continue to provide the high quality of care to all of its patients.

b. In light of the GAO report [GAO-06-359R], what are the actual savings now claimed by VA for each of the fiscal years 2003 and 2004? If the amount claimed is greater than zero, please provide supporting documentation to include a detailed explanation of the methodology used for the determinations that would clearly meet the standard used by GAO in its audit. Do the amounts claimed by VA for actual savings reflect programmatic failures and other management related problems identified by the Inspector General, GAO and other third party evaluators that would clearly contribute to a net savings result? If yes, present documentation to support your position.

Response: As stated in the previous response, the recent GAO report did not find that actual efficiencies were not realized in fiscal years 2003 or 2004. To the contrary, during both years, unobligated balances were carried forward and wait lists were dramatically reduced, enhancing the overall quality of care delivered to our Nation's veterans. VA has concurred with the GAO recommendation that, if VA continues to plan and budget for management efficiency savings, VA will develop a methodology to project savings that provides key data and assumptions used; clear criteria for what constitutes savings; controls to ensure that actual savings are reported and documented properly.

c. During the February 8, 2006, hearing, the Secretary and members of his senior staff referenced a GAO letter to Congressional Appropriators, dated March 2, 2005, as support for VA's projected efficiency claims of $884 million in fiscal year 2006 and as carried over into the fiscal year 2007 budget request. The referenced letter states that, "[VA's fiscal year] 2006 estimate of $590 million in management savings appears achievable" (enclosure IV page 7). The letter also includes a qualifying statement that, "[GAO] did not test the reliability and validity of data used to calculate these [savings] estimates nor did [GAO] test internal controls or compliance with legal and regulatory requirements related to the management of this program." As GAO 06-359R will likely be dispositive over the March 2, 2005, letter because it did review the reliability and validity of data used by VA, and addresses evidence of savings rather than the potential for savings, how does VA justify using unsupported savings estimates to justify any offset to veterans' health care? Please support all aspects of the $884 million claimed for fiscal year 2006 and carried over to fiscal year 2007 by using documentation and detailed analyses. Explain VA's methodology and provide documentation to support: (i.) the $590

million per year claimed that are attributable to the March 2, 2005, GAO letter, and; (ii) the $294 million dollars added to the $590 million to yield the $884 million estimate that was claimed each year. Are these claims based on "Net" efficiencies?

RESPONSE: The VA Under Secretary for Health decided during the formulation phase of the FY 2007 budget that no new efficiencies would be included in either the FY 2006 operating budget or the FY 2007 President's budget that could not be substantiated. The new efficiencies in the FY 2006 Current Estimate and the FY 2007 President's budget consist primarily of pharmaceutical and clinical efficiencies provided to VA by its actuary, Milliman Associates, a highly respected professional actuarial firm. These efficiencies are described as follows:

Clinical savings reflect adjustments to the model for improvements in VA's health care management. Components reflect the impact of Advanced Clinical Access (ACA) in reducing excess utilization of outpatient services; VA's high degree of management of the use of pharmaceuticals, the tight prescription drug formulary, the impact of ACA on prescription drug utilization; and reflects a 2 percent per year improvement in VA's management of inpatient care as measured by a reduction in bed days of care.

Pharmaceutical savings are due to adjustments to the pharmaceutical cost and intensity trends. These adjustments recognize that VA's intensity growth will be slower relative to the private sector as a whole due to its robust formulary and management program and its inflationary growth rate lower due to its bargaining power in negotiations with drug companies.

The clinical and pharmaceutical savings described above and in the President's FY 2007 budget submission are provided by the actuary each year and are cumulative. They do not necessary directly offset any of the inefficiencies previously identified by GAO or the IG in the functional areas of logistics and purchasing & contracting.

d. Under Secretary Perlin made a point at the hearing of distinguishing between "management efficiencies" and "efficiencies" and testified that VA is not claiming management efficiencies; rather VA forecasts additional savings of $197 million from a combination of clinical and pharmaceutical efficiencies. Secretary Nicholson agreed with this characterization. The table titled: VA Medical Care Obligations by Program (FY 07 Budget, Book 1 of 4, p.1-4) uses the term "Efficiencies" to clearly create the offset to health care in fiscal years 2006 and 2007. The following table tracks VA's nomenclature changes for claimed, but unsubstantiated, savings-based offsets during Bush Administration and illustrates that, notwithstanding VA's choice of nomenclature, VA continued to carry over prior year's unsubstantiated savings claims to offset health care.

UNSUBSTANTIATED VA SAVINGS OFFSET CLAIMS AND THE BOTTOM LINE

Year	VA's Nomenclature	Yearly Add-on	Yearly Cumulative Claimed	Grant Total of Offsets
FY03	Management Services	$316 M	$316 M	$316 M
FY04	Mgt. Efficiencies & Competitive Sourcing	$633 M	$950 M	$1.266 B
FY05	Efficiencies	$340 M	$1.29 B	$2.556 B
FY06	Efficiencies (Management Savings)	$590 M	$1.789 B	$4.345 B
FY07	Clinic and Pharma. Efficiencies	$197M	$1.081 B	$5.426 B

In no two years did VA select the same term to define its offsets to veterans' health care. For the fiscal year 2007 budget request the Under Secretary coined the term "Efficiency" and claims it differs from "Management Efficiencies" seemingly because it specifies "Clinical Efficiencies and Pharmaceutical Cost Efficiencies." Understanding that the GAO report is highly critical of VA's claims of "management efficiencies" it is understandable that VA would elect to rename any future savings projection offsets. However, the explanations of "Clinical and Pharmaceutical Cost Efficiencies" in the fiscal year 2007 request (Executive Summary, p. 1-12 to 1-13) both refer to "management" in their explanations and both clearly are management issues that have, to varying degrees, been included in the prior year's savings category explanations. For example, the fiscal year 2003 budget request explanation for "Management Savings" discusses clinical program management and pharmaceutical procurement savings as does the fiscal year 2007 budget request. Please explain, in detail, why the terms coined by VA for efficiencies in the fiscal year 2007 budget are not related to the management of the programs specified. Additionally, please clearly show why management is not a core part of the new savings offset projections.

RESPONSE: The VA Under Secretary of Health decided during the formulation process of the FY 2007 budget that no new efficiencies would be included in either the FY 2006 operating budget or the FY 2007 President's budget that could not be adequately substantiated. It was therefore decided that the general term "Efficiencies" would be used instead of the previous term management efficiencies to simplify the semantics and distinguish the items from the previous terminology. The efficiencies in the FY 2006 Current Estimate and the FY 2007 President's budget are a combination of recurring management efficiencies from 2005 along with new and recurring pharmaceutical and clinical efficiencies provided to VA by its actuary, Milliman Associates. By using the above terminology VA does not imply that management is not an integral part of process to better define, identify, and validate organizational savings and cost avoidance. VA has concurred with the findings of the recent GAO report that a better system needs to be developed that will adequately substantiate any new management efficiencies that are apart from those provided by the actuary.

e. When a major management problem at VA is found and documented by a third party, how does VA offset its losses due to the management problems against the claims of efficiencies to produce a net result management-based savings? Why is it fair to base offsets to health care on other than net savings?

RESPONSE: VA does not disagree with the theoretical concept of basing offsets to inefficiencies that result from management problems identified by a third party such as GAO or the IG, with overall saving generated by operational efficiencies achieved in seemingly related areas. For example, savings from national procurement reforms could be said in a general way to offset inefficiencies identified in inventory management. Because efficiency savings are necessary to balance a network or medical center's budget one could argue that this is already occurring in many VA facilities on an ongoing day-to-day basis. If it was not, shortfalls would occur on a regular basis in many of the facilities. Directors at VA medical centers have the authority and flexibility to offset any inefficiency with any efficiency and it is presumed that they are routinely doing so on a regular basis and that the combined net effect of all of these actions contribute to their being able to stay within their respective allocation limits each year. It would be extremely difficult, if not impossible, however, to document or validate with the financial and accounting systems that are currently in place throughout VA this comprehensive process, which consists of numerous management actions being undertaken on a daily basis at each of 156 medical centers. VA is currently reviewing this process to determine if it would be feasible to attempt to design and implement a new, innovative system that would be capable or doing this.

f. In the enclosure with VA's January 30, 2006, response to the findings in GAO-06-359R, VA notes that the Assistant Secretary for Management will establish processes and procedures to assure the proper documentation is identified and how the realized savings should be tracked and reported. As VA is reporting both carry-over savings ($884 million) from fiscal year 2006 and additional $197 million for fiscal year 2007, please provide the methodology for tracking, documentation, internal controls and analysis for the efficiency savings, which was presumably developed by VA after the start of the GAO audit but before the February 6, 2006, release of the fiscal year 2007 budget request.

RESPONSE: VA has just begun to review the major process to establish policies and procedures to assure proper documentation is identified and control systems are developed to adequately track, monitor, validate, and record authentic instances of bona-fide management savings throughout the 157 medical centers for which it is responsible. Needless to say this is a major undertaking that cannot be completed in a short time frame. The design and implementation of a new computerized financial and accounting system capable of achieving the above objectives will take a significant amount of time and resources. In the

meantime, the VA Under Secretary for Health, as previously stated, has made a policy decision not to include any efficiencies that cannot be substantiated in future budget requests. The efficiencies in the FY 2007 President's budget are broken out as follows:

	FY 2005	FY 2006	FY 2007	Increase/ Decrease
Obligations.....	($679,841)	($883,800)	($1,080,819)	($197,019)

The actuarial efficiencies are included in the demand model provided to VA by the actuary each fiscal year and are further described as follows:

Clinical savings reflect adjustments to the model for improvements in VA's health care management. Components reflect the impact of Advanced Clinical Access (ACA) in reducing excess utilization of outpatient services; VA's high degree of management of the use of pharmaceuticals, the tight prescription drug formulary, the impact of ACA on prescription drug utilization; and reflects a 2% per year improvement in VA's management of inpatient care as measured by a reduction in excess bed days of care.

Pharmaceutical savings are due to adjustments to the pharmaceutical cost and intensity trends. These adjustments recognize that VA's intensity growth will be slower relative to the private sector as a whole due to its robust formulary and management program and its inflationary growth rate lower due to its bargaining power in negotiations with drug companies.

g. GAO reports GAO-06-359R and GAO-06-360R, titled Preliminary Findings Regarding VA's Budget Formulation Process, characterize the efficiency claims as created to fill a gap between what is needed and the amount requested [by the President]. GAO asserts that this characterization was promulgated by VA officials at three interviews and that no other explanation was ever provided. As VA lacked a methodology for the savings assumptions and presented no support for the efficiency savings estimates as well as promised to create these methodologies in its response to GAO – there seems little basis to dispute the characterization used by GAO. During the last 5 budgets, fiscal years 2003 through 2007, VA has offset veteran health care budgets by $5.426 billion dollars total. Also, during that period, this Administration imposed increases in copayments, denied access to the VA health care system to over a quarter million veterans, and was forced to request supplemental funding just to keep VA's doors open. Had the VA not claimed unfounded savings but had secured appropriated funds for health care, would: (i.) the increases in pharmacy copayments to veterans have been necessary; (ii.) priority 8 veterans been able to remain in the health care system because there would be no financial cause for their exclusion, and; (iii.) would the emergency supplemental request in fiscal year 2005 have been necessary?

RESPONSE: With the FY 2007 budget proposal, the President, working in partnership with Congress, will have increased health care funding for veterans by 69 percent since FY 2001. The President requested and Congress passed a $1.5 billion supplemental for FY 2005 because of unanticipated workload, OIF and OEF veterans, along with increases in patient intensity and utilization. The President's FY 2007 request represents a balanced approach to resource management so VA can continue to provide high quality care to those who need VA the most, America's core veterans - those who have service–connected medical conditions, those who are economically disadvantaged, and those with special medical conditions.

2. Please provide detailed explanations regarding the effect of "efficiencies" including "efficiencies" claimed in your fiscal year 2007 budget submission for fiscal years 2006 and 2007, including what was estimated, what was realized, and also provide detailed information regarding the effect of "efficiencies" on the Obligations by Objects charts for medical care, medical services, medical administration, and medical facilities for the past five fiscal years.

RESPONSE: The estimated efficiencies for the FY 2006 current budget and FY 2007 are described in the FY 2007 President's submission as follows:

> *Clinical savings reflect adjustments to the model for improvements in VA's health care management. Components reflect the impact of Advanced Clinical Access (ACA) in reducing excess utilization of outpatient services; VA's high degree of management of the use of pharmaceuticals, the tight prescription drug formulary, the impact of ACA on prescription drug utilization; and reflects a 2% per year improvement in VA's management of inpatient care as measured by a reduction in excess bed days of care.*
>
> *Pharmacy savings are due to adjustments to the pharmaceutical cost and intensity trends. These adjustments recognize that VA's intensity growth will be slower relative to the private sector as a whole due to its robust formulary and management program and its Consumer Price Index growth rate lower due to its bargaining power in negotiations with drug companies.*

It should be noted that estimates for FY 2006 and FY 2007 cannot be realized until after the end of the fiscal years noted. VA did not track, monitor, or record the impact of its management savings during those years by budget object class. VA has already concurred with the findings of the recent GAO audit that it needs to develop a better system and is currently in the process of reviewing the feasibility and practicality of doing so.

MCCF

When VA estimates third-party collections as part of the MCCF, are net collections or gross collections estimated? What percent of the third-party collections reported in the fiscal year 2007 budget is attributable to the cost to collect? Please describe the methodology used to determine the cost to collect.

RESPONSE: When VA estimates collections as part of the budget process, they are gross collections. The cost to collect methodology does not break the cost down by the type of collection. It is an aggregate cost for the total collections. In FY 2005, VHA implemented a new standardized process for facilities to consistently record the costs associated with the revenue cycle, using the VHA cost accounting system. A directive (VHA 2004-068) guiding this process was released in late December 2004. The directive requires that the appropriate staff's time devoted to the revenue cycle is identified and mapped to a specific account level budget cost center using the Decision Support System (DSS) cost accounting system. The directive includes a mapping for each function of the revenue cycle to the appropriate cost center and budget object code which should be used for costing purposes. The costs are then divided by actual collections to determine the cost to collect. The cost to collect is normally expressed as a percentage and is approximately 11 percent, cumulative for fiscal year 2006. VHA monitors the cost to collect on a monthly basis at a national and facility level.

Increased Energy Costs

What steps has VA taken, in addition to your request for $25 million for your Energy Management Program, to plan for and address increased energy costs? In light of the data lag in your budget modeling efforts, have you accounted for the current and projected costs of energy?

RESPONSE: In August 2005, VA formed a Department-wide Energy Management Task Force to address VA's energy challenges, including controlling energy costs and consumption. Task Force members are pursuing energy cost minimization through such strategies as centralized commodity purchasing, bill auditing, prudent energy efficiency investments, advanced metering and other approaches to improving data collection and analysis. VA anticipates energy cost savings of at least $60 million over the next 3-4 years through implementation of these and other actions laid out in the Energy Management Action Plan prepared by the Task Force.

VA projections of energy costs are based on best available information at the time the projections are made. However, energy costs over the past few years have been difficult to predict successfully for a variety of reasons. Chief among these are the instability of prices in newly deregulated electricity markets and the susceptibility of fuel prices to natural disasters (e.g., 2005 hurricanes) and political events in other countries. And, as natural gas becomes the fuel of

choice for centralized electricity generation, fluctuations in natural gas prices increasingly flow through to the delivered price of electricity.

VA's MA/BPR Program

VA briefed Senate Veterans' Affairs Committee staff on July 27, 2005, regarding VA's Management Analysis/Business Process Reengineering (MA/BPR) program. I fully support the stated objectives of the program, but am concerned that it too makes unfounded savings projections. Moreover, if the analytical rigor for the MA/BPR program parallels the faulty analysis used in the budget process VA may embark on more missteps. MA/BPR has potential to be an effective tool so long as the need for change is not consumed by a policy change. In a September 12, 2005, response to an inquiry on the program, the Secretary responded, 'one of the first steps of the MA/BPR initiative is to review and analyze how each of these functions is currently performed, identify new ways to perform the particular work function, implement process improvements, track and report performance results, share success stories and incorporate lessons learned.'

Please describe the level of detail, amount and type of data VA requires and evaluates before reaching a decision point under MA/BPR. Use the two pilot programs indicated in the letter as examples, state the level of confidence that all changes undertaken by VA will be cost effective and produce a better organization.

VA is embarking on its first two pilot studies under the Management Analysis/Business Process Reengineering (MA/BPR) initiative. These studies are piloting the MA/BPR methodology's processes by examining current service, exploring new business methods, and implementing changes to improve performance and demonstrate significant cost savings for direct reinvestment into Veterans needs in two specific areas:

1. Laundry and Linen Management
2. Food Services, including those functions resident in:
    a. The Nutrition and Food Service (N&FS)
    b. The Veterans Canteen Service (VCS)

Savings, improved performance, and sharing and implementing lessons learned are the studies' crucial outcomes. In order to correctly account for these outcomes, VA must be able to monitor and incorporate lessons learned, and measure:

1) baseline costs and Key Performance Indicators (KPIs),
2) estimated costs, savings, and KPIs associated with the reengineered/redesigned organization, Most Efficient Organization (MEO) to be implemented,

3) actual costs, savings, and KPIs associated with the MEO implemented (since in many cases actual costs, savings, and performance measures are not realized for some time after the new organization is implemented), and
4) costs to conduct the study and implement the MEO.

VA has developed and implemented a web-based Business Improvement Tracking System (BITS) to capture all costs, savings, and lessons learned. At each of five phases throughout the MA/BPR process, data and information must be collected and entered into BITS before proceeding to the next phase. This includes but is not limited to baseline, estimated (reengineered MEO), and actual (implemented MEO) costs as follows:

1) Personnel – to include salaries, benefits, overtime, shift differential pay, and holiday and weekend pay;
2) Material and supply costs,
3) Overhead costs,
4) Consulting costs,
5) Other related costs that do not fit logically into one of the aforementioned categories, and
6) One-time costs to perform the study, and implement the MEO (although these one-time costs are not added to the MEO cost).

BITS also captures KPIs for the baseline, reengineered MEO, and implemented MEO. These KPIs are based on a "balanced scorecard" approach to performance measurement and management, and revolve around financial performance, customer service, internal business process performance, and organizational learning and growth. Lastly, BITS was also designed to capture and share lessons learned with all study owners.

VA has a high level of confidence that all changes undertaken will indeed be cost effective and produce a better organization. By tracking current, estimated and actual costs, savings, and performance measures along each step of the MA/BPR process in BITS, as well as identifying and implementing lessons learned, VA management can ensure that no changes are implemented that are not supported by credible business cases.

VA's Office of Policy, Planning, and Preparedness would be happy to brief the House Veterans Affairs Committee staff at your convenience on how we plan to track costs and savings through each step of the MA/BPR process in BITS.

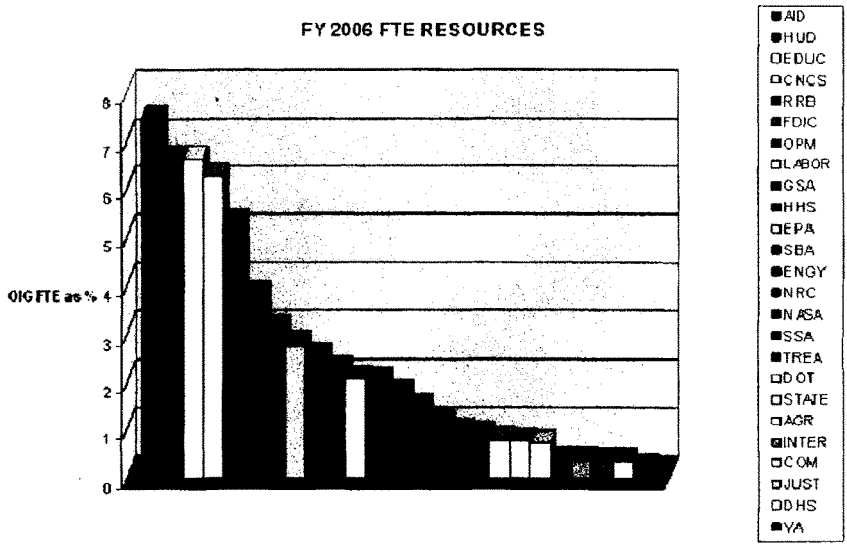
Inspector General

The fiscal year 2007 budget reduces staffing by 27 FTE. Of the offices of the Inspector General (IG) established by statute, how will the 2007 OIG relate – as a ratio of IG staff to employees of the parent agency – to other statutory offices of the Inspector General? As VA claims interest in pursuing real and tangible management efficiencies, why reduce the size of

the one organization that contributes to VA management effectiveness in a demonstrable way?

RESPONSE: When determining the appropriate staffing level for any office, FTEs are only one consideration among many important variables. For example, while VA administers nine major program areas, other departments administer dozens of programs with often smaller staffs. We are confident the VA OIG can continue its successful track record of work with the level of funding provided in the President's budget. The first chart lists the Full-Time Equivalents (FTE) for FY 2006 for 25 OIGs, their parent organizations and ratio of employees. The second chart is a graphical depiction of OIG FTEs.

Agency	OIG FTE	Parent FTE	Ratio
AID	187	2,500	7.5%
AGR	725	100,100	.7%
COM	146	37,400	.4%
CNCS	28	446	6%
EDUC	285	4,300	6.6%
ENGY	279	15,700	1.8%
EPA	362	17,400	2%
FDIC	160	4,200	3.8%
GSA	309	12,200	2.5%
HHS	1395	61,300	2.3%
DHS	540	146,600	.4%
HUD	650	9,800	6.6%
INTER	284	70,200	.4%
JUST	441	118,500	.4%
LABOR	468	16,800	2.8%
NASA	213	18,600	1.1%
NRC	49	3,300	1.5%
OPM	140	4,500	3.1%
RRB	53	1,000	5.3%
SBA	107	5,200	2.1%
SSA	615	64,000	1%
STATE	234	30,300	1%
DOT	435	55,400	1%
TREA	992	112,500	1%
VA	485	222,800	.2%



Health Care

1. At the February 8, 2006, hearing the VA stated that the fiscal year 2007 budget would fund 43 new Community Based Outpatient Clinics and that the fiscal year 2006 budget would fund 15 new CBOCs.

a. Please identify the location of the 15 CBOCs budgeted for fiscal year 2006 and the amount budgeted for each of the 15 CBOCs.

RESPONSE: The 21 Veterans Integrated Networks (VISNs) have analyzed their FY 2006 resources and workload demand and have submitted Community-Based Outpatient Clinic (CBOC) business plan submissions for review by the VA National Review Panel (NRP). The NRP has sent forward those business plans it has recommended for VA final approval and is working with the VISNs to clarify issues of concern on business plans that have not met the evaluation criteria.

The activation of CBOCs by the end of a specific fiscal year is dependent upon final VA approval and contract negotiations and lease agreements. All CBOCs will be funded from within existing VISN resources and budgets. Budgeted cost for the opening of a CBOC is subject to market variations and may differ from business plan proposals.

The NRP is a structured process to ensure commitment to the highest quality CBOCs. There are 31 CBOC business plans at different stages within the review and concurrence process; several have planned activation in FY 2006. A request for additional CBOC business plan submissions was made. VA is in the process of accepting an additional twelve CBOC business plans and they will begin the National Review Process in May 2006.

To date, two CBOC locations have been approved for planned activation within FY 2006:

1. Central Washington, WA
2. Hamlet, NC

b. Please identify the likely location of the 43 CBOCs budgeted for fiscal year 2007, and the amount budgeted for each of the 43 CBOCs.

RESPONSE: The sites and numbers of CBOCs to be implemented in FY 2007 are very preliminary. They will be dependent on the CBOCs approved and activated in FY 2006, the FY 2007 budget allocation in each Network, as well as continued analyses of enrollment projections, workload and demand for health care services that drive the Network Strategic Plans.

2. Last year, the VA had a shortfall due in part to an underestimate of demand for services from returning veterans from Iraq and Afghanistan. VA projects that it will treat 109,191 Operation Iraqi Freedom and Operation Enduring Freed (OIF/OEF) veterans in fiscal year 2007, which is less than the 110,566 OIF/OEF veterans VA estimates it will treat in fiscal year 2006.

a. Please explain in detail how VA arrived at an estimate of OIF/OEF veterans that shows a decline in the number of OIF/OEF veterans VA will treat.

REPONSE: The projection of a slight decline from FY 2006 to FY 2007 is based on a combination of our actuarial projection estimates using historical experience, our most recent actual experience, and the absence of any objective assessment to indicate any dramatic increase or decrease in this experience and the conduct of OIF operations. Through March of this year, we have treated 95,750 patients and obligated $152 million towards OEF/OIF patients. Although this level of patients is running at 35% higher than expected, the obligations are running at 29% below our projection.

b. Does VA's projection for demand from OIF/OEF veterans include any increases in workload that may be attributable to referrals to VA from the Department of Defense as part of the Post-Deployment Health Re-Assessment program (PDHRA)? If not, please provide us with your best estimates at this time as to any VA workload increases and staffing needs attributable to the PDHRA program.

RESPONSE: The projections of demand included in the budget were formulated prior to knowledge of and/or existence of the Department of Defense's Post-Deployment Health Re-Assessment program (PDHRA) plans. VHA is discussing this program with DoD, to better understand its implications for VHA. This is still a program and policy in the pilot stages at DoD, therefore no final estimates of workload or staffing can be made. VHA will coordinate any formal estimates it may make with DoD and OMB to ensure that we provide care and fund for these needs within the appropriate agency.

3. Please provide a detailed breakdown of how the $3.2 billion VA has budgeted for mental health care is projected to be spent in fiscal year 2007. Please also identify the amount of funds that VA projects it will distribute through the VERA formula. If funds are not from the medical services account, please identify the appropriate account (e.g., medical administration, medical facilities, medical & prosthetic research, etc.) for the mental health funds.

RESPONSE: VA's 2007 request includes nearly $3.2 billion ($339 million over the 2006 level) to provide comprehensive mental health services to veterans, including our effort to improve timely access to these services across the country.

Mental Health
FY 2007 Estimate

Description	Dollars in Thousands
Psychiatric Residential Rehabilitation Treatment	$188,016
Psychiatric, Inpatient	$1,109,424
Psychiatric, Outpatient	$1,551,990
Mental Health Initiative	$306,110
Total	$3,155,540

These additional funds will help ensure that VA continues to realize the aspirations of the President's New Freedom Commission Report as embodied in VA's Mental Health Strategic Plan and to deliver exceptional, accessible mental health care. The VERA allocation for FY 2007 will not be made until the appropriation becomes public law.

4. We would appreciate greater detail on VA's fiscal year 2007 budget to meet the long-term care needs of veterans.

Answer: VA's 2007 request includes over $4.3 billion for long-term care ($229 million more than the 2006 level). VA plans to increase the rate of growth on non-institutional care funding about twice as much as that for institutional care. With an emphasis on community-based and in-home care, VA can provide extended care services to veterans in a more clinically appropriate setting, closer

to where they live, and in the comfort and familiar settings of their homes surrounded by their families.

During 2007 VA will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 36,700. This represents a 14.4 percent increase above the level we expect to reach in 2006 and a 33.7 percent rise over 2005.

Long-Term Care
FY 2007 Estimate

Description	Dollars in Thousands
Institutional Care:	
Nursing Home Care	$3,198,937
Subacute Care	152,662
Residential Care	$451,055
Geriatric Evaluation and Management (GEM)	$6,479
Subtotal	$3,809,133
Home & Community-Based Care	$534,712
Long-Term Care Total	$4,343,845

a. VA projects for fiscal year 2007 to increase the Average Daily Census of veterans in the home-based primary care program by 2,599. Please provide a breakdown by state of the location for this increase in ADC. Please provide the budgeted amount for FY 2007 for home-based primary care.

RESPONSE: The FY 2007 estimate for Home-Based Primary Care is $194.9 million.

VHA establishes overall targets for Home & Community Based Care (H&CBC) services for each VISN, not for each state. The attached table shows H&CBC workload estimates by VISN for FY 2006 and FY 2007. Program increases are determined at the local level, based on demand for services and capacity in the community.

b. VA projects for fiscal year 2007 to increase the Average Daily Census of receiving homemaker/health aide services by 966. Please provide a breakdown by state of the location for this increase in ADC. Please provide the budgeted amount for fiscal year 2007 for homemaker/health aide services.

RESPONSE: The FY 2007 estimate for Homemaker/Health Aide Services is $187.4 million.

VHA establishes overall targets for Home & Community Based Care (H&CBC) services for each VISN, not for each state. The attached table shows H&CBC workload estimates by VISN for FY 2006 and FY 2007. Program increases are determined at the local level, based on demand for services and capacity in the community.

VA Home and Community Based Care Workload
Estimates for FY 2006 and 2007, by VISN

Network	Assigned Target for FY 2006	Estimated Target for FY 2007	Increase/Decrease in Census from FY 2006 to 2007
Network 1	1,290	1,476	186
Network 2	1,183	1,095	-88
Network 3	1,388	1,499	111
Network 4	1,518	1,802	284
Network 5	850	888	38
Network 6	1,240	1,484	244
Network 7	1,624	1,823	199
Network 8	2,378	2,760	382
Network 9	1,069	1,293	224
Network 10	1,586	1,530	-56
Network 11	1,435	1,529	94
Network 12	1,248	1,365	117
Network 15	770	1,007	237
Network 16	2,166	2,480	314
Network 17	1,144	1,313	169
Network 18	1,076	1,236	160
Network 19	821	907	86
Network 20	1,036	1,233	197
Network 21	1,222	1,346	124
Network 22	1,316	1,518	202
Network 23	1,146	1,367	221
National	27,506	30,951	3,445

- Targets include Home Based Primary Care, Purchased Skilled Home Care, Homemaker/Home Health Aide, VA and Community Adult Day Health Care, Home Hospice and Home Respite.
- Targets exclude Community Residential Care.
- Targets for VISN #2 and #10 decrease over time, based on population changes.

5. VA requests an additional $6.9 million for the Readjustment Counseling Service Vet Centers for fiscal year 2007, which will increase the number of visits by 25,000. Please provide detail on the projected number of FTEE increase that VA has budgeted for fiscal year 2007 for Vet Centers?

RESPONSE: The additional funding is required primarily for inflation. No additional FTE are planned for FY 2007.

6. VA projects for fiscal year 2007 an increase of $5.4 million for blind rehabilitation service programs. Please provide a detailed breakdown of

the how the increase for blind rehabilitation service is projected to be spent in fiscal year 2007. Please include in the detailed breakdown of projected spending any increase in the number of Blind Rehabilitation Outpatient Specialists, and the projected facility to which theses FTEE will be assigned.

RESPONSE: For FY 2007, VA projects an increase of $5.4 million for blind rehabilitation services. These cost projections are based on the continuation of the same services and the expected increase in patient demand. VA estimates an increase in costs of 7 percent from FY 2006 to FY 2007 resulting from a 4.5 percent estimated increase in the number of patients receiving these services from FY 2006 to FY 2007.

Cost Projections for FY 2007:

	FY 2006 Cost	FY 2007 Increase in Cost	FY 2007 Total Cost
Blind Rehabilitation Inpatient	$61,386,154	$4,358,910	$65,745,064
Visual Impairment Service Team (VIST) Coordinator	$11,119,576	$789,579	$11,909,155
Current Blind Rehabilitation Outpatient Specialist (BROS)	$3,655,754	$259,585	$3,915,339
Total	**$76,161,484**	**$5,408,074**	**$81,569,558**

Four BROS, located at each of the VA's four Polytrauma Centers, Richmond, Tampa, Minneapolis and Palo Alto, have been added as part of the core staffing for the interdisciplinary Polytrauma Rehabilitation Teams.

7. VA's budget projections and assumptions were far off the mark in FY 2005 and FY 2006. Fortunately, in a bipartisan effort, Congress corrected the shortfalls. We are again hearing that facilities are projecting a shortfall between demand and funding. Is this indeed the case? How many VISNs are looking at shortfalls for FY 2006? What are you doing to monitor whether VISNs and Facilities are delaying hiring or delaying purchases, which are indicators of a short budget, and what corrective action is being taken before veterans are affected by such shortfalls? If there are indeed shortfalls, do you plan on requesting supplemental funding to address these needs?

Response: In response to your February 15, 2006, post hearing question on VISNs that might have a negative variance in projected revenues and expense, we conducted a survey to determine if any fit this category. Our survey found, of

the 21 VISNs, 14 currently project that they will fall short of collection goals. To monitor and rectify potential shortfalls, monthly financial execution status briefings are provided to VA senior leadership. No impact on patient care is expected.

The 14 VISNS that project they will fall short of collection goals include VISN 1 Boston, MA; VISN 2 Albany, NY; VISN 3 Bronx, NY; VISN 4 Pittsburgh, PA; VISN 6 Durham, NC; VISN 7 Duluth, GA; VISN 8 Bay Pines, FL; VISN 10 Cincinnati, OH; VISN 12 Chicago, IL; VISN 15 Kansas City, MO; VISN 16 Jackson, MS; VISN 18 Phoenix, AZ; VISN 21 San Francisco, CA; and VISN 22 Long Beach, CA.

In response to your current question concerning FY 2006 funding for medical care programs, at this time, overall funding in the three medical care appropriations is sufficient for FY 2006, and we do not expect any additional funding needs. We will keep you informed of our funding status as we continue to monitor our costs for each of the three medical care appropriations on a monthly basis. Also, we would like to note that collections make up only 6.7 percent of the overall medical care budget; therefore, any shortfall in collections would impact a small portion of the overall budget.

8. Your budget request estimates a total of 5.3 million unique patients, a drop from your current estimate for FY 2006 of 5.4 million. This estimate looks very similar to your estimate in last year's budget submission, an estimate that you were forced to revise and follow up with a request for an additional $677 million last July. How much faith should we place in this year's estimate?

RESPONSE: Under current policy, VA would have expected to treat 5.5 million patients in FY 2007. However, due to the proposed annual enrollment fee of $250, the number of Priority 7 and 8 patients is expected to decrease by approximately 199,700. We have made significant improvements to the actuarial model that was used to support our 2007 budget request, including development of an enhanced methodology for determining enrollee morbidity and a more detailed analysis of enrollee reliance on VA health care compared to other medical service providers. Also, we have added new data sources, including the Social Security Death Index, which resulted in a more accurate count of enrolled veterans. Finally, we have more accurately assigned veterans into the income-based enrollment priority groups by using data from the 2000 decennial census.

VA continues to take steps to ensure the actuarial model accurately projects the needs of veterans from Operation Enduring Freedom and Operation Iraqi Freedom. However, many unknowns can impact the number and type of services the Department will need to provide these veterans, including the duration of the military action, when these veterans are demobilized, and the impact of our enhanced outreach efforts. Therefore, we have made additional

investments in key services, such as mental health, prosthetics, and dental care to ensure we will be able to continue to meet the health care needs of these returning veterans and veterans from other eras seeking more of these same services.

9. Although you have requested an increase in appropriated dollars for VA medical care, to the tune of $2.8 billion, a cursory glance at your FY 2007 budget shows a greater need than the $2.8 billion can meet. You fill these holes with legislative proposals, management efficiencies, and other accounting gimmicks we have seen before. These have not proven successful in the past. How confident can this Committee be that you need no further appropriated dollars?

RESPONSE: The President's 2007 request includes total budgetary resources of $34.3 billion for the medical care program, an increase of 11.3 percent (or $3.5 billion) over the level for 2006 and 69.1 percent higher than the funding available at the beginning of the Bush Administration. The 2007 budget reflects the largest dollar increase for VA medical care ever requested by a President and includes our funding request for the three medical care appropriations – medical services ($27.5 billion, including $2.8 billion in collections); medical administration ($3.2 billion); and medical facilities ($3.6 billion). This increase assumes that Congress will enact three legislative proposals proposed in the 2007 President's budget. If Congress chooses not to enact these three proposals, VA will require an additional $795.5 million in direct appropriation.

10. In light of your budget shortfalls in FY 2005 and FY 2006, how can this Committee be confident that the estimates contained in your FY 2007 budget submission are accurate?

RESPONSE: The FY 2007 budget submission is adequately funded through a combination of direct appropriations, collections, reimbursements, policy initiatives and carryover of prior-year funds.

Direct Appropriation:

- $34.3 billion in total request for the three medical care appropriations including collections ($31.5 billion in direct appropriations)
  - Increase of 11.3 percent over 2006 level (with collections)
  - Increase of 9.4 percent in direct appropriation (without collections)
  - Keeps pace with anticipated increases in medical care

- $2.8 billion from the Medical Care Collections Funds that receives revenues from veterans and their insurance companies
  - $37.9 percent increase over 2006 level (includes legislative proposals that will increase collections by $544 million in)

Reimbursements

- $266 million for reimbursements received from other federal and non-federal sharing agreements for services we provide them

Carryover

- $1.15 billion of carryover of prior-year funds projected to be carried into FY 2007.

11. Although returning combat veterans account for about 2 percent of VA workload, they already account for 5 percent of the VA PTSD workload. How many new returning veterans does VA estimate will need mental health services in FY 2007? How much has been estimated to care for these veterans?

RESPONSE: Projections of the number of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans that will need mental health services in FY 2007 would need to consider a number of uncontrollable variables. For example, 1) DoD is unable to provide data on the anticipated rate or pattern of discharge of troops; 2) VA cannot assume that the pattern of illness would be similar in troops discharged in the later phases of the conflict (e.g., would one expect higher rates of mental illness in troops that are redeployed several times?); 3) VA cannot assume that the pattern of use of VA health care services (vs. use of Vet Center services, private health care options, employer health plans) would be similar for troops discharged in the later phases of the conflict.

From FY 2002 through the fourth quarter of FY 2005, 36,893 OEF/OIF veterans who sought VA medical care received a diagnosis of a possible mental disorder. The President's Budget Request for FY 2007 includes a request for $3.2 billion for mental health programs, to cover psychiatric residential rehabilitation treatment, psychiatric inpatient and outpatient, and mental health initiatives. This is an increase of $339 million over the FY 2006 estimate and reflects increased demand for mental health services and other services for OEF/OIF veterans.

12. The CARES process identified the need for hundreds of Community Based Outpatient Clinics and other expanded access points. How many new CBOCs are funded for FY 2007? How many do you foresee funding over the next three years (FY 2007-FY2009)?

RESPONSE: The sites and numbers of CBOCs to be implemented in FY 2007, as well as the following fiscal years, are preliminary. They will be dependent on the CBOCs approved and activated in FY 2006, the FY 2007 budget allocation in each Network, as well as continued analyses of enrollment projections, workload and demand for health care services that drive the Network Strategic Plans. VA is currently in the process of reviewing CBOC business plans, which are at various stages of approval. The target numbers for how many CBOCs will be

activated by fiscal year will change as proposals move through the review and funding processes. VA is committed to continuing to expedite the CBOC business plan submissions through the process as we move forward into the future fiscal years.

Recognizing that resources are not available to open all of these clinics immediately, VA is managing the implementation by applying decision criteria on a national basis to ensure the greatest benefit to the greatest number of veterans. Each of the 21 Veterans Integrated Service Networks (VISNs) must apply decision criteria in establishing what outpatient clinics are needed and where. Once the VISN has established the need for a clinic it must develop business plans which address the resource requirements needed to provide quality care for our Nation's veterans. VISNs may propose outpatient clinics that are not on the list of 156, or different locations for the clinics. These proposals are then submitted to central office for review, with the consideration of improving access to care to the greatest number of veterans on a national basis.

As stated in the May 2004 CARES decision, it is VA's intention—depending on the availability of resources and validation of the need for an outpatient clinic—to implement 156 priority clinics by 2012. As VA proceeds in implementing CARES and as it engages in future planning, the locations of the outpatient clinics may change. VA's priorities—to enhance access to care in underserved areas with large number of veterans; to help overcrowded facilities better serve veterans; and to continue increase sharing of services and facilities with the Department of Defense—will not change.

13. VA has again decided to ignore the statutory requirement of a minimum capacity for nursing home beds. We are facing a significant increase in the number of aging veterans who will need care at home and in nursing homes. What portion of VA patients will VA not provide needed nursing home care? When do you plan to abide by the law regarding the Average Daily Census in your facilities?

RESPONSE: VA provides long-term care in both nursing homes and in non-institutional care settings. The nursing home care is provided in three venues: VA owned and operated nursing homes community nursing homes, and state veterans homes, each with distinct veteran populations served and each with distinct admission and eligibility requirements. These services complement each other so that veterans' needs for nursing home care can be met to the greatest extent possible. VA continues to expand its non-institutional care which includes home and community-based care to support the wishes of most patients to receive care in the comfort and familiar setting of their home surrounded by their family.

VA's 2007 request includes over $4.3 billion for long-term care ($229 million more than the 2006 level). The patient and cost projections associated with long-

term care have been checked to ensure that they represent our real need in this area. While we aim to expand all types of extended care services, we plan to increase the rate of growth of non-institutional care funding about twice as much as that for institutional care. With an emphasis on community-based and in-home care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live.

During 2007, we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census (ADC), to about 36,700. This represents a 14.4 percent increase above the level we expect to reach in 2006 and a 33.7 percent rise over 2005. This level of 36,700 ADC in 2007 will represent an increase of 85 percent over the 1998 level of 19,810 for non-institutional LTC. This well defined spectrum of care, including an array of home and community-based services, enables VA to honor veterans' preference for care and to provide services in the least restrictive setting, where services are commensurate with a veteran's health status, functional status, and personal circumstances.

Currently, VA is meeting 100 percent of the need for veterans who have mandated eligibility for nursing home care as required by Public Law 106-117. As indicated in the President's FY 2007 budget submission, VA will provide an ADC level of 11,100 in FY 2007. VA has no immediate plans to increase the VA nursing home census level to the 1998 level. VA has increased the overall nursing home care for the three venues by 2 percent from the 1998 ADC level of 33,670 to 34,358. Over this same time period, more veterans received long-term care in State veterans' homes as VA increased the ADC from 14,674 to 19,414, or 32 percent.

Follow-up Questions from the Honorable Stephanie Herseth
Before the Committee on Veterans Affairs
Hearing on the Department of Veterans Affairs
Budget for Fiscal Year 2007
February 8, 2006

1. Please provide a state-by-state breakdown of the location of the VA nursing home beds budgeted for FY 2007 to meet the budgeted 11,100 Average Daily Census (ADC).

RESPONSE: Attached is a state-by-state breakdown of the location of VA nursing home beds budgeted for FY 2007.

VISN	CITY	STATE	NAME
1	WEST HAVEN	CT	VA CONNECTICUT HCS WEST HAVEN
1	BEDFORD	MA	EDITH NOURSE ROGERS MEMORIAL VAMC
1	BROCKTON	MA	BROCKTON VAMC
1	LEEDS	MA	NORTHAMPTON VAMC
1	TOGUS	ME	TOGUS VAMC
1	MANCHESTER	NH	VAMC MANCHESTER
2	BUFFALO	NY	VA WESTERN NEW YORK HCS - BUFFALO
2	BATAVIA	NY	VA WESTERN NEW YORK HCS - BATAVIA
2	CANANDAIGUA	NY	CANANDAIGUA VAMC
2	SYRACUSE	NY	SYRACUSE NY VAMC
2	BATH	NY	BATH VAMC
2	ALBANY	NY	VA HEALTHCARE NETWORK UPSTATE
3	LYONS	NJ	NEW JERSEY HCS AT LYONS
3	BRONX	NY	BRONX VAMC
3	MONTROSE	NY	HUDSON VALLEY HCC - MONTROSE
3	CASTLE POINT	NY	HUDSON VALLEY HCC - CASTLE POINT
3	QUEENS	NY	NEW YORK HARBOR HCS - ST. ALBANS
3	NORTHPORT	NY	NORTHPORT VAMC
4	WILMINGTON	DE	WILMINGTON VAM & ROC
4	ALTOONA	PA	ALTOONA VAMC
4	BUTLER	PA	BUTLER VAMC
4	COATESVILLE	PA	COATESVILLE VAMC
4	ERIE	PA	VAMC ERIE
4	LEBANON	PA	LEBANON VA MEDICAL CENTER
4	PHILADELPHIA	PA	PHILADELPHIA VAMC
4	ASPINWALL	PA	H. J. HEINZ VA PROGSV CARE CTR
4	WILKES-BARRE	PA	WILKES-BARRE VA MEDICAL CENTER
4	CLARKSBURG	WV	LOUIS A JOHNSON VA MEDICAL CENTER
5	WASHINGTON	DC	WASHINGTON VAMC
5	BALTIMORE	MD	VA MARYLAND HCS BALTIMORE LOCH RAVEN

Continued:

VISN	CITY	STATE	NAME
5	PERRY POINT	MD	VA MARYLAND HCS PERRY POINT
5	MARTINSBURG	WV	MARTINSBURG VAMC
6	DURHAM	NC	DURHAM VAMC
6	FAYETTEVILLE	NC	FAYETTEVILLE VAMC
6	ASHEVILLE	NC	ASHEVILLE VAMC
6	SALISBURY	NC	W.G. (BILL) HEFNER SALISBURY
6	HAMPTON	VA	HAMPTON VAMC
6	RICHMOND	VA	RICHMOND VAMC
6	SALEM	VA	SALEM VAMC
6	BECKLEY	WV	BECKLEY VAMC
7	TUSKEGEE	AL	CENTRAL ALABAMA VETERANS HCS EAST
7	TUSCALOOSA	AL	TUSCALOOSA VAMC
7	ATLANTA	GA	ATLANTA VAMC
7	AUGUSTA	GA	AUGUSTA VAMC
7	DUBLIN	GA	CARL VINSON VAMC
7	CHARLESTON	SC	CHARLESTON VAMC
7	COLUMBIA	SC	COLUMBIA VAMC
8	ST PETERSBURG	FL	BAY PINES VAMC
8	MIAMI	FL	MIAMI VAMC
8	WEST PALM BEACH	FL	WEST PALM BEACH VAMC
8	GAINESVILLE	FL	GAINESVILLE VAMC
8	LAKE CITY	FL	LAKE CITY VAMC
8	TAMPA	FL	TAMPA VAMC
8	ORLANDO	FL	ORLANDO VAMC
8	SAN JUAN	PR	SAN JUAN VAMC
9	LEXINGTON	KY	LEXINGTON VAMC
9	MOUNTAIN HOME	TN	MOUNTAIN HOME VAMC
9	MURFREESBORO	TN	ALVIN C. YORK VAMC
10	CHILLICOTHE	OH	CHILLICOTHE VAMC
10	CINCINNATI	OH	CINCINNATI VAMC
10	BRECKSVILLE	OH	LOUIS STOKES CLEVELAND VAMC
10	DAYTON	OH	DAYTON VAMC
11	DANVILLE	IL	DANVILLE VAMC
11	MARION	IN	VA NORTHERN INDIANA HCS - MARION
11	ANN ARBOR	MI	VA ANN ARBOR HEALTHCARE SYSTEM
11	BATTLE CREEK	MI	BATTLE CREEK VAMC
11	DETROIT	MI	DETROIT VAMC
11	SAGINAW	MI	SAGINAW VAMC
12	CHICAGO	IL	JESSE BROWN VA MEDICAL CENTER
12	NORTH CHICAGO	IL	NORTH CHICAGO VAMC
12	HINES	IL	HINES VAMC
12	IRON MOUNTAIN	MI	IRON MOUNTAIN VAMC

Continued:

VISN	CITY	STATE	NAME
12	TOMAH	WI	TOMAH VAMC
12	MILWAUKEE	WI	MILWAUKEE VAMC
15	MARION	IL	MARION VAMC
15	TOPEKA	KS	VA EASTERN KANSAS HEALTH CARE
15	LEAVENWORTH	KS	VA EASTERN KANSAS LEAVENWORTH
15	WICHITA	KS	WICHITA VA MEDICAL CENTER
15	COLUMBIA	MO	HARRY S.TRUMAN MEM. VET. HOSP.
15	ST. LOUIS	MO	VAMC/JB DIVISION
15	POPLAR BLUFF	MO	JOHN J PERSHING VAMC
16	NORTH LITTLE ROCK	AR	CENTRAL ARKANSAS VETERANS HCS
16	PINEVILLE	LA	ALEXANDRIA VAMC
16	NEW ORLEANS	LA	NEW ORLEANS VAMC
16	BILOXI	MS	VA GULF COAST VETERANS HCS
16	GULFPORT	MS	GULFPORT DIVISION
16	JACKSON	MS	GV SONNY MONTGOMERY VAMC
16	OKLAHOMA CITY	OK	OKLAHOMA CITY VAMC
16	HOUSTON	TX	HOUSTON VAMC
17	DALLAS	TX	DALLAS VAMC
17	BONHAM	TX	BONHAM VAMC
17	SAN ANTONIO	TX	SOUTH TEXAS VETERANS HCS SAN ANTONIC
17	KERRVILLE	TX	SOUTH TEXAS VETERANS HCS KERRVILLE
17	TEMPLE	TX	CENTRAL TEXAS HCS TEMPLE
17	WACO	TX	WACO VAMC
18	PHOENIX	AZ	CARL T. HAYDEN VAMC
18	PRESCOTT	AZ	PRESCOTT VAMC
18	TUCSON	AZ	SOUTHERN ARIZONA VA HCS
18	ALBUQUERQUE	NM	ALBUQUERQUE VAMC
18	AMARILLO	TX	VA AMARILLO HEALTH CARE SYSTEM
18	BIG SPRING	TX	BIG SPRING VA MEDICAL CENTER
19	DENVER	CO	ECHCS - DENVER
19	PUEBLO	CO	ECHCS - PUEBLO
19	GRAND JUNCTION	CO	GRAND JUNCTION VAMC
19	MILES CITY	MT	MILES CITY VAMC
19	CHEYENNE	WY	CHEYENNE VAMC
19	SHERIDAN	WY	SHERIDAN VAMC
20	BOISE	ID	BOISE VAMC
20	VANCOUVER	WA	PORTLAND VAMC
20	ROSEBURG	OR	ROSEBURG VA HCS
20	SEATTLE	WA	PUGET SOUND HCS SEATTLE
20	TACOMA	WA	PUGET SOUND HCS AMERICAN LAKE
20	SPOKANE	WA	SPOKANE VAMC
20	WALLA WALLA	WA	JONATHAN M. WAINWRIGHT MEMORIA

Continued:

VISN	CITY	STATE	NAME
21	FRESNO	CA	VA CENTRAL CALIFORNIA HCS
21	MARTINEZ	CA	NORTHERN CALIFORNIA HCS
21	PALO ALTO	CA	VA PALO ALTO HCS - PALO ALTO
21	LIVERMORE	CA	VA PALO ALTO HCS - LIVERMORE
21	MENLO PARK	CA	VA PALO ALTO HCS - MENLO PARK
21	SAN FRANCISCO	CA	SAN FRANCISCO VAMC
21	HONOLULU	HI	HONOLULU VAMC
21	RENO	NV	VA SIERRA NEVADA HEALTH CARE SYSTEM
22	LONG BEACH	CA	VA LONG BEACH HEALTHCARE SYSTE
22	LOMA LINDA	CA	LOMA LINDA VAMC
22	SAN DIEGO	CA	VAMC SAN DIEGO
22	LOS ANGELES	CA	VA GREATER LOS ANGELES HCS WEST LA
22	SEPULVEDA	CA	VA GREATER LOS ANGELES HCS SEPULVEDA
23	KNOXVILLE	IA	KNOXVILLE VAMC
23	MINNEAPOLIS	MN	MINNEAPOLIS VAMC
23	ST CLOUD	MN	ST CLOUD VAMC
23	FARGO	ND	FARGO VAMC
23	GRAND ISLAND	NE	GRAND ISLAND VAMC
23	SIOUX FALLS	SD	SIOUX FALLS VAMC
23	FORT MEADE	SD	VA BLACK HILLS HEALTH CARE SYSTEM
23	HOT SPRINGS	SD	HOT SPRINGS DIVISION

2. Presuming that VA received sufficient funds to support the 13,391 ADC minimum in-house nursing home capacity required by PL 106-117, and provided that VA would have capacity to provide nursing home care for veterans with service connected ratings below 70%, where would VA locate those additional beds to meet the most pressing needs for nursing home care for veterans?

- **RESPONSE:** VA has made no assessment of where additional beds might be placed. If VA were to increase the number of VA Nursing home beds for veterans not mandated for this care (i.e., discretionary care), determining the location would require a new assessment

3. VA projects that in FY 2007, demand from VA's enrollee population for VA sponsored nursing home care would be 80,500 ADC. Please provide us with the comparable projected demand from the VA patient population.

RESPONSE: The Long-Term Care (LTC) demand model projects the enrolled population's demand for nursing home care, regardless of its source (e.g., Medicare, Medicaid, VA, etc.). The 80,500 ADC quoted in the question represents the demand for VA-provided or sponsored care. The LTC demand model projects demand for all enrollees, irrespective of whether they are eligible to receive care. However, not all enrolled veterans are mandated for this care. As a result, VA expects to treat approximately 34,400 ADC, which includes all

nursing home care patients who are mandatory for this care (i.e., those veterans who are rated 70 percent or greater service-connected) as well as some who are not mandatory but provided care due to the availability of space and resources.

4. Please provide us with VA's strategic plan to meet the needs of aging veteran patients.

RESPONSE: VA provides a continuum of long-term care services including institutional care in VA Nursing Homes, State Veterans Homes, and Community Nursing Homes, as well as providing Home and Community based care. In response to Conference Report 109-305 and in consultation with interested stakeholders, the Department conducted a study of demand for mandated long-term care services and undertook a review of funding requirements that would be required to address known life safety deficiencies in State Veterans Homes. The Department expects to submit a report of its findings to Congress shortly.

Follow-up Questions from the Honorable Silvestre Reyes
Before the Committee on Veterans Affairs
Hearing on the Department of Veterans Affairs
Budget for Fiscal Year 2007
February 8, 2006

I am concerned about an article published in the Washington Post dated January 9, 2006, concerning the Department of Veterans Affairs regional offices. The article brought to light an internal memo which indicates that only 19 percent of callers into the regional offices were given accurate information on disability claims. This is to say that 81 percent of incoming calls were given inaccurate information. In addition, the article stated that incoming callers were received by unhelpful and rude VA workers. I would like to know what the Department of Veterans Affairs is doing to correct the problem, what facilities are receiving follow-up action, and the status of any implemented steps already taken.

RESPONSE: The "mystery caller" study that was the subject of the news article you reference was undertaken by VA as an internal quality improvement initiative. Although VBA has had a local quality review process in place for many years that involves silent monitoring of calls by regional office management, the "mystery caller" study was intended to more consistently assess the completeness and accuracy of the information provided to inquiries that are not related to a specific claim. While the results of this internal review were far below expectations, they have been a catalyst for actions to improve the quality of our telephone services.

We continue to strengthen field guidance, oversight, and accountability systems. We are also expanding the training resources available to our employees and providing better information systems and tools. Completion of an on-line reference system to help ensure that employees provide complete and accurate information is being expedited for delivery by the end of the year.

All Regional Office Directors, Assistant Directors, and Veterans Service Center Managers have been advised that immediate and significant improvements are expected. They have also been directed to become personally involved in local telephone quality oversight and improvement efforts.

Mandated training requirements have been established for all public contact employees, and additional training tools have been made available for this training. Of note is the Telephone and Interviewing Techniques Training Video released to regional offices in January 2006 which focuses on customer service and professionalism.

We are in the process of implementing a national telephone quality assurance program that we successfully piloted last year. This program allows us to centrally monitor all types of calls to our system, instead of just assessing responses to "staged" general information calls by "mystery callers." It will also enable us to provide more immediate feedback and training to employees and their supervisors, which the pilot demonstrated can significantly and rapidly improve quality.

We are upgrading our telecommunications technologies in order to implement centralized quality monitoring of our national toll-free telephone network. We are beginning silent monitoring of regional offices as the systems are upgraded. By the end of 2006, we will have the necessary technology installed to enable us to silently monitor 28 regional offices across the country. We will then be able to establish a quality baseline for telephone services and develop regional office and national goals for performance improvement. We are also accelerating plans to acquire the technology to include the remaining regional offices.

Clearly our efforts to date have not achieved the results we are seeking and much more needs to be done. It is absolutely essential that we provide complete and accurate information to all those who call us for assistance – and that our assistance is provided with courtesy, understanding, and professionalism. This is a top priority for the entire VBA organization.

Follow-up Questions from the Honorable Shelley Berkley
Before the Committee on Veterans Affairs
Hearing on the Department of Veterans Affairs
Budget for Fiscal Year 2007
February 8, 2006

The budget calls for a decrease in full time employees who handle compensation claims in the 2007 budget. Since the outreach to veterans in the six states has not yet begun, how realistic is it to assume that claims generated by that outreach will diminish in 2007 to the point where the additional staff provided for 2006 will no longer be needed?

RESPONSE: Although we anticipate receiving the majority of the claims from the special outreach to the six states in 2006, we do not anticipate completing all of them in 2006. This is reflected by the projected increased year-end pending rating related claim inventory of 417,852 for 2006. While the additional claims based on the special outreach were included in determining our workforce needs, our requested FTE levels are based upon the entire VBA workload.

The projected number of pending rating claims for the end of fiscal year 2007 is estimated at 396,834. What level of staffing would be required to bring that number down to the 250,000 number which VA has historically represented as desirable number?

RESPONSE: VBA estimates that an additional 544 journey-level employees would be needed to reduce the pending rating claims to 250,000 at the end of FY 2007. Hiring and training a large number of new employees to achieve this objective would be costly and impractical, and would result in overstaffing when the pending workload returned to more normal levels.

Attachment A

VETSNET Contract	Contractor	Date original contract let	Contract Type	FY 2005 (Million)	FY 2006 (Million)	1st Qtr FY 2006 (Million)	Contract Completion Date	Date, Cost, Justification for extensions, modifications or amendments	Summary of contracted work, including resources
VETSNET Maint. For Conversion & Utilities	Northrup Grumman Information Technology (NGIT)	10/1/03	FFP	0.9	1.6	0.4	9/30/06	none	Provides technical support required to plan, develop, test and execute data conversion. These processes and programs extract, transform and load converted legacy data into VBA's Corporate database. Also supports replatforming of batch programs that allow data exchanges with other government agencies. Includes 4 resources.
VETSNET Testing and Quality Assurance	Science Applications International Corporation	7/11/02	FFP	5.2	5.0	1.3	Pending recompete award, contract completion date is 9/30/06 plus 3 option years.	Pending award of the contract recompete, the FY05 contract was extended through 3/31/06.	Provides technical support who perform independent verification and validation testing of all VETSNET applications. Includes an average of 30 resources.
C&P Payment Sys Replacement	NGIT	10/1/96	FFP	8.2	10.3	2.6	9/30/06	In June of 2005, the development schedule for Award/FAS was accelerated. An amendment was issued to add $2.7M to the contract to acquire additional resources.	Provides technical support to develop and maintain the Award and FAS applications. Includes 46 resources.
VETSNET MAP-D	NGIT	10/1/00	FFP	0.7	0.0	0.0	9/30/05	Beginning in FY06 all MAP-D maintenance performed by government.	Provided technical support to maintain the MAP-D Application. Included 3 resources in FY05.
VETSNET RBA2000	NGIT	10/1/00	FFP	0.9	1.1	0.3	9/30/06	Beginning in FY06 all RBA2K maintenance performed by contractors.	Provides technical support to maintain the RBA2K Application. Includes 5 resources.
VETSNET Study	Software Engineering Institute	5/1/05	FFP	0.7	0.0	0.0	9/30/05	none	Conduct an Independent Technical Assessment of the VETSNET program and make recommendations on the viability of the program. Included 5 resources.

VETSNET PMO Support	Mitre	12/19/05	CPFF	0.0	1.4	0.4	Contract completion date is 12/18/06 plus 2 option years	none	Provide VBA with the program management and system engineering expertise to support the advancement of the VETSNET program. Includes 3 full-time resources.

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