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HEARING ON FISCAL YEAR 2009 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

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FEBRUARY 13, 2008

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HEARING ON FISCAL YEAR 2009 BUDGET FOR VETERANS' PROGRAMS

WEDNESDAY, FEBRUARY 13, 2008

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Tester, Webb, Sanders, Burr, Craig, and Wicker.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. Aloha and welcome to the hearing. Before we begin, I ask for a moment of silence to honor the memory of a longtime member of the veteran community, Richard Fuller, who died last evening.

Richard began his work on veterans' issues in the late 1970's when he joined the staff of the House Veterans' Affairs Committee. Later, and for many years after that, Richard was a tireless and tenacious advocate for the Paralyzed Veterans of America.

Today's hearing is just the sort of event for which he would have prepared testimony or appeared or both. His intelligence and charm and wit were such effective tools in helping policymakers to truly understand the needs of veterans and our responsibility to them.

Richard will be greatly missed by those who knew and worked with him. So let us have a moment of silence for Richard. [Pause.]

We thank God for Richard and send blessings to him and his family.

Again, aloha and welcome to all.

When the President released billions of dollars in contingency funding last month, he put VA on course to make the improvements that we all know are needed. It was my sincere hope that the fiscal year 2009 budget would build upon that financial commitment.

After all, the challenges facing veterans grow more complex as the wars in Iraq and Afghanistan continue. Yet, in his very last budget, submitted to this body, the President is proposing limited funding overall and at the same time some very severe cutbacks to key programs.

The Administration is quick to say that this latest budget, if enacted, would nearly double the budget in effect since President

Bush took office 7 years ago. This statement ignores the fact that it was the work of Congress which has, on average, doubled the President's request each and every year.

While the Administration is requesting a straightforward increase for VA, an even greater of level of resources must be dedicated to care for the newest veterans and for their very specific needs. The Administration has consistently underestimated the impact that Operations Enduring and Iraqi Freedom would have on the VA health care system.

An even more pressing concern is the need for VA to do a better job of reaching out to these veterans and bringing them into the fold for care. Preventing suicide and healing invisible wounds, especially for members of the Guard and Reserves, takes a much more aggressive approach than is embodied in this budget.

It is also true that the budget before us targets key areas for drastic funding cuts. To cut VA research again is incredibly shortsighted. To cut the Inspector General's Office again, the central gear in oversight efforts is unwise. And to drastically cut construction at a time when VA should be upgrading its infrastructure is reckless and will prove to be quite costly in the long run.

On the benefits side of the ledger, in the last year Congress has provided a significant amount of funding through VA for much needed staffing to adjudicate claims. Our Nation's veterans deserve nothing less than having their claims rated accurately and in a reasonable period of time.

Now, the American people, especially veterans, will expect to see a decreasing backlog and increased timeliness and quality. I pledge to you my continuing support to get veterans the benefits they need in an appropriate amount of time. I am committed to working with the Secretary and my colleagues on both sides of the aisle to ensure that the Department gets what it truly requires to deliver high quality benefits and services to veterans.

I am also deeply committed to working with all Members of Congress to recognize the reality that meeting the needs of veterans is truly part of the ongoing costs of war.

This budget takes a meek approach to funding VA, especially in light of the sacrifices made by those who have served in the past conflicts and the devastating injuries sustained by many who are serving today. I do not doubt that we will turn this budget around. We must support a much more aggressive approach for improved health care and benefits, and we have much work to do.

Secretary Peake, before I yield to my colleagues, I want to ask you to pass along to the President, Secretary Gates, and others involved in the process, my very deep disappointment with the proposal made by the President in his State of the Union regarding GI Bill benefits.

To put before the Nation a proposal that does not seem to have been very well thought out, either in terms of cost or impact it could have on the ability to keep critical personnel in the Armed Forces, is ill-advised.

I look forward to our dialog with Secretary Peake and other top VA officials as well as the representatives of veterans service organizations here with us today.

One last matter before I turn to Senator Burr and others for opening statements. Today's hearing is our first event back in the Committee's hearing room following a major renovation which began last spring.

The changes to the room are dramatic, as you can see. When I walked into the room this morning for the first time, I wondered whether I was in the right room. It has certainly been improved. It is much better than it was and it is dramatic. Some of it you can see, but many changes are not visible.

While a great many people had a hand in bringing about these changes, one individual truly made it all happen and that is the Committee's Chief Clerk, and I wanted to point her out.

Kelly Fado, if you are here, will you please stand? [Applause.]

As any homeowner who has been through a renovation can attest, Murphy's Law applies nowhere more strongly than in connection with renovation efforts. Kelly had her hands full for many months, all the while performing myriad other tasks as the Committee's Clerk.

As you can see from the results, she did a superb job. Kelly, I again thank you for your extraordinary and detailed work that brought the Committee this awesome kind of change.

Senator Burr.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman.

One can only walk into the room and say, wow. Being a true conservative, though, I miss the folding tables we used before. [Laughter.]

It is, indeed, a sign that the work that is done in this room is extremely important and, Mr. Chairman, I want to thank you and, more importantly, Kelly, for overseeing the transition to what I think is a state-of-the-art room where people—not just in the room, but people outside, now with the telecommunications ability here and TV capacity—have the opportunity to see these hearings, to hear the substance, to hear the insight of the witnesses.

General Peake, let me take this opportunity to welcome you to your first hearing in the Senate as the man in charge, and I truly do say the man in charge.

You have had a very short time to get your hands around a $90 billion budget, but I know you have prepared well for the hearing and I look forward to your testimony.

Of course, it is helpful to have a good budget to support and I think on the whole you do. The medical care and disability benefits of our Nation's veterans are among our top priorities.

The fiscal year 2009 budget puts the right focus on critical programs that serve our Nation's heroes, wherein the overall medical care increases 5.8 percent. We see a 9 percent growth for mental health services, a 10 percent growth for prosthetics, a 7 percent growth for rehabilitative care; and, maybe most important during this time of war, a 21 percent increase in medical services for veterans of Operations Iraqi Freedom and Enduring Freedom.

But, I would like us to take a new approach in how we view the VA budget. We all know that funding for veterans has doubled

since President Bush took office. This increase has come during a time when most other domestic agencies have been held at little or no growth. So, clearly VA's budget has been and will remain a top priority to this Administration.

What I would like to know is if this money is translating into a better, more modern health and benefits system for our veterans. If it is, then we know we have made a good investment. But, if the system is not what we would like, then I suggest we think a little differently in how we propose to spend over $90 billion to improve the lives of veterans.

Let me give you an example. Recently I introduced the Veterans Mental Health Treatment First Act. That legislation would put VA's focus on what we all agree should be VA's most important job: restoring the capability of disabled veterans and improving their quality of life.

To me, there are two troubling facts for veterans with Post Traumatic Stress Disorder. One, there has been a 120 percent increase in the number of veterans with PTSD on the disability compensation roles since 1999. Two, the VA Inspector General tells us that once a veteran with PTSD is on the rolls, the disability rating tends to get progressively higher until a 100 percent rating is assigned to that veteran.

These facts raise a number of questions. If VA has recognized medical treatment therapies that are effective, then why does the evidence suggest that its core population, the service-disabled, simply progressively get worse and never better?

I believe there are two ways that we can improve on this. First, we need appropriate incentives to get veterans into treatment. Second, we need VA to emphasize wellness, recovery and restoration first, as opposed to focusing on a rush to assign disability ratings.

Both the Dole-Shalala and the Disability Benefits Commission highlighted the need for appropriate incentives to achieve the desired goals of wellness and employment. I happen to agree with both of those commissions.

Although the Treatment First Act focuses on veterans with mental illness, I am wondering if similar problems exist for other veterans. How has VA's focus on prevention and clinical practice guidelines translated into helping veterans with service-related conditions to become less disabled, or, at worst, not as disabled as they would otherwise have been without treatment?

After all, shouldn't that be our primary goal? Is not that the expectation of today's modern warrior? Frankly, a renewed focus on prevention and wellness is the forward thinking solution to the claims backlog problem, as well. After all, if we help veterans get well, stay well and help them to be gainfully employed, maybe they will not need to file disability claims. Under that scenario everybody wins.

Speaking of the claims backlog, it is another area where the traditional approach to solving problems in Washington has not gotten us very far. Veterans from my home State of North Carolina regularly tell me how frustrated they are with the claims process.

I would like everyone to follow along with me as I read from the VA budget on why backlogs and processing delays continue, and I quote, Instead of the traditional average of two to three disabilities

per claim, regional offices are now dealing with a workload in which approximately 16 percent of the cases involve eight or more issues per claim. The multiplicity of issues coupled with the procedural changes flowing from decisions by the court and from the complaint notification requirements mandated by law has increased the amount of time required to resolve an initial disability compensation claim."

Sound familiar? It should. Folks, I just read from the 1997 VA budget submission. The same reasons given in 1997 for backlogs, delays and frustrated veterans are nearly identical to the reasons given for those same problems in this year's budget and I suspect every year in-between.

How has Congress addressed the backlog problem since 1997? Since 1997 the budget has more than doubled, resulting in a doubling of staff dedicated to claims processing. But still the problem remains. What this should tell us is money is not necessarily the cure-all to this problem.

We need a new approach. I am anxious to work with my colleagues here at the VA to try to find something new. We also need to begin addressing the fundamental problems with the disability system. Both the Dole-Shalala and the Disability Benefit Commission tell us that the disability rating schedule is out of date, that it needs to be completely overhauled, that it needs to be updated to reflect loss of quality of life and that a modern compensation system should place more emphasis on treatment and vocational rehabilitation.

These are fundamental reforms that are long overdue. We have got to act with urgency so that there is a modern, coordinated and coherent purpose attached to the overall VA benefits system that we can all be proud of. Our goal should be a system that empowers veterans—a system that gives them the opportunity to return to a full and productive life, yet compensates them for the loss of quality of life and earnings capacity.

Let me finish with one final thought. VA has been a leading innovator in health care delivery. The electronic patient record is an example of this innovation that the private sector should and will do well to follow.

There is one area, however, where I think the VA is lagging behind the private sector. VA does not do enough to compare itself to the services provided to the outside world. I must say, though, that it is not the VA's fault. It is Congress's fault.

We have had a law on the books that says VA cannot compare its own costs for a particular medical service against the same service performed by a non-VA provider. How does this make any sense? Why is this good for veterans? I have yet to hear a good business case made for keeping this outdated ban in place.

Mr. Chairman, in summary, I am pleased to have a good starting point to talk about veterans' services for the coming fiscal year. We also need to start looking at VA's budget differently. Programs need to show results and they should be focused on the goals of restoration, recovery, improved care of the lives of our veterans in this country.

Mr. Chairman, I look forward to exploring these issues with our witnesses today but also with my colleagues on this Committee.

General Peake, once again I welcome you.

Mr. Chairman, if I might have the latitude to also welcome our newest member, Senator Wicker, to our side of the Committee.

Chairman AKAKA. Certainly.

The Chair recognizes Senator Murray for your opening statement.

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman, and thank you, Senator Burr.

We fully appreciate your holding this very important hearing as we talk about the President's proposed VA budget for fiscal year 2009. And I want to thank the representatives from the veterans service organizations who are here with us as well. They put a lot of work into writing and crafting the Independent Budget and they are here today as well to testify about the resources that our veterans really need.

Mr. Chairman, I also want to take a moment of personal privilege to welcome a number of my constituents who are AFGE employees who are here from the Spokane VA and Seattle VA. These are the people who really make it happen on the ground and work very hard for our veterans. If you could just stand up for a minute. I just want to recognize all of you who work for our veterans on the ground out there. [Applause.]

I join with all of you in extending a warm welcome to Secretary Peake. He is here for his very first Senate hearing as Secretary of the VA and we welcome you. And I want you to know I very much look forward to your trip next week to at the Walla Walla VA. I appreciate the fact that you responded to my invitation so quickly to come out and see on the ground what is happening. I think you will be impressed, as we all are, of the needs there and how we are moving forward. I really appreciate your coming out and being there.

Secretary Peake, many veterans and many Members of this Committee have placed a tremendous amount of faith in your ability to rise to the unprecedented challenges that are facing the VA today. We have an opportunity to change course at the VA but we have to do it quickly and we have got to get it right. They say out in VISN 20, where we are, that business as usual is not an option. They wear buttons and T-shirts saying that. And, Secretary Peake, I know that you know that well.

Secretary Peake, Congress and our veterans really are counting on you and your first test arrived on February 4 with the release of the President's budget. Given your short time on the job, I recognize you did not play a large role in creating the document, but you do have the unenviable job of being here today to defend that budget.

I say "unenviable" because at this point I find this budget unacceptable in many areas for a number of reasons, starting with my fear that it would close the VA's door to thousands of our Nation's veterans.

The present budget that was sent to us includes new fees and increased co-pays that I believe really will discourage many of our

veterans from accessing the VA even as our veterans are turning to the VA in larger numbers than ever before.

Now, the VA does not discuss the likely impact of that policy proposal in this year's budget submission but in previous budgets that have been sent to us the Administration estimated that those fees and those co-pays would result in nearly 200,000 veterans leaving the system and more than 1 million veterans choosing not to enroll.

I am also extremely disappointed that this budget continues to ban Priority 8 veterans from enrolling in the VA health care system. It is estimated, Mr. Chairman, that more than 1.5 million veterans have already been turned away from the VA since the Priority 8 ban was put into effect back in 2003 and many more have been deterred from seeking care.

I have made it very clear over the last several years that I believe that denying or discouraging our veterans from seeking care in the VA system because of their income is morally wrong, and I believe it will also make it harder to maintain and ensure that we have a strong voluntary military.

Another issue I want to mention is that while the President's budget does increase spending for VA medical care by $2 billion, it appears that this level will not meet the real needs of veterans once medical inflation and other factors that we need to consider are put in place.

The Independent Budget estimates that the true cost of VA medical care is $1.6 billion more than the President requested. I worry that underfunding medical care will prevent the VA from being able to provide timely and high quality health care that our veterans deserve. And given the Administration's involvement in covering up previous shortfalls in VA funding, I think this Committee has very good reason to be concerned about a future shortfall.

Along the same line, I am very troubled that the President is proposing an 8 percent cut to VA medical and prosthetic research. We all know that one of the signature injuries of the war in Iraq is Traumatic Brain Injury, but there is still a great deal more we do not know about the condition.

Cutting funding for research seems to be the wrong thing to do as we are trying to better understand the injuries that our veterans are experiencing.

Third, I am incredibly concerned that the President's budget proposed cutting funding for major and minor construction by nearly 50 percent at a time when a list of needed repairs and expanded facilities is stacking up.

The Administration's own budget documents detail the numerous projects that will not receive funding this year because of inadequate requests.

Finally, I object to the President's proposed funding cut to the VA Inspector General. I am very concerned about doing anything that might hinder the IG's ability to be an effective watchdog over this incredibly complex system at the very time we are trying to encourage effective oversight.

Secretary Peake, when I voted for your confirmation in December, I said that while we should not dwell on the mistakes of the past, we have to learn from them. So, I am very concerned that this budget is evidence that the Administration yet is not learning.

And in the State of the Union address just a few weeks ago the President said he was dedicated to providing for our Nation's veterans.

But, at a time when we are seeing thousands of new veterans entering the VA system with serious medical needs as a result of the wars in Iraq and Afghanistan, the Administration is underestimating the cost of medical care and it is cutting funding for construction and medical and prosthetic research. And at a time when our older veterans are seeking care in record numbers, the President is proposing fees and co-pays that will literally shut the door to thousands of patients.

We all know too well what happens when the VA gets shortchanged. The men and women who have served us end up paying the biggest price. Our veterans are heroes and they deserve the best we can give them. I believe that we can do a lot better than the budget request that has been sent to us by this Administration.

Secretary Peake, I appreciate your coming before the Senate Veterans' Affairs Committee. We have a number of questions for you and I look forward to hearing your responses this morning.

Thank you.

Chairman AKAKA. Senator Craig.

STATEMENT OF HON. LARRY E. CRAIG,
U.S. SENATOR FROM IDAHO

Senator CRAIG. Mr. Chairman, Ranking Member Burr, again thank you, as all of our colleagues have said, for holding this hearing in relation to the VA budget.

Secretary Peake and his forces are welcomed before the new dias of the Veterans' Affairs Committee. This is a pretty swank place, Danny.

Chairman AKAKA. Yes.

Senator CRAIG. I wonder if we could afford it. But, we are not going to worry about budgets today, obviously. I do want to thank you for being here to present the budget that has been presented to us by the Administration.

I would also like to welcome all of our service organizations and thank them for their work. We appreciate what you do and the value of what you do.

I have got to run to another hearing so I will not go into the detail of the budget. I will say, as a Member of this Committee longstanding, as many of our colleagues are, we are very proud of the fact that we have presided over unprecedented increases in the veterans budget now for nearly 8 years straight—11 percent, 12 percent, 13 percent, and last year 18 percent. No other agency of the Federal Government other than Defense and supplemental spending have grabbed the attention of the Congress like the veterans budget has.

Now, having said that, I also believe it is important that we do not throw money for the sake of throwing money to look good. We put money in the right places to make it work on behalf of America's veterans. I have said it before this Committee before in talking with two former Secretaries, after looking at last year's budget in relation to what we wanted to accomplish, we wanted to go after PTSD and to respond to the needs of our veterans.

They, in a moment of quietness, said to me, Larry, we cannot even spend that kind of money because we cannot bring the systems up fast enough, to go out and recruit the quality of people we need and train them and put boots on the ground in relation to serving our veterans in the time that the Congress expects with the money that we are being sent.

That was a rather dramatic statement but probably an honest one as it relates to gearing up to get things done, and I think that, Mr. Chairman, we need to be cautious. We need to be responsive, and most assuredly, we need to be responsible to our veterans, but just placing money out there to make it look good does not necessarily mean the services get to the ground.

A young Marine was home in Idaho during the Christmas break. He was found in his car dead with a gun on the seat beside him. The moment the news broke, I turned to my wife and said, "I fear that is a suicide." Well, it was.

It spoke to me legions about the reality of service today, the phenomenal responsibility our men and women in uniform have and take and in some instances the consequence of that service. So, it is overpowering to me and I think this Committee that we get it right, we do it right and we respond to these young men and women in a way that things like that, if at all possible, can be avoided and they can transition and live a life as a civilian after they have served our country in a way that we would hope they can and with that and their families.

Mr. Chairman, I have one other item to cover that I will raise with you, Mr. Secretary. It is of concern to me. I introduced legislation in the 109th Congress that became law. But a specific provision of it has not yet been implemented.

I would like to submit for the record two letters, Mr. Chairman, one from the Idaho Division of Veterans Services and one from an Idahoan and his family, who contacted me.

[The letters can be found in the Appendix.]

Senator CRAIG. The issue is quite simply this, Mr. Secretary: the Idaho State Veterans Home, and any State veterans home, as I understand it, is not receiving reimbursement from the Department of Veterans Affairs for housing veterans with a disability rate of 70 percent or more at this time, because the regulation has not been either written or implemented.

Included in the law is the enactment date of 90 days after the enactment of the Act. The bill was signed into law December 2006, and yet the provision, I am told, has not yet been implemented by VA.

Now, amazingly enough, I am also told that VA is currently reimbursing private nursing homes who care for veterans with the same disability rating. In other words, we have been able to respond to the private homes, but we cannot respond to the State homes.

These are the facts I have in front of me. I am not going to ask you to respond at this moment, but if you would get back to me on it. Again, if this is a matter of bureaucratic slowness, then shame on VA. But, there appears to be a discrepancy between what can be provided and is being provided in private homes versus the State homes.

So, with that, again, Mr. Secretary, and the crew you've got with you, thank you. Welcome. We are glad you are here. We look forward to your service to the VA and think you will do a tremendous job.

Chairman AKAKA. Thank you very much, Senator Craig.

STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman. Senator Wicker, welcome to the Committee. I am glad you are on with us.

Secretary Peake, nice to see you. I am proud to have voted for your confirmation, too.

I just listened to the comments around the table, and contrasting that with roundtables I have done around Ohio with different groups of people in 55 of Ohio's counties—some 80 roundtables—many of those roundtables—about a dozen of them—have been exclusively with veterans or just returning Iraq soldiers; I just do not buy the comments I hear around the table implicitly suggesting that we are spending too much, that the VA cannot keep up.

I have more confidence in you perhaps than my friend from Idaho does that you can spend wisely. That is the philosophy of the Defense Department, continuing to pump more money in, assuming that the generals and the Pentagon will spend it wisely.

I have that same confidence in you and all of you at this table. That is why I am so proud that the VSOs have put this document together—the Independent Budget—because it is clear to me that we are in times of war. Of course, our budget has gone up for the VA. It should go up for the VA.

I have met at these roundtables: going to hospitals; going to funerals; talking to families; talking on the phone to families who are being ripped apart because of untreated PTSD.

I mean, it is pretty clear to me that we can do a whole lot better in Congress and certainly the VA is partly at fault, as Senator Burr suggests, on those waiting lists. But, certainly the President's budget is, as Senator Murray articulated so well, is so shortsighted in what we have done.

I have a couple of comments. I will first apologize. I have a Banking markup I need to go to. I have looked at the testimony and I will certainly—Diane and all of us will—pay very specific attention, because by-and-large we know what needs to be done.

At one of my roundtables in Cleveland, at the Louis Stokes Medical Center, I met with some recently returning Iraqi war vets, most in their 20's and 30's. In attendance was also Dr. John Shupe who was going to be in the audience today, but is apparently stuck in traffic. Coming from Cleveland, he knows how to do this traffic. I am surprised he has not been able to get here yet. Dr. Shupe is part of a group at Cleveland State, which is working with returning vets to get them into the classrooms and help make their transition a bit easier.

We have not done that very well. At schools across the country, a recently returned Iraq solider, a recently returned Marine will be stuck in class, will be put in class with 30 other students who have had none of that experience in their lives, and this recently returning soldier has a difficult time.

Dr. Shupe has put together a program at Cleveland State to small groups of students as they integrate into this large campus at Cleveland State groups of veterans, people like Mario Turner, who was in one of these who suffers from PTSD and was uncertain about going into a class of 100 other students.

There are programs like that which we are trying to replicate around Ohio and we would like to work with the VA overall in helping with that. Part of it is passing the new GI Bill and what we can do for educational opportunities. That is great, of course. We should do that. We look at what it did for our country in the 1940's and 1950's—including, I assume, for some of you—and in the 1960's. But we have this opportunity. We need to also do what we can do on the ground that the way.

I also heard in these roundtables consistently the unhappiness of the proposed increased enrollment fees, doubling the co-pay and the President wanting to even increase further than that for prescription drugs. If you are taking four or five drugs and you have to pay $7 per drug per month, that is real money. Maybe not to people that dress like we do around this Committee table. But that is real money for a lot of these vets.

And I would hope the President would back off. He did once already under pressure and I hope all of you would consider that as we move forward.

But another point that I wanted to make, Senator Murray outlined a lot of the issues of the President's budget overall. On the one hand, the President's budget for 2009 is $51 billion in tax cuts for people making over $1 million a year.

Think about the choices and the priorities, $51 billion in tax cuts for people making over a million a year but we cannot fund veteran services well enough, people that many of them are going to be disabled and injured and hurt for the next 30 or 40 years.

It is a moral question. We know that. But also, as Senator Murray pointed out about oversight, the President's budget cuts the budget for Office of the Inspector General by $4 million.

Think of the message that sends. You have problems out there at Walter Reed. You have problems here but we do not really want to know about them so let us just cut the oversight budget. I mean, that just speaks volumes; we are a better people than that, a better government than that. We need to move in a very different direction there.

The last point. I appreciate Senator Burr's comments about the backlog. A veteran population of about a million in my State of Ohio. There is a backlog of 14,000 claims, 5,000 of those claims have been pending for over 180 days.

I asked Secretary Peake about that before. I really appreciate his responsiveness. I know he would want to do something about that. That is a serious, serious issue and I think we can work on that together.

I thank you all for your public service, those of you at the VA, and I particularly thank the public service and service to our country of the activists in the veterans service organizations that did this and have done so much more now and did so much more for our country in their lives.

Thank you.

Chairman AKAKA. Thank you very much, Senator Brown.

Now, I would like to welcome Senator Wicker to the Committee. As you know, Senator Wicker was the Ranking Member on the Mil-Con/VA Appropriations Subcommittee, so we know you know a lot about VA. I welcome you to the Committee and ask for your opening statement.

STATEMENT OF HON. ROGER F. WICKER,
U.S. SENATOR FROM MISSISSIPPI

Senator WICKER. Thank you very much, Mr. Chairman. I guess I have learned a little about the VA during my service in the House but certainly I think I can learn a lot more under your leadership and your tutelage here on this Committee, and it is a pleasure for me to join you and the rest of the Committee.

Secretary Peake, it has been mentioned several times that this is your first appearance before this Committee so you and I have that in common today.

As we listen to the opening statements, there is a bit of frustration that we are going to have a vote at 10:30. There are other Committees that are also working, so Members have to come and go.

I think I am learning that questions we might have been able to ask, we sort of raise in our opening statements and hope that the witnesses will address them during or perhaps after the hearing.

Let me congratulate you on your new position and to mention two things that perhaps the witnesses might talk about when they finally get a chance to speak themselves.

Senator Craig and Senator Brown, and perhaps others before them, mentioned the historic increases that this Congress has provided, and the Chairman is correct. I was happy to have a role in that as Ranking Member in the Appropriations Subcommittee on Mil-Con/VA on the House side.

I know that when we were formulating this budget, whether it was a justified concern or not, we did try to provide the VA with flexibility in case there were some accounts where you would not be able to spend all of the money to ensure that the VA would not be in a position of having to account at the end of the fiscal year for unused funds.

We wanted to give you funds that you could, indeed, expend. So, I would like for you to discuss that when it comes time for your testimony, Mr. Secretary, and particularly with regard to the medical construction budget for fiscal year 2009. Based on the historic increases that we had in 2008, I think that the Committee would benefit from hearing how that played into the request for this year.

Then there has been a lot of concern with regard to the interplay between health records—between DOD and the VA—and this has been a source of frustration for years.

DOD and VA have made progress ensuring electronic health information. Both Departments have been able to meet several milestones in response to the emerging and urgent needs for increased support of care delivered to the returning wounded warriors.

Both Departments, VA and DOD, have established time lines that include specific milestones for exchanging electronic health in-

formation, implementing mechanisms to achieve interoperability and transition from legacy systems.

It does appear that in the hand-off from DOD to VA for so many of our wounded warriors, we are still seeing what might be termed "a patchwork of linkups" between systems that we already had.

So, I would also hope that this Committee in working with you, Secretary Peake, could address the obstacles that there have been and the potential that we have to develop an honest-to-goodness, personal, portable electronic medical record for members to have as members of the military, and also to take with them as they move to veterans care.

Mr. Chairman, once again I thank you for your warm welcome and your courtesies to me during my 6 weeks now in the Senate.

To our witnesses, thank you for your attendance, and certainly also to the veterans who are here today.

I am glad to be part of this and I look forward to working with you all.

Thank you, sir.

Chairman AKAKA. Thank you so much, Senator Wicker.

Senator Tester for your opening statement.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman and Ranking Member Burr. It is a pleasure to be here. I want to also thank the Members of this Committee for being here today.

You guys are doing some great work. I will just tell you that right up front. I will preface all my comments with the fact that once the folks get in the system, you guys are able to provide some pretty darn good health care. We do have some problems and I know that you all are up to the task of meeting those problems.

I also want to welcome especially Secretary Peake. It is good to have you in front of the Committee as the confirmed Secretary of the VA. You have a big job ahead of you, and I know you are up to the task.

Just a couple of things I want to touch on and I do not want to be too repetitive. First of all, an increase in the budget I believe of $2 billion, and there has been eight straight years of budget increases. But I will also tell you there is a conflict going on in Iraq and Afghanistan and there is a big group of folks that are coming home from those conflicts that are going to need some help from injuries that are seen and injuries that are unseen. And we need to be geared up.

If, in fact, we appropriate money to you and you cannot figure out how to utilize it in a timely manner, then we will help you in that. You just need to tell us because the truth is that issues like PTSD are issues that we need to address sooner than later. And you folks know that. You are the experts at it.

But the truth is that when it comes to an issue that is unseen like PTSD or TBI, we need to be ready to handle them, and to be honest with you, the reason I feel more urgency on this now than ever is because of the hearings I have had around the State of Montana and the fact that the Vietnam vets are coming out because it is bringing back memories. They do not want these folks

to go through the same thing that they went through. So we need to be ready to go.

I would just tell you that in the budget, there are some things that I find a bit annoying. The fee increase for prescription drugs and enrollment. It has been mentioned before. I think it is ludicrous. Quite honestly it does not make a lot of sense to me. It is kind of like having a person there and we are going to give you good care but we are going to needle you a little bit, and I just do not think it is necessary.

The same thing under deductibility increase, and you are following the law. I appreciate that. Maybe we need to change the law as far as the deductibility for travel increase because quite honestly, in the way it is worded in my document, there are $20 to $30 million additional if it went back to $6 deductible in medical funds.

The truth is that $20 to $30 million in this overall budget will treat a lot of people for illnesses. Make no mistake about it. But, truthfully, it is not a huge line item in this budget, and we need to figure out how to fund it to get it back down, because in truth, I mean, it just does not make any sense.

Another issue I want to talk about and I will talk to Secretary Peake about it as time rolls on but you need to know it and I do not know if it is this way all over but recruitment of nurses and doctors and administrative personnel is critically important; and if, in fact, it is in your rules that you have to pay less than the private sector, we need to figure out a way to fix that because quite honestly you are not going to get the best people if you are stuck out at that level. We need to figure out ways we can give bonuses for recruitment or some way to get the very best people to treat our veterans in this country.

Right now they are understaffed in Montana, and some people may deny that; but I have talked to veterans, I have talked to staff members, and across the board they will tell you that we are deficient in doctors, nurses and administrative personnel.

Finally, the rating system for vets who are potentially disabled. It has been described to me by veterans on the ground as the equivalent of Chinese mathematics. Now, I do not know what that means because I have never taken Chinese mathematics but it is probably pretty complicated.

If there are ways to simplify that—ways to make a better understanding of how the ratings system works, less complex, takes up less time—I think those are all things we need to strive to work for.

We have a big job ahead of us. This budget, hopefully we will have the opportunity to work it over and honestly get the services to the ground. That is what we all want. We do not want it eaten up by administration. But by the same token, we have to have the people on the ground be able to deliver the service in a timely manner when people need it.

So with that, I thank you, Mr. Chairman. Thank you, Senator Burr, Ranking Member, for holding this hearing and I look forward to further scrutiny of this budget and I look forward to your guys' further good work.

Thank you.

Chairman AKAKA. Thank you very much, Senator Tester.

Now, I want to welcome Secretary James Peake to your first appearance here before the Senate Veterans' Affairs Committee, and we look forward to your statement at this time.

STATEMENT OF HON. JAMES B. PEAKE, M.D., SECRETARY OF VETERANS AFFAIRS; ACCOMPANIED BY: HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS; HON. MICHAEL J. KUSSMAN, M.D., UNDER SECRETARY FOR HEALTH; HON. WILLIAM F. TUERK, UNDER SECRETARY FOR MEMORIAL AFFAIRS; HON. ROBERT J. HENKE, ASSISTANT SECRETARY FOR MANAGEMENT; HON. ROBERT HOWARD, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY; AND HON. PAUL J. HUTTER, GENERAL COUNSEL

Secretary PEAKE. Thank you, Mr. Chairman. I have a written statement that I would like to submit for the record.

Chairman AKAKA. It will be included in the record.

Secretary PEAKE. Thank you.

Chairman Akaka and Senator Burr, ladies and gentlemen of the Committee, I am honored to be here as the sixth Secretary of Veterans Affairs and now responsible for the care of veterans. I appreciate the opportunity that the President has given to be able to make a difference.

With me today to present the President's 2009 budget proposal for VA is the leadership team of the Department. From my right we have General Howard, our Assistant Secretary for Information; Mr. Bill Tuerk, Under Secretary for Memorial Affairs; and Mr. Bob Henke, Assistant Secretary for Management.

On my far left, Mr. Hutter, our General Counsel; Admiral Daniel Cooper, Under Secretary for Benefits; and Dr. General Mike Kussman, Under Secretary for Health.

In my almost 2 months now at the VA, I have seen both the compassion and the professionalism of our employees. It is frankly just what I expected. The culture is one of deep respect for the men and women we serve.

This group at the table and the VA at-large understand that America is at war and it is not business as usual; and I do have my button.

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

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

This budget will allow VA to address the areas critical to our mission, namely, to provide timely, accessible, and high-quality health care to our highest priority patients.

We will advance our collaborative efforts with the Department of Defense, particularly working toward the development of a secure

interoperable medical records system. We will improve the timeliness and accuracy of our claims processing.

We will ensure the burial needs of our veterans and their eligible family members are met and maintain veteran cemeteries as national shrines.

The young men and women in uniform who are returning from Iraq and Afghanistan and their families presents a new generation of veterans. Their transition and reintegration into our civilian society when they take that uniform off is a prime focus.

Those seriously injured must be able to transition between DOD and VA systems as they move on their journey of recovery. This budget funds our polytrauma centers and sustains the network of polytrauma care that Dr. Kussman and his team have put in place.

It funds the Federal recovery coordinators envisioned by the Dole-Shalala report and sustains the ongoing case management at all levels of our system.

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

In 2009 we expect to treat about 333,000 OEF/OIF veterans. That is a 14 percent increase. We are estimating and seeing a slightly rising cost per patient and we have budgeted 21 percent increase in our cost to take care of this group. That is nearly $1.3 billion to meet the needs of the OEF/OIF veterans that we expect will come to the VA for medical care.

This budget will sustain our outreach activities that range from more than 799,000 letters to the more than 205,000 engagements that our Vet Center outreach personnel have made with returning National Guard and Reserve units as part of the post-deployment health reassessment process.

VBA has conducted more than 8,000 military briefings to nearly 300,000 servicemen and women. This is also part of seamless transition. With the authority to provide care for 5 years coming up for service-related issues, we can without bureaucracy offer the counseling and the support and care that might be needed to avert and mitigate future problems. I highlight the outreach piece because we want these men and women to get those services.

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

It will keep expanding mental health access according to a uniform mental health package, train mental health officials and there are 51 new CBOCs planned in 2009 in addition to the 64 that are coming on line 2008.

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

We appreciate the access issues in rural America. In this area our Vet Centers are budgeted for 50 new vans to support remote

access as well as expanding telemental health support in 25 locations.

Even as we speak, Deputy Secretary Mansfield, who would otherwise be with us here today, is testifying with Dr. Chu on the progress that has been made in our collaborative efforts between DOD and VA, in moving forward with recommendations from the Dole-Shalala report, and our focus on getting this transition right.

But this budget and our mission is more than just about these most recently returning servicemen and women. We should remember that 20 percent of VA patients, who in general are older and with more co-morbid conditions than the general population, have a mental health diagnosis.

In fiscal year 2007 we saw 400,000 veterans of all eras with PTSD. This budget will sustain VA's internationally recognized network of more than 200 specialized programs for the treatment of Post Traumatic Stress Disorder through our medical centers and clinics that serve all of our veterans.

We have a unique responsibility to serve those who have served before. We still have one World War I veteran. One died this last week. The World War II and Korea veterans are recipients of our geriatric care and our efforts in improving long-term care, non-institutional care, where in this budget we have increased 28 percent. It will make a huge difference in their quality of life.

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

Overall, the President's 2009 budget request includes a total of $41.2 billion for VA medical care, an increase of $2.3 billion over the 2008 level and more than twice the funding level available at the beginning of the Administration.

With it we will provide quality care, improve access, expand special services to the 5,771,000 patients we expect to treat in 2009. That is a 1.6 percent increase above our current 2008 estimate.

In April of 2006 there were over 250,000 unique patients waiting more than 30 days for their desired appointment date. That is not good. As of January 1, 2008, we had reduced the waiting list to just over 69,000. That is not so great either.

Our budget request for 2009 provides the resources to virtually eliminate the waiting list by the end of next year.

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

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

This IT budget also includes all the infrastructure supports such as hardware and software and communications systems for those 51 new CBOCs, for example. And there is $93 million for cyber security, continuing us on the road to being the gold standard.

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

In addition to IT, this budget sustains a 2-year effort to hire and train 3,100 new staff to achieve a 145-day goal for processing compensation and pension claims in 2009. That would be a 38-day improvement in processing from 2007, a 24-day or 14 percent reduction from what we expect this year.

This is important because the volume of claims received is projected to reach 872,000 in 2009. That is a 51 percent increase since 2000, real numbers even if it is historically a problem.

The active Reserve and National Guard returning from OIF and OEF have contributed to a increase in new claims and bring with them an increased number of issues with each claim.

This graph I think shows that, the number of issues growing significantly compared to the number of claims. The ADC is average days to complete, and what you see is relatively constant even though each one of those individual issues have to be separately adjudicated and rated.

The President's 2009 budget includes seven legislative proposals, totaling $42 million. One of these proposals expands legislative authority to cover payment for specialized residential care in VA approved medical foster homes for OEF/OIF veterans with TBI.

We again bring to you this request for enrollment fees for those who can afford to pay and for a raise of the co-pays. Again this does not affect our VA budget as the funds would return directly to the Treasury and that would be $5.2 billion over 10 years.

But it does reflect the matter of equity for those veterans who have spent a full career in service and under TRICARE to pay an annual enrollment fee for life care.

The $442 million to support VA's medical and prosthetic research program, though less than what we have from the augmented 2008 budget, is actually about 7.3 percent more than what was asked for in 2007 and 2008. It does contain $252 million devoted to research projects focused specifically on veterans returning from service in Afghanistan and Iraq, including projects in TBI and polytrauma, spinal cord injury, prosthetics, burns, pain, post-deployment mental health.

In fact, we anticipate with the Federal and other grants that we would have a research portfolio in the vicinity of $1.85 billion.

This budget request includes just over $1 billion in capital funding for VA with resources to continue five medical facility projects already underway in Denver, Orlando, Lee County, FL, San Juan and St. Louis, and to begin three new medical facility projects at Bay Pines, Tampa and Palo Alto, two of which relate to polytrauma rehab and continue our priority in this specialized area.

Finally, we will perform 111,000 interments in 2009, 11 percent more than in 2007. The $181 million in this budget for the National Cemetery Administration is 71 percent above the resources available to the Department burial program when the President took office. These resources will operationalize the six new national cemeteries that will open this year and provide a burial option to

nearly 1 million previously unserved veteran families and will maintain our cemeteries as national shrines that will again earn the highest marks in government and private sector.

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

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

[The prepared statement of Secretary Peake follows:]

PREPARED STATEMENT OF HON. JAMES B. PEAKE, M.D., SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, good morning. I am happy to be here and I am deeply honored that the President has given me the opportunity to serve as Secretary of Veterans Affairs. I look forward to working with you to build on VA's past successes to ensure veterans continue to receive timely, accessible delivery of high-quality benefits and services earned through their sacrifice and service in defense of freedom.

I am here today to present the President's 2009 budget proposal for VA. The request totals nearly $93.7 billion—$46.4 billion for entitlement programs and $47.2 billion for discretionary programs. The total request is $3.4 billion above the funding level for 2008. The President's ongoing commitment to those who have faithfully served this country in uniform is clearly demonstrated through this budget request for VA. Resources requested for discretionary programs in 2009 are more than double the funding level in effect when the President took office 7 years ago.

The President's request for 2009 will allow VA to achieve performance goals in four areas critical to the achievement of our mission:

- provide timely, accessible, and high-quality health care to our highest priority patients—veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs;
- advance our collaborative efforts with the Department of Defense (DOD) to ensure the continued provision of world-class health care and benefits to VA and DOD beneficiaries, including progress toward the development of secure, interoperable electronic medical record systems;
- improve the timeliness and accuracy of claims processing; and
- ensure the burial needs of veterans and their eligible family members are met and maintain veterans' cemeteries as national shrines.

ENSURING A SEAMLESS TRANSITION FROM ACTIVE MILITARY SERVICE TO CIVILIAN LIFE

One of our highest priorities is to ensure that veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom receive everything they need to make their transition back to civilian life as smooth and easy as possible. We will take all measures necessary to provide them with timely benefits and services, to give them complete information about the benefits they have earned through their courageous service, and to implement streamlined processes free of bureaucratic red tape.

We will provide timely, accessible, and high-quality medical care for those who bear the permanent physical scars of war as well as compassionate care for veterans who suffer from less visible but equally serious and debilitating mental health issues, including Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). Our treatment of those with mental health conditions will include veterans' family members who play a critical role in the care and recovery of their loved ones.

The President's top legislative priority for VA is to implement the recommendations of the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission). The Commission's report provides a powerful blueprint to move forward with ensuring that service men and women injured during the Global War on Terror continue to receive the health care services and benefits necessary to allow them to return to full and productive lives as quickly as possible. VA has initiated studies to determine appropriate payment levels for quality of life,

transition assistance, and loss of earnings. The next step is for Congress to pass the President's legislation, which will modernize the disability compensation system. VA is working closely with officials from DOD on the recommendations of the Dole-Shalala Commission that do not require legislation to help ensure veterans achieve a smooth transition from active military service to civilian life.

For example, VA and DOD signed an agreement in October 2007 to provide Federal recovery coordinators to ensure medical services and other benefits are provided to seriously-wounded, injured, and ill active duty servicemembers and veterans. VA hired the first recovery coordinators, in coordination with DOD, and they are located at Walter Reed Army Medical Center, National Naval Medical Center, and Brooke Army Medical Center. They will coordinate services between VA and DOD and, if necessary, private-sector facilities, while serving as the ultimate resource for families with questions or concerns about VA, DOD, or other Federal benefits.

In November 2007, VA and DOD began a pilot disability evaluation system for wounded warriors at the major medical facilities in the Washington, DC area—Washington VA Medical Center, Walter Reed Army Medical Center, National Naval Medical Center, and Malcolm Grow Medical Center. This initiative is designed to eliminate the duplicative and often confusing elements of the current disability processes of the two departments. Key features of the disability evaluation system pilot include one medical examination and a single disability rating determined by VA. The single disability examination is another improvement resulting from the recommendations of the Dole-Shalala Commission and is aimed at simplifying benefits, health care, and rehabilitation for injured servicemembers and veterans.

VA will continue to work with Congress, DOD, and other Federal agencies to aggressively move forward with implementing the Dole-Shalala Commission recommendations.

MEDICAL CARE

The President's 2009 request includes total budgetary resources of $41.2 billion for VA medical care, an increase of $2.3 billion over the 2008 level and more than twice the funding available at the beginning of the Bush Administration. Our total medical care request is comprised of funding for medical services ($34.08 billion), medical facilities ($4.66 billion), and resources from medical care collections ($2.47 billion). We have included funds for medical administration as part of our request for medical services. Merging these two accounts will improve and simplify the execution of our budget and will make it easier for us to respond rapidly to unanticipated changes in the health care environment throughout the year. We appreciate Congress providing us with the authority to transfer funding between our medical care accounts as this helps ensure we operate a balanced medical program. We will evaluate the potential need for adjustments to our medical accounts during 2008.

Information technology (IT) plays a vital role in direct support of our medical care program and VA is requesting a significant increase in IT funding in 2009, much of which will help ensure we continue to provide timely, safe, and high-quality health care services. The most critical component of our medical IT program is the continued operation and improvement of our electronic health record system, a Presidential priority which has been recognized nationally for increasing productivity, quality, and patient safety. We must continue the progress we have made with DOD to develop secure, interoperable electronic medical record systems which is a critical recommendation in the Dole-Shalala Commission report. The availability of medical data to support the care of patients shared by VA and DOD will enhance our ability to provide world-class care to veterans and active duty members, including our wounded warriors returning from Afghanistan and Iraq.

Workload

During 2009, we expect to treat about 5,771,000 patients. This total is nearly 90,000 (or 1.6 percent) above the 2008 estimate. Our highest priority patients (those in Priorities 1–6) will comprise 67 percent of the total patient population in 2009, but they will account for 84 percent of our health care costs.

We expect to treat about 333,000 veterans in 2009 who served in Operation Enduring Freedom and Operation Iraqi Freedom. This is an increase of 40,000 (or 14 percent) above the number of veterans from these two campaigns that we anticipate will come to VA for health care in 2008, and 128,000 (or 62 percent) more than the total in 2007.

Funding for Major Health Care Initiatives

In 2009 we are requesting nearly $1.3 billion to meet the needs of the 333,000 veterans with service in Operation Enduring Freedom and Operation Iraqi Freedom

whom we expect will come to VA for medical care. This is an increase of $216 million (or 21 percent) over our resource needs to care for these veterans in 2008.

The Department's resource request includes $3.9 billion in 2009 to continue our effort to improve access to mental health services across the country. This is an increase of $319 million, or 9 percent, above the 2008 level. These funds will help ensure VA continues to realize the aspirations of the President's New Freedom Commission Report, as embodied in VA's Mental Health Strategic Plan, to deliver exceptional, accessible mental health care. The Department will place particular emphasis on providing care to those suffering from PTSD as a result of their service in Operation Enduring Freedom and Operation Iraqi Freedom. An example of our firm commitment to provide the best treatment available to help veterans recover from these mental health conditions is our increased outreach to veterans of the Global War on Terror, as well as increased readjustment and PTSD services. Our strategy for improving access includes increasing mental health care staff and expanding our telemental health program that allows us to reach about 20,000 additional patients with mental health conditions each year.

Our 2009 request includes $762 million for non-institutional long-term care services, an increase of $165 million, or 28 percent, over 2008. By enhancing veterans' access to non-institutional long-term care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes surrounded by their families. This includes adult day health care, home-based primary care, purchased skilled home health care, homemaker/home health aide services, home respite and hospice care, and community residential care. During 2009 we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 61,000. This represents a 38 percent increase above the level we expect to reach in 2008.

VA's medical care request includes nearly $1.5 billion to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. This is $134 million, or 10 percent, above the funding level in 2008. This increase in resources for prosthetics and sensory aids will allow the Department to meet the needs of the growing number of injured veterans returning from combat in Afghanistan and Iraq.

Requested funding for the Civilian Health and Medical Program of the VA (CHAMPVA) totals just over $1 billion in 2009, an increase of $145 million (or 17 percent) over the 2008 resource level. Claims paid for CHAMPVA benefits are expected to grow by 9 percent (from 7.0 million to 7.6 million) between 2008 and 2009 and the cost of transaction fees required to process electronic claims is rising as well.

Our budget request contains $83 million for facility activations. This is $13 million, or 19 percent, above the resource level for activations in 2008. As VA completes projects within our Capital Asset Realignment for Enhanced Services (CARES) program, we will need increased funding to purchase equipment and supplies for newly constructed and leased buildings.

Quality of Care

The resources we are requesting for VA's medical care program will allow us to strengthen our position as the Nation's leader in providing high-quality health care. VA has received numerous accolades from external organizations documenting the Department's leadership position in providing world-class health care to veterans. For example, our record of success in health care delivery is substantiated by the results of the December 2007 American Customer Satisfaction Index (ACSI) survey. Conducted by the National Quality Research Center at the University of Michigan Business School and the Federal Consulting Group, the ACSI survey found that customer satisfaction with VA's health care system was higher than the private sector for the eighth consecutive year. The data revealed that patients at VA medical centers recorded a satisfaction level of 83 out of a possible 100 points, or 6 points higher than the rating for care provided by the private-sector health care industry.

In December 2007 the Congressional Budget Office (CBO) issued a report highlighting the success of VA's health care system. In this report—*The Health Care System for Veterans: An Interim Report*—the CBO identified organizational restructuring and management systems, the use of performance measures to monitor key processes and health outcomes, and the application of health IT as three of the major driving forces leading to high-quality health care delivery in VA. In October 2007, the Institute of Medicine released a report—*Treatment of PTSD: An Assessment of The Evidence*—that States VA's use of exposure-based therapies for the treatment of PTSD is effective. This confirms the Department's own conclusions and

bolsters our efforts to continue to effectively treat veterans of the Global War on Terror who are suffering from PTSD and other mental health conditions.

These external acknowledgments of the superior quality of VA health care 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 the medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the clinical practice guidelines index, which focuses on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to grow to 86 percent in 2009, or a 1 percentage point rise over the level we expect to achieve in 2008. As an indicator aimed at primary prevention and early detection recommendations dealing with immunizations and screenings, the prevention index will also grow by 1 percentage point above the estimated 2008 level, reaching 89 percent in 2009.

Access to Care

In April 2006 there were over 250,000 unique patients waiting more than 30 days for their desired appointment date for health care services. As of January 1, 2008, we had reduced the waiting list to just over 69,000. Our budget request for 2009 provides the resources necessary for the Department to virtually eliminate the waiting list by the end of next year. Improvements in access to health care will result in part from the opening of 64 new community-based outpatient clinics in 2008 and 51 more in 2009 (bringing the total number to 846).

The Department will expand its telehealth program which is a critical component of VA's approach to improve access to health care for veterans living in rural and remote areas. Other strategies include increasing the number of community-based outpatient clinics and enhancing VA's participation in the National Rural Development Partnership that serves as a forum for identifying, discussing, and acting on issues affecting those residing in rural areas. In 2009 the Department's Office of Rural Health will conduct studies to evaluate VA's rural health programs and develop policies and additional programs to improve the delivery of health care to veterans living in rural and remote areas.

Medical Collections

The Department expects to receive nearly $2.5 billion from medical collections in 2009, which is $126 million, or more than 5 percent, above our projected collections for 2008. About $8 of every $10 in additional collections will come from increased third-party insurance payments, with almost all of the remaining collections resulting from growing pharmacy workload. We will continue several initiatives to strengthen our collections processes, including expanded use of both the Consolidated Patient Account Center to increase collections and improve operational performance, and the Insurance Card Buffer system to improve third-party insurance verification. In addition, we will enhance the use of real-time outpatient pharmacy claims processing to facilitate faster receipt of pharmacy payments from insurers and will expand our campaign to increase the number of payers accepting electronic coordination of benefits claims.

Legislative Proposals

The President's 2009 budget includes seven legislative proposals totaling $42 million. One of these proposals expands legislative authority to cover payment of specialized residential care and rehabilitation in VA-approved medical foster homes for veterans of Operation Enduring Freedom and Operation Iraqi Freedom who suffer from TBI. Another proposal would reduce existing barriers to the early diagnosis of human immunodeficiency virus (HIV) infection by removing requirements for separate written informed consent for HIV testing among veterans. This change would ensure that patients treated by VA receive the same standard of HIV care that is recommended to non-VA patients.

The 2009 budget also contains three legislative proposals which ask veterans with comparatively greater means and no compensable service-connected disabilities to assume a modest share of the cost of their health care. They are exactly the same as proposals submitted but not enacted in the 2008 budget. The first proposal would assess Priority 7 and 8 veterans with an annual enrollment fee based on their family income:

Family Income	Annual Enrollment Fee
Under $50,000	None
$50,000–$74,999	$250
$75,000–$99,999	$500
$100,000 and above	$750

The second legislative proposal would increase the pharmacy co-payment for Priority 7 and 8 veterans from $8 to $15 for a 30-day supply of drugs. And the last provision would equalize co-payment treatment for veterans regardless of whether or not they have insurance.

These legislative proposals have been identified in VA's budget request for several years. The proposals are consistent with the priority system of health care established by Congress, a system which recognizes that priority consideration must be given to veterans with service-disabled conditions, those with lower incomes, and veterans with special health care needs.

These proposals have no impact on the resources we are requesting for VA medical care as they do not reduce the discretionary medical care resources we are seeking. Our budget request includes the total funding needed for the Department to continue to provide veterans with timely, accessible, and high-quality medical services that set the national standard of excellence in the health care industry. Instead, these three provisions, if enacted, would generate an estimated $2.3 billion in revenue from 2009 through 2013 that would be deposited into a mandatory account in the Treasury.

One of our highest legislative priorities is to establish the position of Assistant Secretary for Acquisition, Logistics, and Construction. The person occupying this new position would serve as VA's Chief Acquisition Officer, a position required by the Services Acquisition Reform Act of 2003. This will elevate the importance of these critical functions to the level necessary to coordinate their policy direction across the Department's programs and other government agencies. An Assistant Secretary with focused policy responsibility for acquisition, logistics, and construction would ensure these vital activities receive the visibility they need at the highest levels of VA. Legislation to accomplish this was introduced in the Senate on October 4, 2007, as S. 2138. We would appreciate Congress' support of this legislation.

MEDICAL RESEARCH

VA is requesting $442 million to support VA's medical and prosthetic research program. Our request will fund nearly 2,000 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of mental illness ($53 million), aging ($45 million), health services delivery improvement ($39 million), cancer ($37 million), and heart disease ($33 million).

One of our highest priorities in 2009 will be to continue our aggressive research program aimed at improving the lives of veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom. The President's budget request for VA contains $252 million devoted to research projects focused specifically on veterans returning from service in Afghanistan and Iraq. This includes research in TBI and polytrauma, spinal cord injury, prosthetics, burn injury, pain, and post-deployment mental health. Our research agenda includes cooperative projects with DOD to enhance veterans' seamless transition from military treatment facilities to VA medical facilities, particularly in the treatment of veterans suffering from TBI.

The President's request for research funding will help VA sustain its long track record of success in conducting research projects that lead to clinically useful interventions that improve the health and quality of life for veterans as well as the general population. Recent examples of VA research results that have direct application to improved clinical care include the use of a neuromotor prosthesis to help replace or restore lost movement in paralyzed patients, continued development of an artificial retina for those who have lost vision due to retinal damage, use of an inexpensive generic drug (prazosin) to improve sleep and reduce trauma nightmares for veterans with PTSD, and advancements in identifying a new therapy to prevent or slow the progression of Alzheimer's disease.

In addition to VA appropriations, the Department's researchers compete for and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2009. Through a combination of VA resources and funds from outside sources, the total research budget in 2009 will be almost $1.85 billion.

GENERAL OPERATING EXPENSES

The Department's 2009 resource request for General Operating Expenses (GOE) is $1.7 billion. Within this total GOE funding request, nearly $1.4 billion is for the management of the following non-medical benefits administered by the Veterans Benefits Administration (VBA)—disability compensation; pensions; education; housing; vocational rehabilitation and employment; and insurance. The 2009 budget request provides VBA over two times the level of discretionary funding available when the President took office and underscores the priority this Administration places on improving the timeliness and accuracy of claims processing. Our request for GOE funding also includes $328 million to support General Administration activities.

Compensation and Pensions Workload and Performance Management

A major challenge in improving the delivery of compensation and pension benefits is the steady and sizable increase in workload. The volume of claims receipts is projected to reach 872,000 in 2009—a 51 percent increase since 2000.

The number of active duty servicemembers as well as reservists and National Guard soldiers who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom is one of the key drivers of new claims activity. This has contributed to an increase in the number of new claims, and we expect this pattern to persist at least for the near term. An additional reason that the number of compensation and pension claims is climbing is the Department's commitment to increase outreach. We have an obligation to extend our reach as far as possible and to spread the word to veterans about the benefits and services VA stands ready to provide.

Disability compensation claims from veterans who have previously filed a claim comprise about 54 percent of the disability claims received by the Department each year. Many veterans now receiving compensation suffer from chronic and progressive conditions, such as diabetes, mental illness, cardiovascular disease, orthopedic problems, and hearing loss. As these veterans age and their conditions worsen, VA experiences additional claims for increased benefits.

The growing complexity of the claims being filed also contributes to our workload challenges. For example, the number of original compensation cases with eight or more disabilities claimed increased by 168 percent during the last 7 years, reaching over 58,500 claims in 2007. Over one-quarter of all original compensation claims received last year contained eight or more disability issues. In addition, we expect to continue to receive a growing number of complex disability claims resulting from PTSD, TBI, environmental and infectious risks, complex combat-related injuries, and complications resulting from diabetes. Claims now take more time and more resources to adjudicate. Additionally, as VA receives and adjudicates more claims, this results in a larger number of appeals from veterans and survivors, which also increases workload in other parts of the Department, including the Board of Veterans' Appeals and the Office of the General Counsel.

The Veterans Claims Assistance Act of 2000 has significantly increased both the length and complexity of claims development. VA's notification and development duties have grown, adding more steps to the claims process and lengthening the time it takes to develop and decide a claim. Also, the Department is now required to review the claims at more points in the adjudication process.

VA will address its ever-growing workload challenges in several ways. For example, we will enhance our use of information technology tools to improve claims processing. In particular, our claims processors will have greater on-line access to DOD medical information as more categories of DOD's electronic records are made available through the Compensation and Pension Records Interchange project. We will also strengthen our investment in Virtual VA, which will reduce our reliance upon paper-based claims folders and enable accessing and transferring electronic images and data through a Web-based application. Virtual VA will also dramatically increase the security and privacy of veteran data. The Department will continue to move work among regional offices in order to maximize our resources and enhance our performance. Also, this year we will complete the consolidation of original pension claims processing to three pension maintenance centers which will relieve regional offices of their remaining pension work. In addition, we will further advance staff training and other efforts to improve the consistency and quality of claims processing across regional offices.

Using resources available in 2008, we are aggressively hiring additional staff. By the beginning of 2009, we expect to complete a 2-year effort to hire about 3,100 new staff. This increase in staffing is the centerpiece of our strategy to achieve our 145-day goal for processing compensation and pension claims in 2009. This represents a 38-day improvement (or 21 percent) in processing timeliness from 2007 and a 24-

day (or 14 percent) reduction in the amount of time required to process claims this year.

In addition, we anticipate that our pending inventory of disability claims will fall to about 298,000 by the end of 2009, a reduction of more than 94,000 (or 24 percent) from the pending count at the close of 2007. At the same time we are improving timeliness, we will also increase the accuracy of the compensation claims we adjudicate, from 88 percent in 2007 to 92 percent in 2009.

Education and Vocational Rehabilitation and Employment Performance

With the resources provided in the President's 2009 budget request, key program performance will improve in both the education and vocational rehabilitation and employment programs. The timeliness of processing original education claims will improve by 13 days during the next 2 years, falling from 32 days in 2007 to 19 days in 2009. During this period, the average time it takes to process supplemental claims will improve from 13 days to just 10 days. These performance improvements will be achieved despite an increase in workload. The number of education claims we expect to receive will reach about 1,668,000 in 2009, or 9 percent higher than last year. In addition, the rehabilitation rate for the vocational rehabilitation and employment program will climb to 76 percent in 2009, a gain of 3 percentage points over the 2007 performance level. The number of program participants is projected to rise to 91,700 in 2009, or 5 percent higher than the number of participants in 2007.

Funding for Initiatives

Our 2009 request includes $10.8 million for initiatives to improve performance and operational processes throughout VBA. Of this total, $8.7 million will be used for a comprehensive training package covering almost all of our benefits programs. A little over one-half of the resources for this training initiative will be devoted to compensation and pension staff while nearly one-quarter of the training funds will be for staff in the vocational rehabilitation and employment program. These training programs include extensive instruction for new employees as well as additional training to raise the skill level of existing staff. Our robust training program is a vital component of our ongoing effort to improve the quality and consistency of our claims processing decisions and will enable us to be more flexible and responsive to changing workload demands.

NATIONAL CEMETERY ADMINISTRATION

Results from the December 2007 ACSI survey conducted by the National Quality Research Center at the University of Michigan and the Federal Consulting Group revealed that for the second consecutive time VA's national cemetery system received the highest rating in customer satisfaction for any Federal agency or private sector corporation surveyed. The Department's cemetery system earned a customer satisfaction rating of 95 out of a possible 100 points. These results highlight that VA's cemetery system is a model of excellence in providing timely, accessible, and high-quality services to veterans and their families.

The President's 2009 budget request for VA includes $181 million in operations and maintenance funding for the National Cemetery Administration (NCA), which is 71 percent above the resources available to the Department's burial program when the President took office. The resources requested for 2009 will allow us to meet the growing workload at existing cemeteries by increasing staffing and funding for contract maintenance, supplies, and equipment, open new national cemeteries, and maintain our cemeteries as national shrines. We will perform 111,000 interments in 2009, or 11 percent more than in 2007. The number of developed acres (7,990) that must be maintained in 2009 will be 8 percent greater than in 2007.

Our budget request includes an additional $5 million to continue daily operations and to begin interment operations at six new national cemeteries—Bakersfield, CA; Birmingham, AL; Columbia-Greenville, SC; Jacksonville, FL; Sarasota, FL; and southeastern Pennsylvania. Establishment of these six new national cemeteries is directed by the National Cemetery Expansion Act of 2003. We plan to open fast track burial sections at five of the six new cemeteries in late 2008 or early 2009, with the opening of the cemetery in southeastern Pennsylvania to follow in mid-2009.

The President's resource request for VA provides $9.1 million in cemetery operations and maintenance funding to address gravesite renovations as well as headstone and marker realignment. When combined with another $7.5 million in minor construction, VA is requesting a total of $16.6 million in 2009 to improve the appearance of our national cemeteries which will help us maintain cemeteries as

shrines dedicated to preserving our Nation's history and honoring veterans' service and sacrifice.

With the resources requested to support NCA activities, we will expand access to our burial program by increasing the percent of veterans served by a burial option within 75 miles of their residence to 88 percent in 2009, which is 4.6 percentage points above our performance level at the close of 2007. In addition, we will continue to increase the percent of respondents who rate the quality of service provided by national cemeteries as excellent to 98 percent in 2009, or 4 percentage points higher than the level of performance we reached last year.

CAPITAL PROGRAMS (CONSTRUCTION AND GRANTS TO STATES)

The President's 2009 budget request includes just over $1 billion in capital funding for VA, $5 million of which will be derived from the sale of assets. Our request for appropriated funds includes $581.6 million for major construction projects, $329.4 million for minor construction, $85 million in grants for the construction of State extended care facilities, and $32 million in grants for the construction of State veterans cemeteries.

The 2009 request for construction funding for our health care programs is $750.0 million—$476.6 million for major construction and $273.4 million for minor construction. All of these resources will be devoted to continuation of the Capital Asset Realignment for Enhanced Services (CARES) program. CARES will renovate and modernize VA's health care infrastructure, provide greater access to high-quality care for more veterans, closer to where they live, and help resolve patient safety issues. Some of the construction funds in 2009 will be used to expand our polytrauma system of care for veterans and active duty personnel with lasting disabilities due to polytrauma and TBI. This system of care provides the highest quality of medical, rehabilitation, and support services.

Within our request for major construction are resources to continue five medical facility projects already underway:

- Denver, CO ($20.0 million)—replacement medical center near the University of Colorado Fitzsimons campus
- Lee County, FL ($111.4 million)—new building for an ambulatory surgery/outpatient diagnostic support center
- Orlando, FL ($120.0 million)—new medical center consisting of a hospital, medical clinic, nursing home, domiciliary, and full support services
- San Juan, PR ($64.4 million)—seismic corrections to the main hospital building
- St. Louis, MO ($5.0 million)—medical facility improvements and cemetery expansion.

Major construction funding is also provided to begin three new medical facility projects:

- Bay Pines, FL ($17.4 million)—inpatient and outpatient facility improvements
- Tampa, FL ($21.1 million)—polytrauma expansion and bed tower upgrades
- Palo Alto, CA ($38.3 million)—centers for ambulatory care and polytrauma rehabilitation center.

In addition, we are moving forward with plans to develop a fifth Polytrauma Rehabilitation Center in San Antonio, TX, with the $66 million in funding provided in the 2007 emergency supplemental.

Minor construction is an integral component of our overall capital program. In support of the medical care and medical research programs, minor construction funds permit VA to address space and functional changes to efficiently shift treatment of patients from hospital-based to outpatient care settings; realign critical services; improve management of space, including vacant and underutilized space; improve facility conditions; and undertake other actions critical to CARES implementation. Further, minor construction resources will be used to comply with the energy efficiency and sustainability design requirements mandated by the President.

We are requesting $130.0 million in construction funding to support the Department's burial program—$105.0 million for major construction and $25.0 million for minor construction. Within the funding we are requesting for major construction are resources for gravesite expansion and cemetery improvement projects at three national cemeteries—New York (Calverton, $29.0 million); Massachusetts ($20.5 million); and Puerto Rico ($33.9 million).

VA is requesting $5 million for a new land acquisition line item in the major construction account. These funds will be used to purchase land as it becomes available in order to quickly take advantage of opportunities to ensure the continuation of a national cemetery presence in areas currently being served. All land purchased from

this account will be contiguous to an existing national cemetery, within an existing service area, or in a location that will serve the same veteran population center.

INFORMATION TECHNOLOGY

The President's 2009 budget provides more than $2.4 billion for the Department's IT program. This is $389 million, or 19 percent above our 2008 budget, and reflects the realignment of all IT operations and functions under the management control of the Chief Information Officer.

IT is critical to the timely, accessible delivery of high-quality benefits and services to veterans and their families. Our health care and benefits programs can only be successful when directly supported by a modern IT infrastructure and an aggressive program to develop improved IT systems that will meet new service delivery requirements. VA must modernize or replace existing systems that are no longer adequate in today's rapidly changing health care environment. It is vital that VA receives a significant infusion of new resources to implement the IT-related recommendations presented in the Dole-Shalala Commission report.

Within VA's total IT request of more than $2.4 billion, 70 percent (or $1.7 billion) will be for IT investment (non-payroll) costs while the remaining 30 percent (or $729 million) will go for payroll and administrative requirements. Of the $389 million increase we are seeking for IT, 86 percent will be devoted to IT investment. The overwhelming majority ($271 million) of the IT investment funds will support VA's medical care program, particularly VA's electronic health record system.

VA classifies its IT investment functions into two major categories—those that directly impact the delivery of benefits and services to veterans (i.e., veteran facing) and those that indirectly affect veterans through administrative and infrastructure support activities (i.e., internal facing). For 2009, our $1.7 billion request for IT investment is comprised of $1.3 billion in veteran facing activities and $418 million in internal facing IT functions. Within each of these two major categories, IT programs and initiatives are further differentiated between development functions and operations and maintenance activities.

The increase in this budget of 94 full-time equivalent staff will provide enhanced support in two critical areas—information protection and IT asset management. Additional positions are requested for information security: testing and deploying security measures; IT oversight and compliance; and privacy, underscoring our commitment to the protection of veteran and employee information. The increase in IT asset management positions will bring expertise to focus on three primary functions—inventory management, materiel coordination, and property accountability.

Our 2009 budget request contains $93 million in support of our cyber security program to continue our commitment to make VA the gold standard in data security within the Federal Government. We continue to take aggressive steps to ensure the safety of veterans' personal information, including training and educating our employees on the critical responsibility they have to protect personal and health information. We are progressing with the implementation of the Data Security—Assessment and Strengthening of Controls Program established in May 2006. This program was established to provide focus to all activities related to data security.

As part of our continued operation and improvement of the Department's electronic health record system, VA is seeking $284 million in 2009 for development and implementation of the Veterans Health Information Systems and Technology Architecture (HealtheVet-VistA) program. This includes a health data repository, a patient scheduling system, and a reengineered pharmacy application. HealtheVet-VistA will equip our health care providers with the modern tools they need to improve safety and quality of care for veterans. The standardized health information from this system can be easily shared between facilities, making patients' electronic health records available to all those providing 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 $99 million in 2009 for the VistA Legacy system.

In support of our benefits programs, we are requesting $23.8 million in 2009 for VETSNET. This will allow VA to complete the transition of compensation and pension payment processing off of the antiquated Benefits Delivery Network. This will enhance claims processing efficiency and accuracy, strengthen payment integrity and fraud prevention, and position VA to develop future claims processing efficiencies, such as our paperless claims processing strategy. To further our transition to paperless processing, we are seeking $17.4 million in 2009 for Virtual VA which will reduce our reliance on paper-based claims folders through expanded use of elec-

tronic images and data that can be accessed and transferred electronically through a Web-based platform.

We are requesting $42.5 million for the Financial and Logistics Integrated Technology Enterprise (FLITE) system. FLITE is being developed to address a long-standing internal control material weakness and will replace an outdated, non-compliant core accounting system that is no longer supported by industry. Our 2009 budget also includes $92.6 million for human resource management application investments, including the Human Resources Information System which will replace our current human resources and payroll system.

SUMMARY

Our 2009 budget request of nearly $93.7 billion will provide the resources necessary for VA to:

- provide timely, accessible, and high-quality health care to our highest priority patients—veterans returning from service in Operation Enduring Freedom and Operation Iraqi Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs;
- advance our collaborative efforts with DOD to ensure the continued provision of world-class health care and benefits to VA and DOD beneficiaries, including progress toward the development of secure, interoperable electronic medical record systems;
- improve the timeliness and accuracy of claims processing; and
- ensure the burial needs of veterans and their eligible family members are met and maintain veterans' cemeteries as national shrines.

I look forward to working with the Members of this Committee to continue the Department's tradition of providing timely, accessible, and high-quality benefits and services to those who have helped defend and preserve liberty and freedom around the world.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO LTG JAMES B. PEAKE, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Board of Veterans' Appeals Performance

Question 1. Despite an increase in the number of appeals decided per Veterans Law Judge, the Board of Veterans' Appeals cycle time continues to increase. Please explain this disparity.

Response. The Board of Veterans' Appeals (Board) "cycle time" is the average time it takes from when a case is received at the Board until a decision on that appeal is dispatched, excluding time the case was with the appellant's service organization representative. The Board's cycle time decreased from 148 days in 2006 to 136 days in 2007. The Board anticipates, however, that cycle time may increase in the short term due to fluctuations in the receipt of certain types of "priority" appeals.

The Board gives priority to certain types of cases: including cases that are advanced on the docket, cases remanded to the Board from the U.S. Court of Appeals for Veterans Claims, cases returned from the agency of original jurisdiction (AOJ) after a Board remand, and cases in which the Board has held a hearing. Historically, when a higher percentage of the Board's workload is made up of these priority appeals, cycle time will increase. This is because "priority" appeals, by nature of being a priority, are quickly sent to a veterans law judge for adjudication, with minimal waiting time. Contrarily, original appeals that do not fall into a "priority" category must be worked in their regular order on the Board's docket.

As productivity continues to increase, the Board is better able to expeditiously adjudicate these priority appeals, and therefore make greater progress in adjudicating original appeals. The more original appeals that the Board is able to adjudicate, the more progress will be made in reducing the backlog. However, the short-term effect is that cycle time may increase as more of the earlier cases on the docket are decided.

It is the Board's intention to meet or exceed the 2009 target of 150 days for cycle time. The Board's strategic target remains 104 days. The Board expects to make progress toward that strategic target as newly hired attorneys become fully trained and as the Board continues to work to improve efficiency and productivity by emphasizing training, focusing on reducing avoidable remands, and ensuring that decisions are clear, concise, coherent, and correct.

Court Decision

Question 2. Should legislative and judicial relief from the effect of the *Haas* decision fail, what are VA's plans for adjudicating the nearly 11,000 Agent Orange claims that have been received since August 2006?

Response. The *Haas* decision could potentially affect many veterans who have claims based on herbicide exposure in which the only evidence of exposure is the receipt of the Vietnam Service Medal or service on a vessel off the shore of Vietnam. In order to be prepared for adjudication of claims that will be influenced by the decision rendered by the U.S. Court of Appeals for the Federal Circuit, the Department of Veterans Affairs (VA) released instructions in December of 2006 to all regional offices on the correct process for tracking and controlling claims with *Haas* issues. Although the Department of Defense (DOD) could not provide us with exact numbers, it estimated that over 800,000 veterans are potentially affected. More 13,000 claims have already been received. We do not believe that Congress intended to provide presumptive exposure to military personnel who served far from Vietnam merely because they were awarded the Vietnam Service Medal (VSM).

If *Haas* is not reversed, the veterans affected by the decision fall within the class in the *Nehmer* v. *United States* litigation. Under that litigation VA would be required to attempt to identify previously denied veterans and readjudicate their claims awarding service connection for any of the presumptive disabilities authorized by Agent Orange Act back to the date the disability was first claimed. Among the presumptive disabilities are several very common conditions, such as diabetes and prostate cancer. We do not have data on current number of denied veterans. We are unable to provide the number because no file exists in DOD or VA of veterans awarded the VSM. As a consequence, VA would be required to review all Vietnam era veterans with denied conditions that are presumptive under the Agent Orange Act.

Proposed Legislative Initiatives

Question 3. The Administration has proposed making permanent the authority for IRS income data matching for VA eligibility determinations. Congress frequently relies on this provision as a saver to pay for enhancements to VA benefit programs. Can Congress expect the Administration to increase its yearly mandatory budget request to pay for such improvements in entitlement programs?

Response. Currently, the mandatory compensation and pension (C&P) account is authorized to reimburse VBA, the Veterans Health Administration (VHA) and Information Technology Service (ITS) for operating costs associated with performing the Internal Revenue Service/Social Security Administration (IRS/SSA) data matches. The income information is used to verify and determine the correct benefit payment, eligibility for health care services, co-payment status and enrollment priority assignment. Income verification helps to ensure the integrity of both VBA's benefit programs, and VHA's health care programs. While the operating costs of maintaining these matches total nearly $27 million in fiscal year 2009 the anticipated savings generated is estimated at $35 million in fiscal year 2009. The net savings over 10 years should reach $270 million. The ability to ensure that veterans and survivors are receiving the appropriate level of benefits and health care services amounts to good stewardship of taxpayer dollars, but the savings aren't separately identifiable within the C&P appropriation. However, if this program is not extended, VA would have to request more funds from Congress to pay benefits, and some of these benefits would be erroneously paid due to the loss of this oversight ability.

Dedicated Staff for Rating Schedule Updates

Question 4. Given the various Commission recommendations on modernizing the rating schedule, I am concerned that VA does not have the resources to undertake this monumental task when the appropriate time arises. How many staff at VA are dedicated solely to updating the rating schedule?

Response. The regulations staff in the C&P service, consisting of seven staff members and the services of a contract consultant, is responsible for maintenance of all regulations in Parts 3, 4 and 13 of title 38 Code of Federal Regulations (CFR).

A contract was awarded to Economic Systems, Inc. the first week of February 2008. Two studies are currently underway: Transition Benefits recommended by the Dole-Shalala Commission, and Quality of Life and earnings loss payments. Both studies are expected to be completed by the end of July 2008.

The rating schedule has been undergoing a complete review and revision since the 1990's through a deliberative process that includes input from, the Veterans Health Administration, non-VA medical experts, and veterans service organizations, among others. The general public also has the opportunity to review and comment on proposed changes to the schedule. To date, 12 of the 16 body system sections in the

schedule have been revised, and a 13th is nearing publication. The remaining three body systems are in various stages of development. Major changes that have been made include the addition of new conditions and deletion of obsolete and rarely used conditions, updating of medical terminology, and most importantly, the development of more objective criteria, based on current medical knowledge. These changes will promote consistency in evaluations nationwide. Necessary revisions of body systems in the rating schedule are being carried out on an ongoing basis.

Adjudication of Global War on Terror Claims

Question 5. VA expects to continue to receive a high volume of Global War on Terror claims. Given the prioritization of such claims, would it be helpful to have dedicated FTE toward this initiative or a Tiger Team of adjudicators for this purpose?

Response. Since the onset of the combat operations in Afghanistan and Iraq, VA has provided expedited and case-managed services for all seriously injured Global War on Terror (GWOT) veterans and their families. This individualized service begins at the military medical facilities where the injured servicemembers return for treatment, and continues as these servicemembers are medically separated and enter the VA medical care and benefit systems. Each regional office (RO) is required to have an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) coordinator to case manage all claims from seriously injured veterans received in their jurisdiction. The coordinator facilitates the veteran's claim through the entire process and is responsible for keeping the veteran and his/her family informed as to the status of their claim.

In February 2007, VBA began to prioritize the processing of all GWOT veterans' disability claims. This initiative covered all active duty, National Guard, or Reserve veterans who were deployed in the OEF/OIF theatres or in support of those combat operations. Each RO has dedicated personnel processing GWOT claims on a priority basis. We also established two development centers in Phoenix and Roanoke to support OEF/OIF claims processing, and we are in the process of expanding these centers and adding two more development centers in Lincoln and Togus.

Status of VA/DOD Disability Evaluation Pilot

Question 6(a). In November 2007, VA and DOD began a pilot disability evaluating system for servicemembers at the major medical facilities in the Washington, DC, area. To date, how many servicemembers have participated in this pilot program?

Response. As of February 22, 2008, a total of 181 soldiers, sailors, airmen, and marines have been designated by the Department of Defense (DOD) for inclusion in the pilot; and 158 servicemembers have participated in the pilot program.

Question 6(b). How many examinations have occurred at the Washington, DC, VA Medical Center?

Response. As of February 22, 2008, 553 specific examinations had been conducted, an average of about 4 examinations per servicemember in pilot.

Question 6(c). How long does it take for a servicemember to receive a decision on a claim?

Response. The strategic target for the pilot is to reduce the average time it takes for a servicemember separated or retired through the disability evaluation system (DES) pilot and to receive their first benefit check from VA on the first day of payment eligibility. The pilot began on November 26, 2007. None of the participants have completed the full physical evaluation board (PEB) process and been separated from service. As of February 17, 2008, one servicemember had been found medically unfit to return to duty by the service PEB and referred to VA for rating. That rating, completed in less than 5 days, was accepted by the member, and he is currently pending separation. The time from referral to the medical evaluation board (MEB) to the member's acceptance of the decision was less than 50 days.

Question 6(d). If this pilot program were expanded to cover all servicemembers who receive a disability decision through the MEB/PEB process, how would VBA's ability to meet current requirements be effected?

Response. Expansion to cover all servicemembers being processed through the MEB/PEB process would impact both VHA and VBA.

At both the MEB and PEB stages of the process, some individuals are found medically fit for retention. VA is conducting the examinations in this DES pilot prior to the MEB and PEB fitness determination. Members who are found fit will have undergone VA examinations that would not have occurred but for the pilot. Additionally, full implementation of the pilot would most logically involve VA in the re-examination of retirees on the temporary disability retired list. In many circumstances, these too would be additional examinations normally not done.

From a benefits perspective, additional military services coordinators would be needed to counsel individual servicemembers, take claims, schedule examinations,

coordinate with PEB liaison officers, and perform other activities that are part of the DES process.

VBA is currently assessing the resources required to meet our current and future needs, should the pilot become the standard business practice in the DES. We believe firmly that a single separation exam is an important component in a single rating determination. At this point in the DES pilot, we have too few data to determine if this process will become a successful standard for all separating servicemembers. Work remains to be done on the process, scalability and model to ensure a successful system-wide deployment.

Cuts to the Office of the Inspector General

Question 7. The President's budget recommends a significant cut to the Office of the Inspector General. This comes at a time when the IG has just finished its review of the failings in the quality management of the Marion VAMC surgical program, in addition to other audits. Please explain why the Administration is seeking this cut, and which specific investigations or staff would be eliminated.

Response. While the budget proposed for the Office of Inspector General (OIG) supports fewer positions, the resource level is sufficient to meet its mandated obligations and to respond to the most urgent issues raised by Congress and the VA. OIG will continue to assess and prioritize its workload to maximize productivity and ensure the greatest impact possible. This budget will allow OIG to continue to address the challenges and growing demand for VA services.

Numbers of OEF/OIF Veterans

Question 8(a). VA has repeatedly underestimated the growth in workload from OEF/OIF veterans. The current budget submission projects that by the end of 2009, VA will have provided health care to 333,275 OEF/OIF veterans, and estimates that in 2007 and 2008, VA will have served 205,600 and 293,300, respectively. Yet, the most recent VA Health Care Utilization report states that as of the 4th Quarter of 2007, VA had served a total of 299,585 OEF/OIF veterans in 2007 and 229,015 by the 1st quarter of 2007, indicating that VA served at least 70,570 new OEF/OIF veterans in 2007. Does VA stand by the prediction that between the end of 2007 and the end of 2009, VA will serve only 33,000 new OEF/OIF veterans?

Response. Yes, based on our experience in fiscal year 2007 and fiscal year 2008 the 14 percent increase (39,930) appears realistic. The fiscal year 2007 actual OEF/OIF unique patients were 205,628. The 299,585 figure referenced is a cumulative total since the beginning of the OEF/OIF. VA estimates it will treat 293,345 and 333,275 OEF/OIF unique patients in 2008 and 2009, respectively.

Question 8(b). Further, please explain significant underestimation of the total number of veterans served in 2007, and explain the changes made in the estimating process as a result.

Response. VA has updated the model each year using the most current baseline data available and has made several enhancements to the model methodology. Significant improvements over the past 3 years include enhanced methodology for projecting OEF/OIF veteran enrollment and health care use, enhanced veteran enrollment projections, and inclusion of a more detailed analysis of enrollee reliance on VA health care versus other providers. VA has also added several new data sources including the Social Security Death Index, which improved the projections by providing a more accurate count of enrolled veterans. In addition, the 2000 Census Long Form has provided more detailed information on the income of non-service-connected veterans, and has enabled us to more accurately assign veterans into the income-based enrollment priorities.

The fiscal year 2007 budget estimate (excluding the effects of proposed enrollment fees and pharmacy co-payment increases) was 5,498,290 unique patients. The fiscal year 2007 actual was 5,478,929 unique patients, a difference of 0.4 percent or 19,361 unique patients. The fiscal year 2008 projection is 5,681,420 unique patients of which 4,219,270 had been seen by December 2007.

Construction

Question 9. The President's budget request would cut both major and minor construction by nearly fifty percent. Minor construction would be reduced as well. Some estimates of the current Non-Recurring Maintenance backlog indicate it could be as high $1.5 billion, yet only $800 million is designated for these projects. Please describe VA's plan to address the widespread facility problems, and explain how the funds requested in this budget would address the looming backlog of projects in all areas of construction.

Response. VHA prioritizes major and minor projects at a national level using set criteria; therefore, the highest priority projects, which best reflect the goals and mis-

sion contained in VA's strategic plan and VHA's goals, are included within the budget. The remaining unfunded major and minor project needs will have to compete in the next submission cycle. Critical needs that were not supported within this budget will be addressed through other capital asset investment options, such as leases or nonrecurring maintenance (NRM).

NRM requests follow a similar prioritizing process; however, the program and funding is decentralized. The veterans integrated service networks (VISN) use criteria to prioritize and fund the highest needs within its respective VISNs. The remaining backlog of NRM needs will be addressed on an as needed basis. If critical issues arise, VISNs can supplement the NRM allocation with medical facilities funds.

Priority 8 Veterans

Question 10. The Committee continues to work to resolve the issues surrounding health care eligibility for priority 8 veterans. In this process, it is essential to determine the effect on VA of admitting this group of veterans. Unfortunately, VA has not been able to provide a reliable prediction of the number of middle-income veterans who would enter the system if they were made eligible. What is the latest estimate for the number of such veterans who have been denied access?

Response. Since the suspension of enrollment in Priority 8 in January 2003 through the end of fiscal year 2007, a total of 386,767 Priority Group 8 veterans have applied for enrollment and were determined to be ineligible to enroll. This figure does not include enrollees who were initially denied enrollment and subsequently enrolled in an eligible priority group based on a change in the veteran's status.

Research

Question 11(a). The budget request would once again cut research funding. Among the research projects that would be cut are: 39 from acute and traumatic injury, 42 from mental health, 26 from substance abuse, and 36 from diabetes and major complications, to name but a few. Yet in his testimony before the Committee on February 13, 2007, Secretary Peake said that mental health and the needs of servicemembers recently returned from Iraq and Afghanistan are major priorities. In light of the major advances achieved by VA researchers, and the enormity of the challenges ahead, how does VA justify a cut in research funding and the elimination of so many projects?

Response. VA remains committed to increasing the impact of its research program. We have carefully prioritized our research projects to ensure they address the needs of OEF/OIF veterans as well as other veteran populations. In fact, the fiscal year 2009 budget request includes $252 million for research directed at the full range of health issues of OEF/OIF veterans, including Traumatic Brain Injury (TBI) and other neurotrauma, Post Traumatic Stress Disorder (PTSD) and other post-deployment mental health, prosthetics and amputation health care, polytrauma, and other health issues. Additional research funding priorities covered by the fiscal year 2009 budget request include aging and geriatrics, chronic diseases and health promotion, personalized medicine, women's health, and long-term care. VA researchers also compete for and receive funding from other Federal and non-Federal research sponsors that provide additional resources for VA's research program.

Question 11(b). The Institute of Medicine recently published a report addressing the status of research on PTSD treatments. One clear recommendation was that more research be conducted to determine the most effective treatments, and that such research ought to be centrally coordinated and directed. What plans does VA have to coordinate and advance research on PTSD?

Response. VA has an ongoing, well-established collaboration with other Federal funding organizations to coordinate and advance PTSD treatment research. The Institute of Medicine (IOM) report details important research recommendations that will guide future PTSD interventional studies in meeting the highest accepted standards for randomized controlled trials. VA convened a scientific working group in February 2008 that included National Institute of Mental Health (NIMH) and DOD representatives to consider the IOM report as well as to provide guidance for scientists developing PTSD treatment studies. Other ongoing activities include VA's collaboration with DOD on reviewing PTSD and TBI research proposals for funding, issuing joint research solicitations with NIMH, and managing the PTSD research portfolio to preclude overlap, all of which will lead to even more treatment advances for PTSD.

VA continues to lead in supporting treatment research related to the mental and physical health consequences of military service, including PTSD. VA is particularly proud of the scientists who contributed to establishing the evidence base supporting

the effectiveness of a psychotherapeutic approach and prolonged-exposure therapy, highlighted as an example of the highest level of evidence in the IOM report (October 2007) now being implemented in clinical care.

A few examples of important PTSD research currently being conducted by VA include: a large trial to determine how well the drug risperidone works in patients with chronic PTSD when other drug therapy has failed; a multi-site trial of the drug prazosin that has been found to be particularly effective in reducing sleep-related problems in PTSD patients; a longitudinal study of Vietnam veterans to determine the long-term health consequences related to PTSD; and an innovative study following veterans from Iraq to determine emotional and psychological changes related to their deployment.

Question 11(c). Tinnitus is now the number 1 service-connected disability for servicemembers returning from Iraq and Afghanistan, yet VA dedicates very little research to this condition. How does VA plan to address tinnitus, and the linkages between this condition and other serious medical conditions?

Response. VA supports a broad sensory loss research portfolio, including several projects addressing tinnitus. VA scientists have developed a research-based model of tinnitus clinical management that is designed for efficient implementation in VA audiology clinics. The researchers plan to implement this program at one VA audiology clinic and then evaluate its effectiveness and acceptability to patients and audiologists. If shown to be effective, the program could establish the standard for tinnitus management at all VA medical centers and clinics. VA researchers are also developing a diagnostic test to identify tinnitus, which is currently done by self-report.

In collaboration with DOD, VA investigators are conducting a study to determine which auditory processing disorders are more often associated with exposure to high-explosive blasts, whether there is spontaneous recovery of auditory function after blast exposure, how much recovery may be expected, and how rapidly it occurs.

In addition, VA researchers are developing new methods capitalizing on the ability of the ear to produce low level sounds in response to tones delivered to the ear for the early detection of changes in the cochlea before permanent noise-induced hearing loss has occurred. Early detection can allow for the implementation of precautionary procedures to protect military personnel.

In the clinical setting, VA tinnitus treatment involves a progressive approach ranging from patient education to more comprehensive services involving amplification, biofeedback-relaxation techniques, cognitive-behavioral therapy, drug therapy, sound therapy (maskers and masking devices), and combined techniques. Because tinnitus has many causes, many of which are outside the audiology scope of practice, the approach to tinnitus is multi-disciplinary. Some of these services are done by audiologists and some are referred to appropriate professionals. VA has also produced a veteran health initiative on hearing impairment that devotes a chapter to tinnitus.

Vocational Rehabilitation and Employment

Question 12. Budget documents state that VR&E has implemented over 80 of the 2004 Task Force report and that you "plan to continue to implement the remaining recommendations based on receiving the requested levels of funding and FTE." Please explain in detail how your requested fiscal year 2009 level of 1,073 FTE—which provides no increase over the fiscal year 2008 level—will allow you to continue to implement these recommendations.

Response. Fiscal year 2009 will see a continued focus on implementing and refining the remaining 2004 task force recommendations. Our initiatives include targeted training for the field on changes to policy and procedures resulting from task force recommendations and a study of long-term outcomes geared toward increasing our rehabilitation rate. The budget level of 1,073 full time employees (FTE) represents a 6 percent increase since release of the task force report and will enable us to achieve our program goals of high-quality, consistent, and outcome-oriented services to veterans.

Question 13. In your budget documents, you note that VA's VR&E program "will continue to grow in the area of increasing partnerships with other agencies and organizations." Please provide the Committee with the amount of funds earmarked for these partnerships in fiscal year 2008 and proposed for fiscal year 2009.

Response. Vocational rehabilitation and employment (VR&E) continues to work to extend our partnerships with the community in order to enhance services for veterans and develop employment opportunities for veterans. This outreach, funded at over $4.5 million in fiscal year 2008 and $5 million in fiscal year 2009, includes: disabled transition assistance program (DTAP) presentations and materials, coordination with community and military organizations via career fairs; together with

DOD, support of early intervention through the Coming Home to Work program; a joint demonstration project with the Department of Labor VETS program to improve employment services to veterans; and aggressive outreach to the employment community.

Education

Question 14. VA has requested a funding level of only $13 million for reimbursement to State Approving Agencies for fiscal year 2009. This would constitute over a 30 percent reduction in funds available for this purpose. Please explain the impact of this reduction on VA's workload, and on the accuracy and timeliness of approval of education programs.

Response. VA did not submit a legislative proposal to restore funding in the fiscal year 2009 budget submission because bills were already before Congress that would restore or increase funding.

S. 1215 would continue State Approving Agency (SAA) funding at $19 million for years after fiscal year 2007. At a hearing before the Senate Veterans' Affairs Committee on May 9, 2007, VA testified in support of S. 1215. VA stated that the statutory requirement to reduce SAA funding to $13 million would cause SAAs to reduce staffing, severely curtail outreach activities, and perform fewer supervisory and approval visits. VA further stated that reduced funding might cause some SAAs to decline to enter into contracts with VA and that VA would have to assume the additional duties.

H.R. 2579 would make only $13 million available from the Readjustment Benefits (RB) account for SAA expenses and permit VA to use General Operating Expenses (GOE) appropriations for the additional funds. At a hearing before the House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity, on June 21, 2007, VA testified against H.R. 2579 because VA maintains that funding for SAA activities should be an authorized expenditure from the RB account rather than a discretionary expense from the GOE account to guarantee that funding is available for these contracts.

Information Technology

Question 15. The budget request calls for improved collaboration with the Department of Defense to efficiently and effectively transfer records between the two agencies, to share critical medical information, and to process disability claims quickly. The 2009 budget request does not provide details on how these outcomes will be achieved or resourced. Specifically, how does the fiscal year 2009 budget request support IT initiatives to improve VA/DOD collaboration?

Response. The fiscal year 2009 budget request currently identifies over $65 million to support improved VA/DOD collaboration.

The largest portion of the request, $50.2 million is in direct support of the wounded, ill and injured, and supports the following:

- Automated workflow processes, an expanded document management capability and the exchange of clinical data from the combined exam process.
- The TBI/psychological health center of excellence requirement to exchange information collected in the cognitive assessment tool.
- Non-clinical case management by the creation and integration of a case management system and the development of the My e-Benefits portal.
- More timely exchange of current admissions, discharge and transfer data to support accurate compensation determination.
- Development of an embedded fragment registry.

Indirect support for interagency collaboration is also provided by various electronic data sharing initiatives. The fiscal year 2009 budget request includes $10.5 million to support the following projects:

- Expansion of the VA/DOD identity repository (VADIR) and the implementation of the VA Identity and Access Management Strategy. VADIR is the enterprise database that contains the common population of active servicemembers, veterans and beneficiaries served by VA and DOD.
- Clinical health data repository (CHDR), allowing computable exchange of lab data with DOD.
- Federal health information exchange (FHIE), to provide clinically relevant data feeds, from DOD's electronic health records (EHR) to the FHIE repository, for active duty, retired and separated servicemembers. FHIE is DOD and VA's current interagency method of storing electronic health records, when servicemembers are separated from active duty.

The fiscal year 2009 budget request also includes $5 million to support the North Chicago Federal Health Care Facility initiative. Funds will be used to address Navy

health care provider and administrative functions such as patient registration and billing, software designs to enable functions that include single sign-on and exchange of orders, and project management services.

NCA

Question 16. The 2009 budget request includes $5 million for land acquisition for future National Cemeteries. How many projects does VA believe these funds will support, and over what period of time will this money be spent?

Response. It is difficult to estimate how many land purchases the $5 million will support or over what period of time the money will be spent. Recent land acquisition costs associated with major cemetery construction projects have ranged from $4 million to $12 million. Much will depend on the location, the existing market conditions, and the number of acres involved. The money will be spent when an acceptable parcel becomes available for purchase.

Benefits Delivery at Discharge

Question 17. How does the President's budget request support BDD, especially for members of the Guard and Reserve?

Response. The President's budget will support expansion and enhancement of services we provide to separating servicemembers, including benefits delivery at discharge (BDD) and services to members of the Guard and Reserves. We operate 153 BDD sites, and we are working with DOD to pilot a new DES for servicemembers undergoing the MEB/PEB process. DOD will use this program to determine fitness for continued military service, and VA will use the program to determine service-connected disabilities and their severity for purposes of expediting disability compensation benefits.

The fiscal year 2009 budget request supports expansion of our outreach to returning National Guard and Reserve soldiers and their families. When units of National Guard or Reserves soldiers are returning home, VA provides briefings and assists with filing claims. A memorandum of agreement was signed in 2005 between VA and the National Guard Bureau to institutionalize our partnership and support better communication. We are encouraging State National Guard coalitions to improve local communication and coordination of benefits briefings to assure that National Guard and Reserve soldiers are fully aware of benefits. In 33 States, memoranda of understanding have been signed between VA, the State National Guard offices, and the State department of veterans affairs to promote the relationship and cooperation in providing services and benefits to their members. VA has a memorandum of agreement with the Army Reserve in the concurrence process that will formalize this relationship, as we did with the National Guard. We are also working on agreements with the other Reserve components to formalize those relationships.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. RICHARD BURR TO LTG JAMES B. PEAKE, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Medical Care

Question 1(a). The nearly 2.8 million veterans in receipt of disability compensation have a wide range of conditions. I would imagine that the Department of Veterans Affairs (VA) offers treatment or physical therapy for a good number of those conditions which could, at best, make a veteran less disabled or, at worst, halt or slow the progression of a disability. Is that a fair characterization?

Response. Yes, VA offers treatment of physical therapy for a good number of conditions. Patients who do not have chronic, degenerative, or non-reversible disabling conditions are most likely to benefit from those treatments. In fiscal year 2007, VA provided outpatient physical therapy services to nearly 304,000 unique veterans, occupational therapy to more than 104,000 unique veterans, and kinesio therapy to more than 58,000 unique veterans.

Question 1(b). How many of the 2.8 million service-disabled veterans seek treatment from VA for their service-connected conditions?

Response. In fiscal year 2007, VA treated 1,373,129 veterans for their service-connected condition in outpatient clinics and 60,474 as inpatients. But, because of the overlap (with some patients receiving treatment both inpatient and outpatient), the net is 1,378,742 veterans treated overall.

Question 1(c). For those who do seek treatment, do you see an improvement in their disability status?

Response. Yes, for example, as patients improve their functioning in the mental health care and polytrauma/TBI, symptoms associated with disability can often decrease, even if the disability status remains unchanged.

Question 1(d). Does VA track the relationship between the treatment it provides and improved disability status?

Response. VA does not systematically track physical disability status as part of the clinical process of delivering mental health care and polytrauma/TBI care. Disability rating is a separate process performed by VBA.

Question 1(e). For those veterans who do not seek treatment from VA, what incentives do you have to get them to do so?

Response. The best incentive for veterans to seek treatment is the high-quality care provided at our facilities and our world-class electronic health record system. To let veterans know about these opportunities, and given the importance of outreach to servicemembers and veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), VA promotes and conducts activities at both national and local levels. Our outreach begins with a letter from the Secretary of Veterans Affairs to each newly separated OEF/OIF veteran. The letter thanks veterans for their service, welcomes them home, and provides basic information about health care and other benefits provided by VA. To date, VA has mailed over 766,000 initial letters and 150,000 follow-up letters to veterans. VA also partners with Federal agencies, Veterans Service Organization (VSOs), and State, county, and local agencies and governments to contact veterans, and we offer outreach to active duty personnel at military demobilization sites. Special outreach to Guard and Reserve soldiers is an integral part of VA's outreach efforts; we provide briefings on benefits and health care services at town hall meetings, family readiness groups, and during unit drills near the homes of returning Guard and Reserve soldiers. Our Vet Centers provide outreach and a full range of readjustment counseling services to combat veterans in a comfortable, nonclinical environment for veterans.

Veterans choose their health care providers based on a number of factors such as: quality of care, economics, demographics, and the ability of the health care provider to respond to their unique health care needs. VA's proven track record for providing high-quality health care is equal to or higher than private-sector health care providers. VA health care is also cost effective for eligible veterans. Moreover, VA understands veterans' issues and the health consequences resulting from their military experience whether combat related or not.

VHA's most powerful incentive is the scope and quality of its services. As a nationally integrated health care system, VHA provides veterans with a high-quality and low-cost health care. Through a network of 153 hospitals and medical centers, over 731 CBOCs, 209 Vet Centers, and 135 nursing home facilities, VA offers to eligible veterans a full continuum of health care—from health promotion, disease prevention, diagnostic, therapeutic, and rehabilitative to recovery and palliative care.

Question 2(a). The Government Accountability Office (GAO) criticized VA in prior years for relying on unspecified "management efficiencies" to reduce its need for appropriated dollars. GAO rightly opined that, if VA couldn't measure how exactly it saved money by becoming more efficient, then it shouldn't count those savings in the budget. That does not mean, however, that VA should stop looking to become more efficient altogether. Please describe VA's efforts to contain costs by improving operations and service delivery?

Response. Performance measures are used to evaluate the performance of all facilities in the field to determine if network and facility directors are providing the oversight to ensure our veterans are receiving appropriate care in a cost effective manner.

For example, efficient formulary management is an area of cost avoidance that is measured. This is accomplished through the use of preferred drug regimens developed at the national and/or network level. The overall cost avoidance is based on the aggregation of potential cost savings in 15 drug regimens on the pharmacy benefits management grid. The potential cost saving is based upon closing 75 percent or more of the gap between current costs and the average costs of the five networks with the lowest unit costs.

Advanced clinical access (ACA) is a patient-centered, scientifically-based set of redesign principles and tools that enable staff to examine their health care delivery processes and redesign them. The ACA principles are extraordinarily powerful and result not only in improved access, but also in improved patient, staff and provider satisfaction, improved quality, improved efficiency, and decreased cost. The implementation of ACA assists health care delivery providers eliminate delays within its systems by implementing key principles such as measuring supply and demand, reducing backlogs, decreasing appointment types, developing contingency plans, predicting and anticipating patient care needs and improving efficiency through actions such as optimizing rooms and equipment.

The Office of Productivity, Efficiency and Staffing provides effective management tools for the systematic, longitudinal measurement and reporting of productivity, efficiency and staffing in VHA. It produces recommendations for standards and guidance to enhance the provision of safe, efficient, effective and compassionate care. The office conducts studies and produce data on "best practices" to optimize clinical productivity, efficiency and staffing, promoting the goals of clinical excellence and accessible health care. The scope of this office includes the creation and publication of longitudinal databases, directives, guidelines, best practices, benchmarks.

The foundation of VHA's integrated delivery system is a primary care model and, as such, was the first priority for the development of a staffing model. The primary care panel size staffing model is fully operational in VHA. A panel size defines the number of active patients assigned to each primary care provider. The staffing model permits VHA to measure the overall productivity of primary care providers, system capacity and staffing. The staffing guidance establishes that for every 1200 active primary care patients (adjusted for patient risk, support staff and exam room capacity), a 1.0 primary care direct patient care provider is recommended. This places VHA in the unique position of having the ability to study and understand the relationship of panel size (productivity) versus outcomes (quality and satisfaction), access, and efficiency (cost).

VHA staffing models will be consistent with the President's Executive Order to ensure health care programs administered by the Federal Government promote quality and efficient health care delivery. The Executive Order further calls for Government programs to explore similar initiatives in the private and non-Federal sector with the purpose of improving the quality and efficiency of health care. To this end, VHA will continue to use a relative value unit (RVU) model to measure productivity of specialty providers. RVU is an industry accepted metric used in Medicare and the private sector that considers the time and intensity of the service delivered by the specialty physician. The use of an RVU model permits the assessment of productivity and efficiency (cost/RVU) within VHA and comparison to external benchmarks.

Other examples are: (a) decrease the cost per unit in fee care for radiation therapy; (b) decrease the cost per unit in fee care for non-health care common procedure coding system in home services and supplies; (c) decrease unintended variation in length of stay in non-VA contract hospitalization for pacemaker care and (d) decrease unintended variation in level of service in non-VA contract hospitalization for cardiology care.

Question 2(b). How does VA measure whether it is, in fact, becoming more efficient and, yet, maintain its quality?

Response. The actuarial model reflects the impact of VA health care clinical practices that are expected to result in more efficient use, thereby moderating the increase for 2009 expenditures.

- Clinical cost avoidance: Cost is decreased through initiatives like ACA, management of inpatient care, and high degree of management for pharmaceuticals.
- Pharmacy cost avoidance: This item recognizes that VA's intensity trend growth (cost trend) will be slower relative to the private sector as a whole because of its formulary and robust pharmacy benefit management.

Question 3(a). VA's medical care budget has been criticized by some as not providing sufficient resources to account for medical inflation.

Response. The President's 2009 request includes total budgetary resources of $41.2 billion for VA medical care, an increase of $2.3 billion or 5.9 percent over the 2008 level and more than twice the funding available at the beginning of the Bush administration. Our total medical request fully accounts for inflation and is comprised of funding for medical services ($34.08 billion), medical facilities ($4.66 billion), and resources from medical care collections ($2.47 billion).

Question 3(b). Please provide the assumptions that you used to build your request for medical services and medical facilities.

Response. Our 2009 request for $41.2 billion in support of our medical care program was largely determined by three key cost drivers in the actuarial model we use to project veteran enrollment in VA's health care system as well as the use of health care services of those enrolled:

- inflation;
- trends in the overall health care industry; and
- trends in VA health care.

The impact of inflation will increase our resource requirements for acute inpatient and outpatient care by more than $1.4 billion.

There are several trends in the U.S. health care industry that continue to increase VA's cost of doing business regardless of any changes in enrollment, number of patients treated, or program initiatives. The two most significant trends are the rising use and intensity of health care services. In general, patients are using medical care services more frequently and the intensity of the services they receive continues to grow. For example, sophisticated diagnostic tests, such as magnetic resonance imaging (MRI), positron emission tomography (PET), and computed tomography (CT), are now more frequently used either in place of, or in addition to, less costly diagnostic tools such as x-rays. As another illustration, advances in cancer screening technologies have led to earlier diagnosis and prolonged treatment which may include increased use of costly pharmaceuticals to combat this disease. These types of medical services have resulted in improved patient outcomes and higher quality health care.

The cost of providing timely, high-quality health care to our Nation's veterans is also growing as a result of several factors that are unique to VA's health care system. We expect to see changes in the demographic characteristics of our patient population. Our patients as a group will be older, will seek care for more complex medical conditions, and will be more heavily concentrated in the higher cost priority groups. Furthermore, veterans are submitting disability compensation claims for an increasing number of medical conditions, which are also increasing in complexity.

Question 3(c). What inflationary factors are included in your assumptions? What inflation rates did you apply to those factors?

Response. Inflation factors such as medical inflation and special cost trends such as pharmacy, which reflects the increase or decrease in a constant set of services due to labor and supply costs, were included in the assumptions.

Question 3(d). How were the inflation rates determined?

Response. Assumptions about future inflation trends are developed by a workgroup of VA staff and experts on health care trends in the U.S. The workgroup reviews VA historical inflation trends and historical and estimated Medical Consumer Price Index (CPI) trends in developing the assumptions. Separate inflation trends are developed and applied to inpatient services, ambulatory services, pharmacy, and prosthetics. This allows the model to be sensitive to the different inflationary pressures within the various services. The inflation factors are then used in the model to trend forward the unit costs from the most recently completed fiscal year to develop unit costs for future years. The composite impact of the multiple inflation trends in the expenditure projections supporting the 2009 VA health care budget was 4.63 percent.

Question 3(e). Are there significant one-time expenditures, such as equipment purchases, obligated in fiscal year 2008 that explain why obligations for medical services are expected to grow at a rate that is less than expected Consumer Price Index inflation?

Response. Yes, the equipment decrease of $1.131 billion is the result of one-time purchases of state-of-the-art equipment in fiscal year 2008 and investments in non-recurring maintenance of $0.3 billion.

Question 3(f). What other factors help to explain the low percentage increase in expected obligations from fiscal year 2008 to 2009?

Response. As stated in the response to Question 3(e), the equipment decrease of $1.131 billion is the result of one-time purchases of state-of-the-art equipment in fiscal year 2008 and investments in non-recurring maintenance of $0.3 billion.

Question 4(a). VA's medical care budget has also been criticized for possibly underestimating demand for VA care, i.e., many believe you'll see more Global War on Terror veterans than you've projected. How did you arrive at the number of total veterans you estimated would seek treatment in fiscal year 2009 for each priority group? How many total episodes of care (inpatient, outpatient, Vet Center visits, etc.) did you project for fiscal year 2009 relative to fiscal year 2008?

Response. VA uses an actuarial model to forecast patient demand and associated resources needs. Actuarial modeling is the most rational way to project the resource needs of a health care system like the VHA. The annual patient projections generated by the VA enrollee health care projection model are a function of the projected enrolled population and the mix and intensity of workload for those enrollees as projected by the model. The patient projections are then adjusted to account for those enrollees who seek only non-modeled services such as Vet Centers. While historical relationships are used to develop the patient projection model, it is recognized that there may be variation between projected and actual annual patient counts. These variations derive from differences between priority groups in the percent of respective enrollees who use VHA services. In addition to the projections

made by actuarial model, VA tracks actuals against projections on a monthly basis for the prior year and adjustments are made to the budget accordingly.

The estimates in the 2009 President's submission represent the best possible estimates based on the information available at that time. Workload estimates are shown in the chart below:

Summary of Workloads for VA and Non-VA Facilities

Description	2008 Current Estimate	2009 Estimate	Increase/ Decrease
Outpatient Visits (000):			
Staff	57,139	62,024	4,885
Fee	6,604	7,211	607
Readjustment Counseling	1,113	1,222	109
Total	64,856	70,457	5,601
Patients Treated:			
Acute Hospital Care	567,503	573,326	5,823
Rehabilitative Care	13,933	13,748	(185)
Psychiatric Care	119,948	130,548	10,600
Nursing Home Care	92,144	93,002	858
Subacute Care	7,318	6,294	(1,024)
Residential Care	26,962	26,520	(442)
Inpatient Facilities, Total	827,808	843,438	15,630
Average Daily Census:			
Acute Hospital Care	8,356	8,219	(137)
Rehabilitative Care	1,097	1,073	(24)
Psychiatric Care	5,343	5,899	556
Nursing Home Care	34,633	34,970	337
Subacute Care	195	145	(50)
Residential Care	8,157	8,072	(85)
Inpatient Facilities, Total	57,781	58,378	597
Home and Community-Based Care	44,192	61,029	16,837
Inpatient and Home and Community-Based Care, Grand Total	101,973	119,407	17,434
Length of Stay:			
Acute Hospital Care	5.4	5.2	(0.2)
Rehabilitative Care	28.8	28.5	(0.3)
Psychiatric Care	16.3	16.5	0.2
Nursing Home Care	137.6	137.2	(0.4)
Subacute Care	9.8	8.4	(1.4)
Residential Care	110.7	111.1	0.4
Dental Procedures	3,475,395	3,620,884	145,489

Question 4(b). How did you arrive at the number of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans you estimated would seek treatment? How many episodes of care did you assume for these veterans?

Response. VA uses an actuarial model to forecast patient demand and associated resources needs. Actuarial modeling is the most rational way to project the resource needs of a health care system like VHA. The estimates in the 2009 President's submission represent the best possible estimates based on the information available at that time. VA estimates it will treat 293,345 and 333,275 OEF/OIF unique patients in 2008 and 2009, respectively. In addition to the projections made by actuarial model, VA tracks actuals against projections on a monthly basis for the prior year and adjustments are made to the budget accordingly.

The annual OEF/OIF patient projections generated by the VA enrollee health care projection model are a function of the projected enrolled population and the mix and intensity of workload for those enrollees as projected by the model. While historical relationships are used to develop the patient projection model, it is recognized that there may be variation between projected and actual annual patient counts. These

variations derive from differences between priority groups in the percent of respective enrollees who use VHA services. The number of OEF/OIF veterans projected to seek services was adjusted from the model results to account for veterans who only use non-modeled services and non-enrolled veterans. Using the base year 2006 enrollee health care projection model, VA projects following use of modeled services for OEF/OIF enrolled veterans:

Service Category	2008	2009
Inpatient bed days of care	53,646	65,506
Special program services bed days of care	135,507	188,842
Ambulatory care services	4,090,239	5,078,094
Outpatient mental health services	47,884	67,995
Pharmacy/durable medical equipment services	2,803,401	3,595,196
Other devices and equipment services	153,932	198,672
Dental procedures	314,798	377,898

Question 4(c). To get a sense of how accurate VA's forecasting of demand is, how did your projected demand in the fiscal year 2007 budget match with the actual demand numbers?

Response. The fiscal year 2007 budget estimate excluding the effects of proposed enrollment fees and pharmacy co-payment increases was 5,498,290 unique patients. The fiscal year 2007 actual was 5,478,929 unique patients, a difference of 0.4 percent or 19,361 unique patients.

Question 4(d). How has your projected demand for fiscal year 2008 matched up with actual demand so far this year?

Response. The fiscal year 2008 projection is 5,681,420 unique patients of which 4.2 million had been seen by December 2007. The fiscal year 2008 OEF/OIF fiscal year projection is 293,345 of which 126,000 had been seen by December 2007.

Question 5. What is the per-patient cost for veterans in each of the eight priority groups? What is the per-patient cost of OEF/OIF veterans?

Response. Cost per patient, fiscal year 2009 estimates by priority group is shown in the chart below.

Priority Groups	Cost Per Patient
1	$13,943
2	6,501
3	5,755
4	22,477
5	7,122
6	3,359
1–6	8,997
7	3,837
8	3,946
7–8	3,916
OEF/OIF	3,802

Question 6. Assuming that veterans received 100 percent of their care from VA (i.e., there was no reliance on other sources of care), what is the total cost of providing health care to veterans in each of the eight priority groups?

Response. Based on an analysis using the VA enrollee health care projection model, VA projects that an additional $77.9 billion would be expended in fiscal year 2009 if all enrollees obtained 100 percent of their care for modeled services from VHA. The current reliance expenditures in the table below reflect the model settings and assumptions developed to inform the fiscal year 2009 budget process. Non-modeled services such as Vet Centers, long-term care, spina bifida care, and foreign medical programs are excluded.

The 100 percent reliance expenditures reflect the cost estimates when adjustments under the current reliance scenario are set to 100 percent for all modeled services, including special programs, dental and pharmacy. For the 100 percent reliance scenario, all other assumptions outside of reliance reflect the current scenario; the unit costs for new services are the same as those developed under the current reliance scenario. This assumes that VA will provide services in-house to the same

extent that services are currently provided. Capacity constraints would require many of these services to be purchased in the community at costs that will vary from VA costs. These projected additional expenditures do not include the costs of capital infrastructure that would be needed to provide services in-house under a 100 percent reliance scenario.

Priority Level	Average Enrollment	2009 Expenditure Projections ($ in millions)		
		Current Reliance	100 percent Reliance	Additional Expenditures
1	955,551	$8,984.4	$19,529	$10,544.5
2	575,201	2,215.4	6,396.6	4,181.2
3	1,034,069	3,089.5	10,509.2	7,419.7
4	242,301	3,417.3	7,937.4	4,520.2
5	2,349,789	10,604.7	30,123.0	19,518.3
6	265,712	466.4	2,311.8	1,845.4
7a	19,985	38.7	322.4	283.8
7c	560,975	1,039.6	8,745.9	7,706.3
8a	77,648	171.4	1,161.7	990.3
8c	1,621,256	3,308.8	24,232.9	20,924.2
All	7,702,486	$33,336.3	$111,270	$77,933.7

Question 7. What provisions in the budget advance or contribute to the Military Sexual Trauma Program?

Response. In fiscal year 2007, The Office of Mental Health Services (OMHS) funded a military sexual trauma (MST) support team that is designed to help ensure that VA is in compliance with legally mandated monitoring of MST screening and treatment. The team also helps to coordinate and expand legally mandated education and training efforts related to MST, and to promote best practices in the field.

In fiscal year 2008, OMHS approved funding for additional personnel in order to enable the expansion of training/education and program development efforts, particularly with regard to MST among men. For example, OMHS conducts monthly national training teleconference and sponsors an annual MST clinical training program. OMHS has focused on increasing veterans' access to MST related care by redesigning and disseminating a MST brochure for veterans; making materials available to clinical staff on-line; training efforts targeted at frontline staff who are often pivotal in ensuring that veterans get directed to the people able to help them get access to MST related care; and, increasing staff awareness of issues specific to men who experience MST.

In fiscal year 2009, the MST support team will assess the need for additional residential treatment programs/treatment tracks for MST, continue to focus on improving access to MST related care, assure that all MST coordinators receive evidence-based training for trauma and assure that the residential and in-patient treatment environment promotes safety, security and privacy. Based on our initial fiscal year 2008 focus on MST among men there will additional needs for improving access and training in this specific area.

Question 8(a). It is my understanding that VA is expected to update its physical therapy qualification standards by July 2008. Is this correct? If not correct, please provide a timeline on when those standards will be updated?

Response. Yes. Proposed qualification standards for physical therapy are currently under review for concurrence within VA from all parties involved (e.g., labor partners, human resources, etc.). We expect that final qualification standards would be approved for implementation in 2008.

Question 8(b). Are there qualification standards for other VA service providers that are in the process of being revised or will soon begin the process of being revised? If so, please provide the scheduled updates.

Response. We are currently revising or developing new qualification standards for the following health care occupations:

Occupation	Received	Anticipated completion
Blind rehabilitation specialist	11/2004	Fall 2008
Nurse anesthetist (CRNA)	5/2006	Summer 2008
Occupational therapist	3/2006	Summer 2008
Pharmacist	1/2004	Fall 2008
Social worker	12/2003	Fall 2008

Question 9. What are VA's plans with respect to the authority granted it under section 201 of Public Law 109–461?

Response. In May 2007, VA provided a report to Congress entitled "Marriage and Family Therapy Workload." As a follow-up to that report, a recently initiated occupational study will assess the current and future use of therapists and counselors within VA. During this endeavor, VA has been in contact with key officials at the American Association for Marriage and Family Therapy, the American Counseling Association, the American Mental Health Counselors Association, and VA professionals in the areas of mental health, social work and pastoral counseling.

We have received a great deal of information from these organizations. This information, along with a survey of facility staffing and health care needs that VA will undertake in the next few months, will allow VA to create an action plan to properly use these professionals.

Compensation and Pension

Question 1. If the fiscal year 2009 budget request is adopted, direct full-time employees for the Compensation and Pension Service will increase by over 2,600 from fiscal year 2007 to fiscal year 2009. With those staffing levels, VA expects to complete approximately 943,000 claims in fiscal year 2009, which is about 118,000 more claims than were decided in fiscal year 2007. Although I applaud the increase in total production, VA will be producing only 45 additional decisions per year for each additional direct full-time employee hired since fiscal year 2007. Do you think this is a good return on our investment? Do you expect to see bigger gains in productivity in later years?

Response. Our aggressive recruitment program to increase the staffing level in C&P program is absolutely essential to reducing our pending claims inventory and providing more timely decisions to veterans. Because it takes 2 years for new employees to complete their training and become productive in all aspects of claims processing, this initial investment in both formal and on-the-job training must be made.

Our recruitment plan calls for us to continue to add new employees throughout 2008. This timeline allows us to support their training requirements and complete the necessary infrastructure changes to our facilities. As a result of our recruitment initiative as well as our normal rate of employee attrition, we project that more than one third of our workforce will have less than 2 years of experience at the end of fiscal year 2008.

We fully expect decision output per employee to continue increase in subsequent years as these new employees complete their training and gain experience.

Question 2(a). In the fiscal year 2008 budget proposal, VA projected productivity of 101 claims per direct full-time employee in fiscal year 2008. Now, VA is predicting that productivity in fiscal year 2008 will be only 85.2 claims per direct full-time employee. What factors account for this 16 percent drop in this productivity goal since last year?

Response. The significant increase in new hires lowers the overall average of cases completed per employee, since these are less experienced workers

Question 2(b). How do you determine the per-full-time-employee output goal?

Response. It is important to understand that for the purposes of the C&P budget, we report output per direct FTE for our primary and most resource-intensive work unit, disability claims requiring a rating decision. We project to complete over 878,000 disability rating claims this fiscal year and over 942,000 in fiscal year 2009. However, in total we will complete over 2.2 million award actions of all types, as well as nearly 7 million non-claims related correspondence actions, over 340,000 fiduciary actions, 8,500 military service briefings to nearly 400,000 servicemembers, nearly 7 million telephone calls, and 1 million personal interviews. Our direct labor employees in C&P support all of these requirements, as well as appellate processing

requirements, and include managerial, supervisory, and administrative support personnel in the field and in Headquarters.

In projecting output per FTE for disability rating claims, VBA takes into account the total number of direct labor FTE in C&P and the experience level of our employees. Employee experience is categorized in 6-month increments until the journey level is attained. An average weight is assigned to the projected contribution at each experience level. The weights for fiscal year 2008 are as follows:

0–6 months: 40 percent
6–12 months: 60 percent
12–18 months: 70 percent
18–24 months: 80 percent

Question 3. During fiscal year 2008, the Compensation and Pension Service expects a direct full-time employee level of 10,304 and a productivity level of 85.2 decisions per direct full-time employee. If that same level of staffing was maintained in fiscal year 2009 but productivity improved to 100 claims per direct employee—a level VA has achieved in the past—VA would be able to handle over 1 million claims. That's almost 10 percent more claims than VA expects to complete in fiscal year 2009 with the addition of almost 700 direct full-time employees. What factors were considered by VA in deciding to seek more employees rather than simply focusing on increasing productivity of the existing employees?

Response. VA considered the continuing rate of increase in our disability claims workload, as well as increases in all other workload areas including public contact and outreach; pension, burial, and other ancillary benefit claims; and appellate workload. Additional resources are also required to support more and better training, an enhanced and expanded quality assurance program, and an aggressive program of field oversight, all of which are also essential to improving the quality and consistency of our decisions. Increasing and maintaining a staffing level commensurate with our increasing workloads in all areas will be key to reducing the inventory, improving both the quality and timeliness of service delivery, and ensuring we are meeting the needs of veterans and their families.

Question 4. As partial justification for the requested staffing level for the Compensation and Pension Service, the Administration's fiscal year 2009 budget request includes the following explanation:

> Recent decisions of the Court of Appeals for Veterans Claims (CAVC) have also had an impact on [VA's] ability to bring claims inventories into a more acceptable range and make progress in achieving our timeliness goals * * *. Court decisions that mandate the specific content of our notices to claimants and the specific timing of the notice impose both highly complex and problematic duties in a claims system that was designed to be informal.

Are there specific CAVC opinions that, if overturned by Congress, would help improve VA's ability to handle its caseload without negatively impacting outcomes for veterans? If so, please list the specific opinions.

Response. We have identified the following decisions of the United States Court of Appeals for Veterans Claims (Veterans Court) that, if overturned, would improve our ability to manage our caseload without negatively impacting outcomes for veterans:

***Mayfield* v. *Nicholson*, 19 Vet. App. 103 (2005) (Mayfield I)—**Framework was provided for prejudicial error analysis concerning all four Veterans Claims Assistance Act (VCAA) notice elements. The Court held that first element notice error, informing the claimant what is needed to substantiate his/her claim, is presumptively prejudicial and the burden automatically shifts to VA in all cases before the Veterans Court to demonstrate that did not prejudice the appellant. The U.S. Court of Appeals for the Federal Circuit (Federal Circuit) affirmed this holding in *Sanders* v. *Nicholson*, 487 F.3d 881 (2007), and further held that any error by VA in providing the notice is presumptively prejudicial to the appellant.

These decisions primarily contribute to decisional documents being unnecessarily lengthy and complex, as any error in the approximately 800,000 notice letters VA sends out annually would be presumptively prejudicial. Also, it delays resolution of appeals by the Board and the increased number of remands from the Board solely for notice compliance exacerbates VBA's workload and claims processing delays with little tangible benefit flowing to the claimant.

***Pelegrini* v. *Principi*, 18 Vet. App. 112, 121 (2004)—**VA's implementing regulation imposes a fourth requirement that VA "request that the claimant provide any evidence in the claimant's possession that pertains to the claim," and that notice is defective if it does not specifically make such a request.

This decision imposes a burden upon veterans service representatives (VSR) to ensure that VA's notice document specifically includes this request.

***Dingess/Hartman* v. *Nicholson*, 19 Vet. App. 473 (2006)—**Notice must be provided to a claimant of how a VA service connection claim may be substantiated as to all five elements of that claim, to include disability rating and effective date, and that certain standards apply for the timing and content of that notice. The Court extended the notice requirements of 38 U.S.C. §5103(a) to the disability rating and effective date elements as well.

The Court also held that, if a claimant's application suggests there is "specific information or evidence necessary to resolve an issue relating to elements of a claim," VA must "tailor the notice to inform the claimant of the evidence and information required to substantiate the elements of the claim reasonably raised by the application's wording."

This decision significantly expanded the content of notice letters with requirements for heightened specificity on downstream elements that we do not believe are consistent with the intent of the VCAA to only provide generic notice of how to substantiate a claim.

***Kent* v. *Nicholson*, 20 Vet. App. 1 (2006)—**In claims to reopen for service connection on the basis of new and material evidence, the VCAA requires VA to review the bases for denial in the prior decision and respond with a notice letter that describes what evidence would be necessary to substantiate the element or elements required to establish service connection that were found insufficient in the previous denial. Failure to comply with this requirement, in most circumstances, is presumed to be prejudicial error.

This decision places high burden upon VSRs to ensure that VCAA notice is compliant with this holding as VSRs must review the file to determine the exact basis of previous the denial and also inform the claimant of possible evidence and/or theories to substantiate a claim that were not considered in the previous denial. In many circumstances such detailed notice may not be possible without the assistance of a rating qualified decisionmaker.

***Hupp* v. *Nicholson*, 21 Vet. App. 342 (2007)—**The Court held that the notice provided in response to a claim for dependency and indemnity compensation (DIC) benefits under 38 U.S.C. §1310 must include:

(1) A statement of the conditions, if any, for which a veteran was service-connected at the time of his or her death;

(2) an explanation of the evidence and information required to substantiate a DIC claim based on a previously service-connected condition; and

(3) an explanation of the evidence and information required to substantiate a DIC claim based on a condition not yet service-connected.

This decision imposes high burden upon VSRs to review claims file and create a notice document that is compliant with this holding and lengthens the time to process such claims.

***Palor* v. *Nicholson*, 21 Vet. App. 325 (2007)—**Persons claiming benefits based upon service in the guerrilla forces of the Philippines during World War II must be notified by VA: (1) of the opportunity to submit official United States documentation of service as evidence; and (2) that United States service department certifications that Philippine service either qualifies or does not qualify the claimant for veteran status may be binding.

This decision imposes a high burden upon VSRs to review a claims file and create a notice document that is compliant with this holding and lengthens the time to process such claims.

***Vazquez-Flores* v. *Peake*, Vet. App. No. 05–0355 (January 30, 2008)—**The Court interpreted 38 U.S.C. §5103(a) as requiring significantly more content to be contained in VCAA notice letters sent to veterans in response to claims for increased ratings. The Court held that, if VA receives a claim for an increased rating and if the diagnostic code ("DC") under which the disability is rated contains criteria necessary for entitlement to a higher disability rating that would not be satisfied by the claimant demonstrating a noticeable worsening or increase in severity of the disability and the effect that worsening has on the claimant's employment and daily life (such as a specific measurement or test result), VA must provide at least general notice of those criteria to the claimant.

This case expands upon the Court's holding in *Dingess* with substantial expansion of the specificity of the notice for increased ratings claims that is a significant departure from the intent that such notices be generic concerning an increased rating claim. The burden upon VBA personnel processing claims will be enormous and re-

quire labor-intensive efforts and scrutiny to ensure that such letters pass judicial muster at the administrative, appellate, and judicial review levels.

***Haas* v. *Nicholson*, 20 Vet. App. 257 (2006)—**The Court determined that Vietnam veterans who served in the waters off the shore of Vietnam, and did not set foot in Vietnam or serve on its inland waterways, are entitled to a presumption of exposure to herbicide agents, to include Agent Orange.

This case expanded the class of veterans determined to have been presumptively exposed to herbicides in Vietnam significantly beyond the intent of Congress and VA's implementing regulation, which we believe is limited to veterans who served on land in Vietnam or service on the inland waterways. The *Haas* decision would significantly increase VA's adjudication workload because if the decision is upheld it would extend the presumption of exposure to herbicide to as many as approximately 832,000 veterans not previously covered. (This number consists of all veterans who received the Vietnam Service Medal but did not serve within South Vietnam.)

Question 5. In 2001, a task force chaired by Admiral Daniel Cooper recommended that VA allocate employees "to those Regional Offices that have consistently demonstrated high levels of quality and productivity in relation to workload and staffing levels." If the fiscal year 2009 budget request is adopted, would the additional staff for claims processing be allocated to offices that have consistently performed well?

Response. VBA allocates resources based on a number of factors, including the number of claims received at a regional office (RO) and specific performance factors. VBA's resource allocation model allocates more FTE to ROs that process claims more efficiently and accurately, as well as those that receive a greater share of the workload. The model allocates staffing levels based on four factors: (1) performance on timeliness measures; (2) accuracy of completed work; (3) volume of incoming claims work, including compensation and pension claims, telephone inquiries, and non-rating claims; and (4) performance on appeals measures. Additional adjustments are made for special circumstances and new or unique missions performed by an RO. These new missions include the consolidation of all original pension workload to the pension maintenance centers, the creation of additional development centers, and the consolidation of general assistance and education calls to national call centers.

Question 6(a). According to the fiscal year 2009 budget request, the Compensation and Pension Service "proposes to design and develop a Web-enabled, rules-based automated information system to improve the business process of [Compensation and Pension] claims adjudication." What impact would this initiative potentially have on productivity?

Response. VBA, in collaboration with VA's Office of Information and Technology (OIT), is developing the paperless delivery of veterans benefits initiative. This initiative is envisioned to employ a variety of enhanced technologies to support end-to-end claims processing. In addition to imaging and computable data, we will also incorporate enhanced electronic workflow capabilities, enterprise content and correspondence management services, and integration with our modernized payment system, VETSNET. We are also exploring the utility of business-rules-engine software for both workflow management and to potentially support improved decision-making by claims processing personnel.

The initiative builds on two pilot programs currently underway. These pilot projects have demonstrated the utility of imaging technology in our C&P business line. Both projects use our virtual VA imaging platform, which is a document and electronic claims-folder repository.

To fully develop this initiative, VBA will be engaging the services of a lead systems integrator (LSI). The LSI will work closely with VBA and OIT to fully document business and system requirements. In addition, we will document demonstrable milestones and performance metrics, as well as life-cycle funding requirements.

Until we have had the opportunity to fully develop the initiative, it is premature to speculate on productivity or other performance improvements.

Question 6(b). What are the proposed milestones for this initiative and target completion dates for those milestones?

Response. As noted above, we will be engaging the services of a LSI to assist us in fully developing the initiative. Until we have had the opportunity to complete this development process, it is premature to speculate on milestones and timelines. In the interim, however, we are working to expand our current pilot projects to increase the use of the "e-file" in compensation claims processing.

Question 6(c). How much funding, in total, would VA need to complete this initiative?

Response. We will be engaging the services of a LSI to assist us in fully developing the initiative. Until we have had the opportunity to complete this development process, it is premature to speculate on the life-cycle cost of the initiative. By proxy, SSA's "eDib" initiative has a reported life-cycle cost of $800 million and a timeline of 8 years to fully implement.

Question 7. For fiscal year 2009, what level of funding is requested for the Appeals Management Center and how many full-time employees will that funding level support? What were the key performance outcomes (e.g., timeliness and accuracy) for the Appeals Management Center in fiscal year 2007 and what are they expected to be in fiscal years 2008 and 2009?

Response. In fiscal year 2008, the Appeals Management Center (AMC) is funded at $9.5 million and is staffed with 114 full-time employees. The AMC will hire an additional 6 FTE in fiscal year 2008. The budget request for fiscal year 2009 provides funding for the AMC to sustain this increased staffing level.

In fiscal year 2007, the AMC's accuracy rate was 85 percent. The AMC accuracy target for fiscal year 2008 is 90 percent. Through the first quarter of fiscal year 2008, the AMC achieved an accuracy rate of 89 percent. It is expected that the quality of decisions will continue to improve through the remainder of fiscal year 2008 and in fiscal year 2009 as the experience level of decisionmakers increases. In fiscal year 2007, the average age of remands in AMC's inventory was 349 days. This was above the fiscal year 2007 target of 317 days. The AMC is taking several steps to improve the timeliness of pending remands and to reduce the pending inventory. In addition to significantly increasing its staffing level, the AMC is brokering claims to VBA resource centers for processing and has also increased overtime funding. The AMC's fiscal year 2008 target for the average age of the remand inventory remains 317 days. Performance targets for the AMC in fiscal year 2009 have not yet been established.

Insurance

Question 1. A Servicemembers' Group Life Insurance Advisory Council Meeting was held in November 2007. At that meeting, VA recommended very specific improvements to the Traumatic Injury Protection coverage under Servicemembers' Group Life Insurance. For example, VA recommended that the categories of loss that are eligible for payment be expanded to include second degree burns on at least 20 percent of the body or face. What is the status of those recommendations and when do you anticipate that they will be fully implemented?

Response. A summary of the draft version of the Traumatic Injury Protection Under Servicemembers' Group Life Insurance (TSGLI) Year One Review has been presented to DOD for concurrence or comment. Once DOD's input is received, VA will prepare and implement the final report. At this date we are awaiting the response from DOD.

Vocational Rehabilitation and Employment

Question 1(a). The Administration's fiscal year 2009 budget request includes funding for 1,073 direct full-time employees for the Vocational Rehabilitation and Employment (VR&E) program. Would you please provide a breakdown of the number of those requested VR&E employees that would serve in each type of position, including counselors, employment coordinators, contracting specialists, and support staff?

Response. For fiscal year 2009, staffing is projected as follows:

- Counselors: 764
- Employment coordinators: 85
- Contract specialists: 24
- Management and administrative support: 200

Question 1(b). With the requested funding level, what would be the average caseload per counselor?

Response. The requested funding level and projected workload enables us to achieve our average caseload standard of 125 participants per rehabilitation counselor.

Question 2. According to the Administration's fiscal year 2009 budget request, VA sends "a motivational letter to all new [individual unemployability (IU)] beneficiaries to advise them of potential eligibility to Vocational Rehabilitation and Employment Benefits." Does VA plan to revise this policy in response to the Veterans' Disability Benefits Commission's recommendation that all applicants for individual unemployability benefits be screened for employability by VR&E counselors before an IU rating is assigned? What impact would it have on VR&E's staffing requirements if this recommendation were adopted?

Response. VA has formed a work group to review the Commission's recommendations concerning the screening of all individual unemployability (IU) applicants by VR&E counselors prior to assignment of IU ratings. Included in this study is an analysis of VR&E staffing implications. The work group expects to complete its study and provide recommendations within the next 3 months.

Question 3(a). The fiscal year 2009 Independent Budget recommended that VR&E "follow up with veterans after being referred to other agencies for self-employment to ensure that the veteran's entrepreneurial opportunities have been successfully achieved." What procedures now govern follow-up with these veterans? Are there additional steps that should be taken to ensure that veterans who opt to pursue this track do not fall through the cracks?

Response. Numerous steps and procedures are involved with the development and follow-up of a plan of service under self-employment. The veteran is responsible for developing a written business plan for consideration by either a case manager or contractor specializing in business plans. The assigned VR&E case manager will ensure that the veteran works with a professional business consultant, either on a voluntary or contractual basis, to develop a proposed business plan. The VR&E case manager continues to work with the veteran during this initial process. Once the business plan has been developed, a professional consultant evaluates the economic viability of the proposed business plan. After acceptance of the business plan and economic viability evaluation by the VR&E case manager, the veteran along with the VR&E case manager will develop the self-employment plan. The VR&E case manager remains involved with the veteran for a minimum of 12 months after the self-employment plan has been implemented. The VR&E case manager has scheduled meetings with the veteran to review his/her individual progress and evaluate any further needs to ensure success of the veteran.

Question 3(b). Would any such additional steps require more VR&E staffing?

Response. No additional steps are necessary, and we do not project the need for any additional FTE.

Question 4. During fiscal years 2008 and 2009, how many VR&E staff will be dedicated to supporting the CHTW program? How many participants do you expect during those years?

Response. In order to meet the increased need for VR&E early outreach, the "Coming Home to Work" (CHTW) program has been expanded to all 57 VR&E field offices. Each VR&E field office will have at least one person assigned to the CHTW program. Prior to the expansion of the CHTW program, there were 438 participants. Although we cannot estimate precisely, this number is expected to increase significantly as a result of the expansion of the program.

Question 5(a). According to the fiscal year 2009 budget request, VR&E will be conducting a study of the long-term outcomes of veterans participating in VR&E programs. What is the expected timeline for this initiative?

Response. Contractor support is required in developing the design of the study and survey instrument. The contract is projected to be awarded in fiscal year 2009 with a completion date for final results by the end of fiscal year 2010.

Question 5(b). How many veterans do you anticipate surveying?

Response. During the development of the project, the various statistical elements such as methodology, sample size, and population to survey will be determined.

Question 5(c). How long after they have completed the VR&E program will former participants be contacted?

Response. We are unable to make this projection at this early stage of developing the study.

Education

Question 1(a). As one means of gauging productivity, the Compensation and Pension Service reports the output per direct full-time employee. What would be a reasonable per-full-time employee output goal for the Education Service?

Response. In the education program, we track completed work units, which includes both original and supplemental education claims as well as other award actions of all types. A reasonable output goal per direct education FTE would be approximately 1900 completed work units per year.

Question 1(b). What level of productivity per direct full-time employee did the Education Service attain in fiscal year 2007 and what are the expected productivity levels per full-time employee for fiscal years 2008 and 2009?

Response. In fiscal year 2007, education attained productivity of 1935 completed work units per direct FTE, and we expect to achieve 1820 completed work units per direct FTE in fiscal year 2008 and 1850 in fiscal year 2009. While we are adding

employees in the education program in fiscal year 2008, the trainees' lack of experience will limit their contribution to productivity in fiscal year 2008 and 2009. In fiscal year 2007, education processed original and supplemental claims in 32 and 13 days, respectively. In fiscal year 2008, education expects to process original and supplemental claims in an average of 24 and 11, days, respectively. In fiscal year 2009, education expects to process original and supplemental claims in an average of 19 and 10 days, respectively. The education payment accuracy rate will increase from 95 percent in 2007, to 96 percent in 2008 and 2009.

Question 2(a). According to the fiscal year 2009 budget request, the Education Service "will continue in 2009 the process of centralizing Regional Processing Office call centers, which accept all calls directed to the 1–888–GIBILL1 number." During fiscal years 2008 and 2009 how many of these calls do you anticipate receiving?

Response. We project to receive approximately 2 million education calls in each of these 2 fiscal years.

Question 2(b). During fiscal years 2008 and 2009 how many full-time employees will be devoted to answering these calls?

Response. We expect to devote approximately 180 FTE to answering education calls and providing administrative/managerial support to the Education Call Center in each of these 2 fiscal years.

Question 2(c). Where will those employees be located?

Response. During first quarter of fiscal year 2008, employees assigned to the four regional processing offices continued to answer calls to our education toll-free number. Beginning February 2008, phone service is being transferred sequentially from the Buffalo, Atlanta, and St. Louis offices to the Education Call Center at the Muskogee office. By the beginning of fiscal year 2009, all employees devoted to education phone service will be in Muskogee.

Question 3(a). According to testimony submitted by VA regarding the fiscal year 2008 budget request, the Education Service was working on providing individuals with greater access to information about their education benefits on-line and VA expected "a decline in the number of telephone inquiries that we receive as we add more self-service options on our GI Bill Web site." What information is now available to education participants on-line?

Response. The following on-line services are available to current Montgomery GI Bill Active Duty (MGIB–AD) and Montgomery GI Bill Select Reserve (MGIB–SR) program participants: certification of monthly enrollment, change of address, access to status of pending claim, access to remaining benefit entitlement, access to delimiting date, and establishing and changing direct deposit accounts.

Question 3(b). Has VA seen a decline in the number of telephone inquiries?

Response. During the first 4 months of fiscal year 2008, call volume has been at its lowest level since fiscal year 2004. This is in spite of significant increases in education program participation. A significant factor in the lower call volume is VA's improvements in claims processing timeliness. On-line self service is a contributing factor as well. For example, during fiscal year 2007, over 82,000 changes of address were processed on-line. Prior to fiscal year 2007, this action would have required contacting a benefits counselor during normal business hours at one of our regional processing offices.

Question 4(a). According to the Administration's fiscal year 2009 budget request, the Education Service "is working to determine what outcome-based performance measures will be used to measure the effectiveness of the [State Approving Agency (SAA)] efforts." When do you anticipate having these performance measures in place? In the meantime, what steps are being taken to ensure that veterans are being well-served by the funding provided for SAAs?

Response. Beginning with the fiscal year 2008 SAA contracts, VA has begun collecting data that will provide baseline information on resources expended on certain SAA functions. Additionally, VA is working with the SAAs to determine outcome measures that would be appropriate and consistently measurable. We are working to incorporate outcome-based performance measures in the fiscal year 2009 SAA contracts and business plans.

Question 4(b). Does the fiscal year 2009 budget request include any funding for SAAs, above the $13 million from the readjustment benefits account that may be used for that purpose?

Response. VA did not submit a legislative proposal to restore mandatory funding in the fiscal year 2009 budget submission because bills were already before Congress that would restore or increase funding.

S. 1215 would continue SAA funding at $19 million for years after fiscal year 2007. At a hearing before the Senate Veterans' Affairs Committee on May 9, 2007,

VA testified in support of S. 1215. VA stated that the statutory requirement to reduce SAA funding to $13 million would cause SAAs to reduce staffing, severely curtail outreach activities, and perform fewer supervisory and approval visits. VA further stated that reduced funding might cause some SAAs to decline to enter into contracts with VA and that VA would have to assume the additional duties.

H.R. 2579 would make only $13 million available from the RB account for SAA expenses and permit VA to use GOE appropriations for the additional funds. At a hearing before the House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity, on June 21, 2007, VA testified against H.R. 2579 because VA maintains that funding for SAA activities should be an authorized expenditure from the RB account rather than a discretionary expense from the GOE account to guarantee that mandatory funding is available for these contracts.

Board of Veterans' Appeals

Question 1. During fiscal year 2009, how many appeals do you expect the Board of Veterans' Appeals (Board) to receive and how many decisions do you expect the Board to produce?

Response. In fiscal year 2009, the Board expects to receive 43,000 cases and produce at least 41,000 decisions. We expect even greater productivity in the future as recently-hired attorneys become fully trained and more experienced as they reach the journeyman level (GS–14) over the next several years.

Question 2. According to the fiscal year 2009 budget request, the Board is responsible for deciding allegations of clear and unmistakable error in prior Board decisions. How many of these cases did the Board receive in fiscal year 2007? How many do you expect the Board to receive in fiscal years 2008 and 2009?

Response. In fiscal year 2007, the Board received 48 motions for revision of prior Board decisions based on clear and unmistakable error (CUE). The Board cannot predict the number of motions for revision of Board decisions based on CUE that will be received in fiscal year 2008 and 2009. However, over the past 3 fiscal years, the Board has received an average of 78 such motions per year. There is no reason to expect that the number received for fiscal year 2008 and 2009 would substantially differ from prior years.

Question 3. According to the fiscal year 2009 budget request, "[r]ecent judicial precedent had significant effect on the Board's workload." Would you please provide additional detail as the impact these court opinions have had on the Board's workload? For example, how many appeals have been stayed, remanded, or reconsidered based on these opinions?

Response. Veterans law continues to become increasingly complex. In addition to statutory and regulatory changes, a significant number of decisions continue to be issued by the Veterans Court and the Federal Circuit that have immediate and dramatic impact on the policies and procedures that must be followed by VA in developing and deciding claims for veterans benefits. One of the most sweeping changes to occur in the area of veterans' law during the past decade was the promulgation of the VCAA in November 2000. This legislation continues to have major impact on VA due to the ongoing issuance of significant court decisions interpreting VA's duties under the VCAA.

Although VCAA was enacted more than 7 years ago, the courts continue to provide novel interpretations of the duties to notify and assist a claimant in substantiating a claim for benefits, as required by the VCAA. Most recently, the Veterans Court issued a decision in *Vazquez-Flores* v. *Peake*, No. 05–355 (U.S. Vet. App. Jan. 30, 2008), which sets forth detailed and specific requirements for the type of VCAA notice that must be provided to claimants seeking an increased disability rating. Given that increased rating claims constitute 30.8 percent of all issues on appeal (i.e. issues where a notice of disagreement (NOD) has been filed), this Court decision has had an immediate and dramatic impact on all pending increased rating claims and appeals.

VA disagrees with the detailed notice requirements set forth in *Vazquez-Flores*, and, as such, has filed a motion for reconsideration of this decision with the Veterans Court. Simultaneously, a motion was filed requesting that the Veterans Court stay the precedential effect of *Vazquez-Flores* while it rules on the reconsideration motion. Until such time as these motions are ruled upon, VA is obligated to apply the holdings in this decision to all increased rating claims and appeals. While the Board is currently making every effort to render final decisions in cases involving increased rating claims, these efforts may be unsuccessful and may result in the need for large numbers of cases to be remanded to the AOJ for compliance with the detailed notice requirements set forth in *Vazquez-Flores*.

Vazquez-Flores is one of several major court decisions issued since 2000 interpreting the requirements of the VCAA. With such ever-changing interpretations of

the duties under the VCAA, many of which include increased specificity in notice, it has become increasingly challenging for the Board to render timely final decisions for all types of claims. Depending on the facts in an appeal, a large portion of each Board decision is now devoted to a discussion of VCAA compliance. When VCAA notice is found to be inadequate, the Board must engage in a lengthy prejudicial error analysis. See *Sanders* v. *Nicholson*, 487 F.3d. 881 (Fed. Cir. 2007); *Simmons* v. *Nicholson*, 487 F.3d. 892 (Fed. Cir. 2007). If the Board finds that the claimant was prejudiced by inadequate VCAA notice, and the appeal cannot be granted in full, the case must then be remanded to the AOJ to cure any VCAA notice defect. This process significantly lengthens the time to obtain a final resolution in the appeal, and contributes to the much criticized "hamster wheel" of appeals and remands in the veterans claims adjudication system.

Question 4. If the fiscal year 2009 budget request is adopted, the number of staff for the Board's Decision Teams will have increased from 303 in fiscal year 2007 to 352 in fiscal year 2009, a 16 percent increase. During that same period, the deficiency-free rate is projected to decline from 94 percent to 92 percent, the appeals resolution time is projected to increase from 660 days to 700 days, and the cycle time is projected to increase from 136 days to 150 days. What specific factors account for these lowered performance goals?

Response. In order to fully respond to the concerns raised by this question, each of these performance measures is addressed separately, below.

Deficiency-free rate: The Board's performance goal for the deficiency-free decision rate has remained unchanged at 92 percent over the past few years. This goal remains the same for future years. In practice, the Board's actual performance has exceeded our goal and we are making every effort to ensure that this trend will continue in the future. For example, in fiscal year 2007, the Board exceeded the 92 percent goal with a deficiency-free decision rate of 93.8 percent. So far in fiscal year 2008, through January 31, 2008, the Board is on target to again exceed our 92 percent goal with a deficiency-free rate of 94.2 percent. We are endeavoring to maintain this high level of achievement by a program of rigorous training, mentoring and quality review.

Appeals Resolution Time (ART): ART is the average length of time it takes VA to process an appeal from the date the claimant files a NOD until the case is finally resolved, including resolution at the RO level or by issuance of a final, non-remand decision by the Board. ART was initially established as a tracking measure before VCAA was enacted in November 2000. VCAA, among other things, heightened VA's duty to assist and duty to notify claimants of the type of evidence needed to substantiate their claim. This resulted in adding more steps to the claims process and a concomitant increase in the length of time required to develop claims. In addition, the Veterans Court and the Federal Circuit have issued a series of precedential decisions interpreting VCAA, which required additional action on VA's part. See *Holliday* v. *Principi*, 14 Vet. App. 280 (2001), *Quartuccio* v. *Principi*, 16 Vet. App. 183 (2002), *Charles* v. *Principi*, 16 Vet. App. 370 (2002), *Pelegrini* v. *Principi*, 18 Vet. App. 112 (2002), *Mayfield* v. *Nicholson*, 444 F.3d 1328 (Fed. Cir. 2006), *Dingess/Hartman* v. *Nicholson*, 19 Vet. App. 473 (2006), *Kent* v. *Nicholson*, 20 Vet. App. 1 (2006), and *Vazquez-Flores* v. *Peake*, No. 05–355 (U.S. Vet. App. Jan. 30, 2008). The evolving nature of VA's responsibilities under the VCAA, as interpreted by the courts, has continued to cause increases in ART.

Other factors affecting ART are the statutory and regulatory prescribed time periods that are built into the adjudication process, which allow claimants time to take certain action, such as respond to requests from VA, submit evidence or argument in support of their claim for benefits, and pursue the next step in the adjudication and/or appeals process. After the point in which a NOD is filed, there are 330 days of potential mandatory waiting times in the adjudication system.

For example, the law requires that a NOD shall be filed within 1 year from the date of mailing of the notice of the result of initial review or determination. 38 U.S.C. § 7105(b)(1); 38 CFR § 20.302(a). If a purported NOD is filed, but the statement is unclear and the AOJ cannot identify whether the claimant intends to appeal, or what adverse decision the claimant may be disagreeing with, the AOJ will contact the claimant to clarify whether the statement was intended as a NOD. 38 CFR § 19.26(b). The claimant will have a period of 60 days to respond to that request, or 1 year from the date or the decision being appealed, whichever is later. 38 CFR § 19.26(c)(1).

Once an appellant has filed a NOD, the AOJ sends a notice informing the claimant that he or she has the right to have the decision reviewed by a decision review officer (DRO) under 38 CFR § 3.2600(a). To obtain such review, the claimant is provided a period of 60 days after VA mails the notice to elect DRO review. 38 CFR

§ 3.2600(b). The case must sit without any action for the full 60 day period, or until the appellant responds to the notice, whichever comes first. If the appellant chooses to have a DRO review the decision, the reviewer may conduct additional development, hold an informal conference with a claimant and/or conduct a hearing, if appropriate. 38 CFR § 3.2600(c). If the DRO process is not selected, or if the review process is complete and the decision remains unfavorable, at least in part, a statement of the case (SOC) is sent to the claimant. 38 CFR § 19.29. The claimant is then provided a period of 60 days from the date of the SOC, or the remainder of the 1-year period from the date of the mailing of the notification of the determination being appealed, whichever is later, to file a substantive appeal. 38 CFR § 20.302(b). If additional evidence is received after the substantive appeal is filed, a supplemental statement of the case (SSOC) must be issued. 38 CFR § 19.31. A claimant is provided a period of 60 days to respond to the SSOC, 38 CFR § 20.302(c), and the claimant may request an extension of this period, for good cause. If an appellant requests a hearing before a member of the Board, written notice must be provided to the appellant not less than 30 days prior to the date a hearing will be held before the Board at a VA field facility. 38 CFR § 19.76. Once an appeal is before a Veterans Law Judge (VLJ) for adjudication, if the VLJ determines that a legal or medical opinion is required in the case, the appellant is provided a copy of the legal or medical opinion and provided a period of 60 days to respond. 38 CFR § 20.903(a).

Taking into account the evolving and increasing nature of VA's responsibilities, and the time needed to train new employees at both the RO and Board levels, VA expects ART to increase slightly from 660 days to 700 days in 2009. The department's strategic target is 675 days.

The Board and VBA are working together to reduce ART and to reduce avoidable remands. Veterans deserve timely and correct decisions on claims for benefits. The record must contain all evidence necessary to decide the claim and show that all necessary due process has been provided. If the record does not meet these requirements, and the benefits sought cannot be granted, a remand for further development is necessary. However, remands from the Board to the AOJ significantly increase the time it takes for a veteran to receive a final decision. A remand typically adds more than a year to the appellate process. Furthermore, about 75 percent of cases remanded are subsequently returned to the Board, which increases the Board's workload and further degrades timeliness. Eliminating avoidable remands is a goal that will provide better service to veterans and their families and, ultimately, help diminish the growing backlog and improve timeliness. VA has made significant progress toward this goal. The Board's remand rate was 35.4 percent in fiscal year 2007, which is down from a high of 56.8 percent in fiscal year 2004.

In addition, at the direction of the Secretary and in coordination with VBA, the Board has proposed an expedited claims adjudication (ECA) initiative that will be launched as a 2-year pilot program at four ROs. In order to help accelerate the timely processing of all claims and appeals, VA will offer represented claimants the option of participating in the ECA initiative for expedited processing of claims and appeals. A claimant who elects to participate in the ECA will voluntarily waive specified procedural rights and, in return, be placed on a fast track for adjudication. The expected rapid disposition of these claims should reduce the backlog and thereby ultimately improve the overall timeliness of claims processing.

Participation in the ECA Initiative will be offered in writing by VA as an option when a claim is received. During the pilot program, participation will extend to claims for benefits administered by VBA at four ROs for veterans who are represented. Participation will be only open to claims for disability compensation benefits under 38 CFR Parts 3 and 4, excluding a narrow class of claims including pension benefits, survivor benefits, and simultaneously contested claims.

In addition to expedited claims at a participating RO, any claims appealed to the Board under the ECA Initiative will be screened upon arrival at the Board to ensure that the record is adequate for decisional purposes when the appeal reaches its place on the Board's docket. If the record is inadequate, the Board will take prompt action under existing law and regulations, such as soliciting a waiver of RO consideration of additional evidence, and remand the case for further development, if necessary.

During the summer of fiscal year 2007, the Chairman briefed the Veterans Service Organizations (VSO), the Senate Veterans' Affairs Committee, the Subcommittee on Disability Affairs and Memorial Assistance of the House Veterans' Affairs Committee, and the Office of Management and Budget regarding the ECA Initiative.

VA is currently in the process of drafting proposed regulations to implement the ECA pilot program. The Department is excited about this program and the positive impact it is expected to have in speeding up the adjudication of claims and appeals before VA, which should be reflected in an improvement in ART.

Cycle time: The Board's "cycle time" is the average time it takes from when a case is received at the Board until a decision on that appeal is dispatched, excluding time the case was with the appellant's service organization representative. The Board's cycle time decreased from 148 days in 2006 to 136 days in 2007. The Board anticipates, however, that cycle time may increase in the short term due to fluctuations in the receipt of certain types of "priority" appeals.

The Board gives processing priority to certain types of cases, including: cases that are advanced on the docket, cases remanded to the Board from the Veterans Court, cases returned from the AOJ after a Board remand, and cases in which the Board has held a hearing. Historically, when a higher percentage of the Board's workload is made up of these priority appeals, cycle time will decrease. This is because "priority" appeals, by nature of being a priority, are quickly sent to a VLJ for adjudication, with minimal waiting time. Contrarily, original appeals that do not fall into a "priority" category, must be worked in their regular order on the Board's docket.

As productivity continues to increase, the Board is better able to expeditiously adjudicate these priority appeals, and therefore make greater progress in adjudicating original appeals. The more original appeals that the Board is able to adjudicate, the more progress will be made in reducing the backlog. However, the short-term effect is that cycle time may increase as more of the earlier cases on the docket are decided.

It is the Board's intention to meet or exceed the 2009 target of 150 days for cycle time. The Board's strategic target remains 104 days. The Board expects to make progress toward that strategic target as newly hired attorneys become fully trained and as the Board continues to work to improve efficiency and productivity by emphasizing training, focusing on reducing avoidable remands, and ensuring that decisions are clear, concise, coherent, and correct.

General Counsel

Question 1(a). Under Public Law 109–461, veterans and other VA claimants may now hire attorneys to assist with their claims once a Notice of Disagreement has been filed. What role does the General Counsel's office play in monitoring fee agreements from these attorneys and ensuring that attorneys have complied with all applicable requirements, such as any training or education standards?

Response. In Public Law 109–461, Congress authorized the Secretary of Veterans Affairs to review attorney fee agreements and order a reduction of any fee that is excessive or unreasonable, such decisions being appealable to the Board. In May 2007, VA published a notice of proposed rulemaking under which attorneys would be required to file all fee agreements with the Office of the General Counsel (OGC). Agreements that are on file with OGC could be reviewed at the request of a claimant or on OGC's own initiative. A presumption of reasonableness would attach to fee agreements calling for a fee of not more than 20 percent of past-due benefits awarded by VA. Agreements calling for a fee exceeding 20 percent would be reviewed for reasonableness under a standard established in VA's regulations.

VA's notice of proposed rulemaking also addressed the provisions in Public Law 109–461 that affect VA's accreditation of attorneys. VA proposed to implement the new law by, among other things, establishing a standard of conduct for attorneys who represent VA claimants, establishing accreditation application requirements for attorneys, and prescribing a qualification standard for attorneys. Under the proposed rule, OGC would review the application of each attorney to determine whether he or she meets the accreditation requirements. Additionally, OGC may initiate suspension or cancellation of accreditation proceedings when it receives information that an attorney no longer meets the accreditation requirements, has engaged in improper conduct, or has demonstrated a lack of competence in providing representation. The General Counsel's decision canceling the accreditation of an attorney may be appealed to the Board and reviewed by the Veterans Court and, as to legal matters, the Federal Circuit. The qualification standards for attorneys were the subject of extensive comments during the public comment period. These comments will be addressed in the final-rule notice.

Question 1(b). Does the requested level of funding provide sufficient staff to handle those functions?

Response. The requested level of funding is adequate for staffing OGC's administration of the accreditation and fee-review programs based on the number of attorneys currently providing representation before VA. As the program develops, we will monitor the impact of Public Law 109–461 on OGC resources and collect data to support future funding requests.

Question 2(a). As the Administration's fiscal year 2009 budget request points out, the caseload at the U.S. Court of Appeals for Veterans Claims increased by 76 per-

cent from 2004 to 2007. How many full-time employees of the General Counsel's office are now allocated to handling appeals before that court?

Response. The employees of Professional Staff Group VII (PSG VII) of OGC represent the Secretary in all cases filed with the Veterans Court. There are 108 full-time employees of PSG VII allocated to the various administrative and legal functions required for handling cases at the Veterans Court. In addition to that number, there is one full-time employee (FTE) of VA's Office of Information and Technology who supports the computer system of PSG VII, and there are three full-time employees on contract from Xerox Business Systems who support the photocopying needs of PSG VII.

OGC has increased the FTE in PSG VII in each of the last 5 fiscal years in response to the rising workload before the Veterans Court.

- Current FTE level—108
- FTE level fiscal year 2007—98
- FTE level fiscal year 2006—96
- FTE level fiscal year 2005—79
- FTE level fiscal year 2004—73

Moreover, it is anticipated that PSG VII will expand by an additional 12 employees before the end of fiscal year 2008.

Question 2(b). Would any of the additional staffing requested for fiscal year 2009 be allocated for that purpose?

Response. No. After ramping up staffing levels in PSG VII over the past 5 years, OGC will seek to address other growing needs in fiscal year 2009. OGC intends to place 13 of the additional 14 requested FTE in its field offices (Regional Counsel). The following table shows trends in OGC's field and headquarters staffing:

	2007 Actual	2008 Budget Estimate	2008 Current Estimate	2009 Estimate	Increase (+) Decrease (−)
Average employment:					
Field	408	400	412	425	13
Central Office	262	245	245	246	1
Total	670	645	657	671	+14

Question 2(c). What is the average caseload handled by VA attorneys practicing before that court and what is an optimal caseload?

Response. For the 12-month period extending from February 2007 through February 2008, the average caseload per attorney was approximately 73 cases (72.637 cases per attorney). We are currently evaluating the optimal caseload per attorney.

Question 3. VA recently announced that it has awarded a $3.2 million contract to Economic Systems Inc. to study the feasibility of implementing transition payments, the appropriate levels of disability compensation for loss of earning capacity, and the appropriate payments for loss of quality of life. Those studies are expected to be completed in August 2008. If VA were to undergo a comprehensive overhaul of the disability rating schedule based on the results of those studies or others, would additional staff be required in the General Counsel's office?

Response. Staffing needs related to overhaul of VA's rating schedule would depend upon the breadth of the contractor's findings and recommendations with regard to the rating schedule, decisions by the Secretary and Congress about whether and how to implement the contractor's recommendations, and the time period during which the overhaul of the rating schedule would occur. However, any effect of such an overhaul on OGC's staffing needs would not be expected until after fiscal year 2009.

Information Technology

Question 1. Information Technology (IT) will provide the infrastructure to accomplish most of the VA-wide improvements you are trying to accomplish. Please explain how the requested funding level for IT will ensure that your short, medium, and long term goals are met with both the speed and the success that they deserve.

Response. VA requested $2.442 billion in fiscal year 2009 to support IT development, operations and maintenance, and payroll. This level of funding provides ade-

quate resources to meet VA's most critical, immediate needs as defined and agreed to by the members of the IT governance structure.

The IT governance procedures allow VA to effectively manage competing initiatives, funding allocations, and emergent requirements in an orderly and disciplined manner while, at the same time, targeting numerous goals with varying timeframes. In the short term, VA's infrastructure requires sufficient funding to meet day-to-day service agreements to ensure effective operational readiness and maintaining a secure environment. For example, by the end of fiscal year 2009, VA will have completed 50 percent of the infrastructure for the personal identification verification initiative, a key element of cyber security in direct support of a Homeland Security Presidential Directive. We are also investing in replacement projects to meet future medium and long term requirements (goals). Our VETSNET initiative, a suite of applications that permit an orderly transition from the benefits delivery network (BDN), is on-target to support the retirement of the BDN in early 2012, while the veterans' health information systems and technology architecture (VistA) will be replaced by a new system, VistA Health*e*Vet, using modern applications and tools well suited to accommodate future enhancements.

VA's Business Needs and Investment Board (BNIB) is charged with balancing the immediate needs of today with the emerging needs of the future while skillfully determining the most appropriate mix of expenses and investments. The BNIB is comprised of representatives from VA's business lines and OIT. It provides recommendations to the Information Technology Leadership Board (ITLB), a senior governance element, for additional due diligence to make sure the planning process correctly supports established needs. Finally, the Senior Management Council (SMC) confirms that the requested IT budget is in harmony with the strategic goals of VA. Using this method, the operators/providers/designers of VA's IT infrastructure, architecture, projects, and programs are accountable to ensure that, not only are the needs of our internal customers accommodated, but also the needs of our primary customer, the veteran, are accommodated at the highest level of satisfaction possible.

National Cemetery Administration

Question 1(a). The National Shrine Commitment list consists of projects and repairs that must be completed at NCA National Cemeteries to bring them into compliance as National Shrines. It is my understanding that new requirements are added annually to the existing list and then the list is re-ranked in order of assessed importance and that the number of items on the list that are repaired depends solely on whatever money you receive that year. Is that correct?

Response. The number of items that are repaired in the National Shrine project inventory depends on the amount of money received in a given year, the cost of the items and their priority relative to other system-wide needs such as gravesite expansions. Keeping existing National Cemeteries open for burials is NCA's highest priority.

The fiscal year 2002 Millennium Act Report to Congress identified 3,566 repair items for $280 million (i.e., the "National Shrine Commitment list"). NCA believes that 497 of these items—estimated at $35 million—can be deferred indefinitely, leaving a total inventory of 3,069 items for $245 million. Through fiscal year 2007, NCA completed work on 1,130 items estimated at $100 million. The cost of the remaining 1,939 items to be accomplished is estimated at $145 million.

NCA's focus on the shrine commitment is not limited to the Millennium Act study. The report's list represents a "snapshot" of requirements in 2002.

Since that time, other shrine needs have emerged and have received funding as higher priorities. NCA anticipates spending approximately $55 million in fiscal year 2008 on National Shrine projects from all accounts.

Question 1(b). Do you have a strategic plan in place to address the repairs on the list, e.g., does your budget request use a recapitalization methodology?

Response. NCA's budget request does not reflect a formal recapitalization methodology. NCA currently relies on its annual construction planning process and gravesite assessment survey as the primary sources for developing the inventory of shrine-related work and determining project priorities.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO LTG JAMES B. PEAKE, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Secretary Peake, I know you are aware of the serious need to train psychologists who are skilled in treating PTSD, TBI and other post-deployment issues—it has been documented in numerous commission reports just in the past

year. In an effort to address this training pipeline crisis, I spearheaded an effort in VA's 2008 Appropriations Bill providing you with immediate authority to transfer up to $5 million for a joint effort with HHS. The idea is to take advantage of their existing Graduate Psychology Education Program to quickly begin training more specialists in the types of conditions facing returning veterans. Secretary Peake, can you tell me where this effort stands at the VA, what your plans are, and your expected timeframe for initiating this program?

Response. Congress has authorized:

> Sec. 227. (a) Upon determination by the Secretary of Veterans Affairs that such action is in the national interest, and will have direct benefit for veterans through increased access to treatment, the Secretary of Veterans Affairs may transfer not more than $5,000,000 to the Secretary of Health and Human Services for the Graduate Psychology Education program, which includes treatment of veterans, to support increased training of psychologists skilled in the treatment of Post Traumatic Stress Disorder, Traumatic Brain Injury, and related disorders.

The Department of Veterans Affairs (VA) has determined not to transfer funding to the Department of Health and Human Services (HHS). VA recognizes the need for psychology training and has taken internal steps to expand psychology internship and postdoctoral training opportunities, thus using this funding to directly enhance care for veterans mental health. Those have been expanded by 160 positions for the upcoming training year for a total of 640 funded training positions in psychology that will recur on a yearly basis.

We do recognize that there are training needs at the graduate level that would better prepare psychology graduate students for VA internships and postdoctoral fellowships, as well as eventual VA employment. Rather than fund graduate programs indirectly in a manner that would not necessarily result in curricular changes or increased numbers of VA qualified psychologists, VA will work toward greater collaboration with selected graduate programs of psychology to enhance training in clinical content related to VA care, including effective functioning within an interdisciplinary health care system. For example, such collaboration might include identifying graduate programs in psychology to work closely with affiliated VA medical centers that provide psychology internship or postdoctoral training:

a. In these collaborations, affiliated VA medical center psychology staff should have faculty appointments in the graduate psychology education programs to supplement the graduate education in content areas including:

i. Concepts of interdisciplinary health care provision and the skills necessary for effective provision of interdisciplinary care.

ii. Clinical content related to Post Traumatic Stress Disorder, Traumatic Brain Injury and related disorders, if such expertise is not well-represented among the faculty of the graduate program.

iii. Clinical content related to the "President's New Freedom Commission on Mental Health: Transforming Mental Health Care in America." This would include emphasis on the Recovery Model of Treatment for Serious Mental Illness.

b. Students in such collaborative programs would be eligible to apply for practicum training experience with VA during the years of graduate training. Psychology training staff at the affiliated VA facility will make decisions regarding acceptance of students for training, based on their judgment of the students.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO LTG JAMES B. PEAKE, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Secretary Peake, as you know in January of 2003 the VA announced that it would no longer allow Priority 8 veterans to enroll into the VA health care system. Can you tell me the amount of time, the resources, and anything else that the VA would need from Congress so that we can bring these Category 8 veterans back into the system in an orderly way? Can you also provide your best estimate of how many veterans per year have not been able to use the VA health care system due to this Priority 8 policy?

Response. At the request of the House Veterans' Affairs Committee, VA analyzed the strategic resources related to reopening enrollment for Priority 8 veterans. The report was sent to Chairman Filner on 2/25/08.

• VA's projected demand for health care services is expected to increase in the next several years under the current enrollment policy. Accounting for the increased growth expected under the current enrollment policy and reopening enrollment in

2013 to new Priority 8 veterans would result in a total growth in enrollees of 22 percent and a total growth in users of 21 percent.

• VA estimates that it would require $3.1 billion dollars to provide health care services to the additional 1.4 million enrollees and approximately 750,000 patients during the first year of implementation. The full magnitude of the cost of reopening enrollment to new Priority 8 veterans must be viewed within a long-term strategic framework, namely the estimated 5-year cost of $16.9 billion and the 10-year cost of $39.2 billion, as well as capital costs not included in these estimates.

• As of the end of fiscal year 2007, 386,767 Priority Group 8 veterans had applied for and been determined to be ineligible to enroll based on the January 2003 enrollment decision. This figure does not include enrollees who were initially denied enrollment and subsequently enrolled in an eligible priority group based on a change in the veteran's eligibility. VHA analysis of current Priority Group 8 enrollees indicates that 45 percent are not users of VHA health care services in any year. Assuming that the non-enrolled Priority Group 8 veterans exhibit the same characteristics (and thus would use services in a similar way), we estimate that approximately 212,722 non-enrolled Priority Group 8 veterans have not been able to use VHA services due to the 2003 enrollment decision.

Question 2. Secretary Peake, there was a good deal of discussion at this week's hearing of the need for more extensive outreach to our returning and existing veterans. Given this and the fact that you mentioned you would soon be talking about outreach with the Nation's Adjutant Generals, I wanted to inform you about an innovative outreach program we have in the State of Vermont. This program, established with funds secured through the Department of Defense, is run by the Vermont National Guard, in coordination with the local VA Medical Center. It uses trained veterans to contact each and every returning Iraq and Afghanistan servicemember and their family to check in on them and see if they are getting the help they need. This could include but is not limited to: mental health counseling (such as for PTSD), VA benefits, military benefits, marriage counseling, financial counseling, suicide prevention, substance abuse, and other areas. They also provide appropriate referral services to the VA, State, local, or other appropriate avenues for assistance. This program is coordinated with the Guard's existing Family Assistance programs. The program also has a 24-hour helpline staffed by Vermonters who work for the National Guard, who are there to help returning veterans and their families in need. While this program is operated using DOD resources, I believe a similar effort could be established within VA. Working with my colleagues, I was able to secure $3 million in the Department of Defense Appropriations bill to have this program replicated on a national level. The funding is now part of the larger Yellow Ribbon Reintegration Program established in Public Law 110–181. I would welcome the opportunity to discuss our Vermont program with you and explore ways that the VA can become more actively involved in similar outreach programs. I would appreciate any comments you may have on our Vermont program and the possibility to expand these types of programs.

Response. VA is in full support of GWOT Guard and Reserve soldiers returning from the war and VA participates in the execution of Guard and Reserve post-deployment health re-assessment (PDHRA) events along with reintegration programs. VA also collaborates with the National Guard in the execution of State coalitions and full collaboration and training with the National Guard and VA transitional assistance advisors (TAAs). These State coalitions use the State leadership Triad of the State Director VA, State Adjutant General and VA leadership in each State.

The Vermont Door Knockers Program is an additional program in the State that hired National Guard staff to proactively divide the State into regions and act as State outreach mobile teams to provide face-to-face contact to those returning from the war. Information about home of record is shared with outreach workers to facilitate enrollment into VA health care and other VA benefits. Those needing additional services are referred to the State TAA for specialized outreach and coordination efforts with the local VA medical center or RO. VA is supportive of all outreach efforts and facilitates the development and maintenance of State coalitions to ensure the integration of services that are delivered to Guard and Reserve soldiers returning home. VA is partnering with all stakeholders at the State and local area by providing training, outreach materials and access to health care and benefits by experts at the VA medical center, RO, Vet Centers, VSOs, community organizations, State directors VA; as well as, active participation in Welcome Home and Family Program events held in regions throughout the State for returning troops.

Question 3. Secretary Peake, can you provide me with the VA's best estimate of how many veterans would leave the VA system or choose not to enroll if VA

were to implement the copayment and enrollment fees proposed in the President's budget?

Response. VA estimates that approximately one-half of the estimated 1.7 million enrolled Priority 8 veterans, or 852,000 enrollees, would be assessed the tiered enrollment fee in 2010—the first year the tiered enrollment fee would be assessed. Of these 852,000 Priority 8 veterans, VA estimates that 440,000 enrollees will choose not to pay the enrollment fee. According to VHA's analysis of enrollment and use data, approximately 45 percent of Priority 8 enrollees do not seek VHA health care in any given year. VA estimates nearly two-thirds of enrollees who will choose not to pay the tiered enrollment fee are non-users of VA health care.

A very large proportion (all but 1 percent) of Priority 7 enrollees have incomes below the $50,000 threshold; therefore most Priority 7 enrollees would not be subject to the tiered enrollment fee.

Question 4. Secretary Peake, establishing a Community-Based Outpatient Clinic in Brattleboro, VT, is an issue that is very important to the veterans that live in the southern part of my State. I was very interested and happy to see you discuss CBOCs in your prepared remarks and I very much hope that a CBOC in Vermont is among those 64 CBOCs you discussed opening this year. My office has heard from many veterans who live in this southern part of the State who are without a nearby veterans' health care facility. My understanding is that the proposed 2008–2012 VA New England Health Care System Strategic Plan has come to the same conclusion about the challenges to access our veterans in this region are experiencing. Since the need for a facility is something that there seems to be agreement on, I would like to work with you to advance this process and take the steps necessary to establish the clinic, including securing the appropriate funding and receiving approval from the VA Central Office in Washington. Is that something we can work on together and that I can count on your support for?

Response. We are continuing to evaluate the health care services being provided within the VISN 1—VA New England Health Care System, and will consider expanding those services as needs are identified.

The Secretary's 2004 Capital Asset Realignment for Enhanced Services (CARES) decision document for VISN 1 did not include a CBOC for the Town of Brattleboro, VT; however, a preliminary review conducted by VISN 1 has identified Brattleboro as an underserved area. In order to determine the validity of establishing a CBOC, a business plan must be reviewed and approved. A business plan to open a CBOC in Brattleboro is currently under development. VISN 1 will submit a proposal during the fiscal year 2008 national call for CBOC business plans for potential fiscal year 2009 activation. This proposal will be evaluated against a set of national criteria and will prioritize the need for a CBOC in this location against other proposals nationwide.

Question 5. Secretary Peake, as you may know, the VA's National Center for PTSD has it Executive Division located in White River Junction, VT, at the VA Medical Center there. The Center, with its six divisions, has emerged as the world leader in research and education on PTSD and provides essential clinical tools and guidance to facilities around the country. In fact, your prepared remarks hailed the work that the VA has done in PTSD research. Now, with so many returning servicemembers experiencing PTSD and older veterans from the Vietnam era experiencing reoccurrence of their PTSD, the work of this center is more important than ever. Currently the Center is experiencing a major space shortage at its Executive Division in Vermont. It shares space with the VA Medical Center and while they are honored to have the Center in White River, the current need for space is hampering the operation of both facilities. I wrote to then-Secretary Nicholson about this in August of 2007 and Acting Secretary Mansfield wrote me back in October of 2007 saying that the VA Central Office was planning to provide $2.4 million in funding for a modular building, archival storage space, and video conferencing capabilities to meet these needs. This was very welcome news. Can you give me an update on the status of that project and when these resources will be available to begin construction?

Response. The expansion project for the National Center for PTSD (NCPTSD) is still being developed. The tentative plan consists of erecting a modular building of approximately 7,500 gross square feet, which would meet the NCPTSD expanding requirement needs.

White River Junction VA Medical Center is currently working on a minor construction proposal to submit to VA Central Office by the end of fiscal year 2008.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO LTG JAMES B. PEAKE, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Previous Federal regulations provided for reimbursement to States for a $300 per burial interment cost if the interment took place within 2 years of the permanent burial cremation. This is important to me because my State of Idaho paid for numerous remains of veterans to be moved to our State Veterans Cemetery, although Idaho did not qualify within the 2-year timeframe.

In Public Law 110–157, language would eliminate the 2-year timeframe and allow States, such as Idaho, to receive the $300 reimbursed by the Department of Veterans Affairs. My question is, whether States have begun to get reimbursed for the cost of reinterment. If not, can you please provide me with a timeframe for reimbursement to take place?

Response. Section 202 of Pub. L. 110–157 removed the time limit for States to file for reimbursement for the burial in State cemeteries of unclaimed remains of deceased veterans (for interments and inurnments occurring on or after October 1, 2006). States may apply for retroactive reimbursement for burials from that date. Guidance to implement this provision has been drafted and will be released to regional offices in the spring.

Question 2. Public law 110–157, section 202, also contains language for a grant program for States, not to exceed $5 million, to be used for operating and maintenance costs of veterans' cemeteries. Can you please provide me with the information, criteria and methodology for implementing this grant and when you think this grant will be made available to the States?

Response. NCA is developing a regulation to implement the amendment for operation and maintenance grants for State cemeteries. The methodology for the grants will be similar to NCA's program to maintain national cemeteries as shrines. The focus will be to correct gravesite deficiencies, such as cleanliness, height and alignment of headstones and markers, leveling of gravesites, and turf conditions. The proposed regulation will be published in the Federal Register, and we expect to begin awarding grants for operation and maintenance in fiscal year 2009.

RESPONSE TO QUESTIONS ARISING DURING THE HEARING BY HON. DANIEL K. AKAKA TO LTG JAMES B. PEAKE, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Question 18. What is the funding for outreach in the fiscal year 2009 Budget.

Response. This is still in process and should be provided shortly.

RESPONSE TO QUESTIONS ARISING DURING THE HEARING FROM HON. PATTY MURRAY TO LTG JAMES B. PEAKE, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Clarify what is and is not funded at American Lake complex.

Response. *What is funded:* American Lake Seismic Corrections—Nursing Home Care Unit & Dietetics. The project will construct a one story, 83-bed Nursing Home Care Unit with Alzheimer Ward, Dietetics and other support functions. The project is intended to improve patient and staff flow as well as correcting life safety, fire and seismic deficiencies.

What is not funded: Two projects for Seattle—Nursing Home Care Unit and Replacement of the Mental Health and Research building. The NHCU includes seismic corrections, and the Mental Health and Research building provides appropriate space and life safety corrections. Both were submitted in the fiscal year 2009 Major Construction cycle, but were not scored high enough for funding. Therefore, they were submitted for the fiscal year 2010 cycle.

RESPONSE TO QUESTIONS ARISING DURING THE HEARING FROM HON. LARRY E. CRAIG TO LTG JAMES B. PEAKE, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

VHA ISSUE BRIEF

Issue Title: Status of Regulations to implement Public Law 109–461—Full Cost of Care for State Veterans Nursing Homes

Date of Report: 2/20/2008

Issue: Members of Congress are querying VA about the status of the development of regulations for the State veteran nursing homes so that they may be reimbursed for providing services to disabled veterans rated at 70 percent or higher. These inquiries are being made a result of questions they have received from their constitu-

ents, primarily the members of the National Association of State Veterans Home Administrators.

Background: On December 22, 2006, the President signed Public Law 109–461, Full Cost of Care for State Veterans Nursing Homes, which added a new section 1745 to title 38, United States Code. This new section requires VA to begin paying States a higher rate for nursing home furnished to certain veterans in State nursing homes. The higher rate must be paid for veterans with an SC disability rated 70 percent or higher, and those receiving care for an SC disability. The new law also includes a provision requiring VA to furnish or pay for drugs for certain additional veterans receiving care in a State nursing home. Both of these new provisions are effective 90 days after the law was signed, or in late March 2007.

Current Status: The following information is provided in response to recent Congressional inquiries from Hon. Larry E. Craig:

Question 1. Why has it taken over a year and yet the regulations are still not implemented for the State VA nursing homes to be reimbursed for providing services to disabled veterans rated at 70 percent or higher.

Response. The regulation development process for all Federal agencies has prescribed phases that proposed regulatory changes must go through; these include initial development, internal agency concurrences, submission to OMB, and publication in the Federal Register for public comment. Following the public comment period, issues that are raised are reviewed and changes, when appropriate can be incorporated into the final rule. The average VA time for processing two-stage regulations is 22.4 months. VA is presently at the 13-month point in processing these new State nursing home regulations.

Question 2. Where is VA in the process of implementing these regulations? Have the regulations been drafted? Are the regulations being reviewed by OMB?

Response. VA has been actively pursuing the regulation development process. The regulations have been drafted. VA expects the regulations to be forwarded to OMB by April 30, 2008. The history and projected timelines associated with this initiative are included in attachment one, Chronology of Regulation Development Actions Related to Pub. L. 109–461.

Question 3. What is the projected implementation date and timeline so that constituents can be advised?

Response. VA expects the projected implementation date to be October 2008. This includes allocations for 45 days for internal VHA and VA reviews and concurrences; 90 days of processing time through OMB; 60 days for publication in the Federal Register and allowing for the public comment period; and 30 days for VA to review and respond to comments. After the regulation process has been completed, VA, at the facility level, will most likely make payments retroactive to March of 2007 (to the date that was 90 days after the President signed the new Public Law). We would pay the difference between the regular per diem rate that the veteran received, and the amount that will be given with the implementation of this new law.

ATTACHMENT 1

CHRONOLOGY OF REGULATION DEVELOPMENT ACTIONS
RELATED TO PUBLIC LAW 109–461

December 2006: On December 22, 2006, the President signed Public Law 109–461, Full Cost of Care for State Veterans Nursing Homes.

January 2007: Preliminary discussions were held at VA and a VA workgroup of subject matter experts was formed.

February 2007: VA work group, led by the Office of Geriatrics and Extended Care, was formed. It included VA representatives from Pharmacy Benefits Management, the Chief Business Office, and the Office of General Counsel. Preliminary reviews were conducted to determine the issues associated with the new per diem payable and the issuance of medications and drugs.

March 2007: VA addressed the National Association of State Veteran Home Administrators (NASVHA) at their winter conference in Alexandria, VA. VA considers NASVHA to be one of our primary stakeholders for the State home program. At this meeting, based on a NASVHA request, VA committed to working proactively with their membership to assure that they had an opportunity to actively participate in the regulation development process, versus having to wait until the public comment period.

April 2007: Rewriting of the regulation and development of the rate chart began.

May/June 2007: Meetings were held at VACO to determine proposed content. Significant effort was put into developing payment computation formulas that would

be consistent with the spirit and intent of the new Public Law and, at the same time, would give due consideration to patient needs and revenue generation issues that were surfaced by the State homes.

July 2007: NASVHA summer conference. VA representatives again addressed the National Association of State Veteran Home Administrators (NASVHA) at their summer conference in New Orleans, LA. At this meeting, VA discussed the regulation development process, associated timelines, and the proposed methodology for calculating payments under the new Public Law.

August 2007: Three NASVH members came to VA Central Office and several NASVHA members joined the meeting via conference call to meet with members of VA staff who were drafting regulations to implement Pub. L. 109–461. This meeting included representatives from VA's Office of Geriatrics and Extended Care, the Office of General Counsel, the Chief Business Office, and the Office of Public and Intergovernmental Affairs. Based on discussions at that meeting and the information in their follow-on letter, dated September 21, 2007, VA modified the VA SC per diem calculation methodology that was proposed in March 2007, to include the 13 percent profit margin as a part of the prevailing rate payable in the geographic area in which the State home is located. VA also agreed to grant NASVHA additional time so that they could further define their positions regarding the billing of secondary payers (such as Medicare) and issues associated with bed holds and social worker qualifications.

September 2007: Met with Cheryl Sklar and other members of the Requirements Analysis and Engineering Management Office (RAEM), to discuss how to capture veteran's priority group status to be able to report and receive information on 70 percent service-connected veterans and 50 percent service-connected veterans for full cost of care and/or free medications.

October 2007: Multiple discussions with VHA staff, attorneys who were drafting the proposed regulation, and members of the National Association of State Veterans Homes.

November 2007: Developed a new VA Form for the pharmacy benefit of free medications for veterans that are 50 percent or more service-connected. Worked with the Office of Forms and Publications to give the form a number and the final touches on the form itself. Also, the 10–5588 and the 10–10SH Forms needed to be revised to include the full cost of care veterans and the veterans who are eligible for free medications.

December 2007: Developed the Impact/Cost Analysis with the cost for the full cost of care and the cost of the medications for the above mentioned veterans.

January 2008: On Monday, January 28, 2008, VA received final comments and recommendations from the National Association.

February 2008: VA reviewed comments. Decisions were made to remove two other sections from the proposed regulations because they were not mandated by Pub. L. 109–461 and because there were concerns from NASVHA about their appropriateness. This was delaying the processing of the regulation. These two items, which addressed bed hold and social worker qualifications, will be processed through a separate regulatory change action.

On February 14, 2008, the Office of Geriatrics and Extended Care submitted the regulation to the office of the Assistant Secretary, Regulation Policy and Management (00REG) so that it can be placed into formal VHA and VA concurrence processes.

Chairman AKAKA. Thank you very much, Secretary Peake. I also want to welcome your Under Secretaries and Assistant Secretaries who are here with you at this time and thank you for your testimony.

Secretary Peake, during your confirmation hearing before this Committee you said you would, and I quote, "work hard with the Administration, with OMB and would come forward, if needed, to ask Congress for additional funding for VA."

Are you fully confident in this budget, given that the growth in total spending recommended by the President is actually below the rate of inflation?

Secretary PEAKE. Sir, I believe that with this budget, as I just testified, that we can meet the needs of our veterans as we move forward to improve the access to care, to continue to improve the

quality of the care, and I believe that I have confidence that we can do that with this budget.

Chairman AKAKA. Secretary Peake, Congress has extended the access afforded to combat veterans for VA health care from 2 to 5 years.

Secretary PEAKE. Yes, sir.

Chairman AKAKA. Improving access will help, but it will not be the catalyst for all veterans to come in for the care and services they need. Outreach is what is critical now and that falls squarely on your shoulders.

How much is designated in this budget for outreach? And are you confident that this is enough to move VA from a passive approach to a much more aggressive one to prevent suicides and improve the quality of life for veterans?

Secretary PEAKE. Sir, I believe that I tried to highlight in my testimony what I believe is the importance of outreach and I think that we can do better with it.

We send out an unbelievable number of letters—800,000—that go out from the Department. The Under Secretary for Benefits sends out two different packages with all the information.

One of the things that I touted recently at a talk with the military health system was the importance of grabbing the reservists as they come back, and trying to make sure that they get oriented.

I think we need to do a better job of reaching to their families, because they are the ones— particularly in the area of mental health—that may be able to recognize an issue and throw the flag, and encourage the soldier, sailor, airman or Marine to come in for assistance.

So, I met just last night with the Oregon Adjutant General to talk about issues. I look forward to engaging the TAGS when they come into town about how to better reach National Guard and Reserve populations.

But, with this opportunity to bring people in now with 5 years that gives us a chance, even if they are still getting their benefit adjudicated—it does not rely on that—that we can still get them into our system and give them the counseling that they need, the care that they need. That is what we will be focusing on, sir.

Chairman AKAKA. Will you please provide the amount of funding for outreach, for the record?

Secretary PEAKE. Sir, I will take that for the record.

Chairman AKAKA. I have other questions, but let me first ask for questions from our Ranking Member.

Senator BURR. Thank you, Mr. Chairman.

Secretary Peake, the Institute of Medicine issued a report last year indicating that there was one kind of treatment for PTSD, exposure therapy, that it found to be effective.

However, the IOM also found that the quality of research on PTSD treatment as whole, and I quote their report, "has not received the level of research activity needed to support conclusions about the potential benefits of treatment modalities." And went on to say that the studies conducted for nearly three decades, and again I quote, "do not form a cohesive body of evidence about what works and what does not work."

Now, given this criticism, I do not understand why the budget proposes a $9.3 million reduction in research on mental illness to a level that is even below the level found in 2007.

Can I ask you to comment or somebody to comment?

Secretary PEAKE. Yes, sir, you will notice that it still is, in fact, the largest budget line in the resource portfolio at $52 million or so, with the addition of substance abuse on top of it, because I think these are all related. It starts to get up toward a quarter of our resource portfolio.

We are also going to work very closely with DOD, which has a big effort in this as well, and in fact, we will be proposing a deputy to be part of General Sutton's task force in looking at PTSD as we move forward.

As you know, we have centers around the VA that focus on PTSD that really are paid for out of clinical funds, as well. So, although I appreciate and, frankly, agree with the Institute of Medicine—that we need to know more about PTSD, mental health, all the comorbid mental health conditions that come together—I think we have a reasonably robust portfolio that I think will give us the information that we need.

Senator BURR. General, let me ask specifically. How does the VA intend to improve the quality of the research on PTSD so that we have more evidence-based treatments available for our veterans?

Secretary PEAKE. In the clinical environment where you are taking care of people on protocol and measuring the results, and with the ability to leverage our computerized patient records, I think we can follow through with our patients and be able to develop that kind of information so that we keep moving the ball forward on that.

Senator BURR. I am not accusing the VA of focusing on a single treatment, but clearly there are some red flags that we are raising that we are not aggressively going after. I have talked to Dr. Kussman and there are efforts being made; and I commend you for that.

There are over 150 projects listed in your 5-year department-wide major construction plan. All of these projects, I would assume, are based on the Capital Asset Realignment for Enhanced Services, CARES, analysis completed several years ago.

In North Carolina, however, CARES underestimated the veteran demographics considerably; and I suspect that it is already obsolete in other areas of the country as well.

Two specific questions. Is CARES still a valid blueprint on which to base future capital funding decisions?

Secretary PEAKE. Well, sir, I think CARES is based generally on 2004 data basically and I think that, as you rightfully point out, some of the demographics have shifted. I think it is the kind of thing that needs to be evaluated as we move along.

In fact, when I asked about the CBOCs, an example, there were 156 that were in the CARES program, 24 now we think probably do not really fit the future needs. And when you look at the 51 that are going to be done in 2009, there are probably still 10 of the CARES that have not made the priority list.

So I think it is, like any plan, it never survives first contact with the enemy, you know. But it is better to have a plan that we can

then march off of as we look and continue to re-evaluate the needs and follow the migration of our veterans.

Senator BURR. I appreciate the fact that you are re-evaluating.

One last question. I was disturbed, as I am sure you were and everyone within the VA, to read the Inspector General's report regarding the substandard care provided to a veteran at the Salisbury VA Medical Center that may, and I stress may, have cost him his life.

Let me quote from the IG's report. "We have determined that the patient's diagnostic testing was delayed on several occasions and that providers missed multiple opportunities over a period of years to diagnose colon cancer. Had providers followed up with the appropriate colonoscopy surveillance testing to remove polyps, it is possible that the patient's developing colon cancer could have been detected and treated in time to prevent metastatic disease."

What quality assurance mechanisms are in place to ensure that this type of mistake is not repeated?

Secretary PEAKE. Sir, there are a variety of quality assurance mechanisms across the VA, to include our surgical quality assurance, that look statistically at outcomes. At the local level there are quality measures. I think our computerized patient record is one of the things that will help us move forward, where clinical reminders are appropriately made available, where all the tests and all of the diagnostic x-rays are available to the clinician and not being lost. So I think there are many mechanisms in place to try to improve that.

I do not know the specifics of the individual case and perhaps, Mike, if you have a comment on that specific. I just do not.

Dr. KUSSMAN. Thank you, sir.

Senator Burr, as you know, that case goes back to 2005. The IG came and looked at that and came back again, as you know, to look at what had been put in place. A lot of things were put in place at Salisbury and across our system to be sure this does not happen again.

One of the things that I have instituted now is we have been measuring a lot of things as outpatients and we have done very well. The question is, well, what is actually going on in our hospitals and things? And so we have now put in some new performance measures to look at, if somebody needs a colonoscopy, how long does it take for that colonoscopy to be done? How long does it take if something is found in that colonoscopy, how long does it take to get the definitive procedures like a biopsy or further surgery.

We are also looking at how long it takes to get cataracts done, hip replacements, knee replacements. We looked at high volume procedures. So, we are starting to measure those just like we measure the blood pressure and other things that people have. So, there is a lot of effort to try to eliminate those types of things from happening.

Senator BURR. I appreciate the efforts that you are making.

I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman.

Secretary Peake, last year Congress passed the Joshua Omvig Suicide Prevention Act, which gave the VA some very important tools to deal with the tragedy of suicide. This is something I have been following very closely. I am deeply concerned about and I am very saddened to hear that we are continuing to hear about the increases in the number of suicides among our active duty soldiers.

Yesterday, the AP reported on a VA study that found that Guard and Reserve soldiers accounted for 53 percent of the veterans' suicides from 2003 to the end of 2005. That statistic really raised concerns for me because I know that members of our Guard and Reserve oftentimes do not think of themselves as veterans. They see themselves as going back—going back to their same jobs—and sort of disassociate themselves from the VA system.

What are we doing in particular to reach out and find those Guard and Reserve soldiers who go back often to very remote communities not associated with a military base on the ground? The VA may not know of them. They may not think of themselves as veterans. How are we going to get those Guard and Reserve soldiers who are struggling today and as we see these increased numbers of suicides, know that it is a population we need to reach?

Secretary PEAKE. There were two great examples—one in Minnesota and one in New Hampshire—where the Guard really focused on pulling people back in. They got them home and then they brought them back and had a chance to really get integrated with the VA and all of the services that were available to them.

I think that is the kind of effort that we dovetail with when the units have their post-deployment health reassessment, which is designed to come later rather than right away because we know the propensity of soldiers to say, OK, let me fill this out. I want to go home. We want to get to them after that.

Senator MURRAY. Is the DOD cooperating with you in trying to find a way to go out and find these men and women so they do not get lost?

Secretary PEAKE. Yes. As I was saying, I would like to find a way to reach out even further than that, perhaps with calls or whatever. We send letters, but as you know, that sometimes winds up in file 13.

Senator MURRAY. For somebody who is sitting in a chair in a remote community, a letter does not mean much.

Secretary PEAKE. The other is to reach their families and do a family education because it is the family that will notice something different. We know from the research that was done in the military that it is the people that may need the help the most that are least likely to assess it.

When we looked at the information that you reported from, you mentioned yesterday that population that was looked at was all the people that had separated. That is active and reserve. That is about 50/50.

Senator MURRAY. Right.

Secretary PEAKE. So, it is not surprising that about half and half in that particular group. So, it is not an alarming big difference between the active and the reserves. It is still significant. There were 144 deaths in that cohort that were due to suicide and anyone of them is unacceptable.

But, going back to the Act—we have that suicide hot line. They have had 23,000 calls. 250 of those calls were from active duty people. We had about 400 rescues is what I understand just from the suicide hot line piece of it.

We have had a teaching program so that everybody is aware in our VA facilities. If somebody comes in, they get screened not only for PTSD but for TBI and suicide tendencies. One of my former officers told me that she went in and in the radiology department they were asking her. She says, they are really serious about this.

Senator MURRAY. I am glad to hear that and we need to stay on top of this and we really need to think particularly about Guard and Reserve soldier while reaching those men and women out there.

Let me ask you another question. I called you a little over a month about some serious issues that I had heard about happening at the VA's Polytrauma Rehab Center in Palo Alto, California. We have a reporter from KOMO News in Seattle that had been chronicling the story of several families that had gotten very poor treatment at the Polytrauma Rehab Center.

As you know, we have a number of men and women coming home with serious head injuries. They are being sent to that. They are being told that that is a premier facility and I have to tell you, it is pretty disheartening for me to watch that news story and hear that one of the mothers of a young soldier who had been treated there said if that is premier, then I do not know what the worst is, honestly. I mean those really stab at the heart of all of us who want to make sure every one of those men and women are treated to the best of our ability and are not forgotten and really treated quickly, fast and with the best care possible.

I called you about that probably 5 or 6 weeks ago now and you told me that you were going to look into it and I wanted to ask you today, for the record before this Committee, what has happened now at Palo Alto and what are we doing to make sure that does not happen again?

Secretary PEAKE. First of all, we acknowledge that there were some issues. These were cases back in October, as I understand it,

Senator MURRAY. Right.

Secretary PEAKE. And to my knowledge we have not had new instances.

There was a hard look at what was going on out there. I think there were some staffing issues. There was a 16-point plan put in place. One of the issues was leadership. We have a new director that has now been identified who will be starting in April who is already making rounds there.

In the 16 initiatives, they range from policy and procedures to new hiring to training. We have had folks rotate actually back to Bethesda and Walter Reed. So, they actually get a sense of where these Soldiers, Sailors, Airmen and Marines are coming from. So, what was laid out by Dr. Kussman and his team I think was a good plan and my sense is that it is moving forward.

Senator MURRAY. OK. So you have evaluated the situation. You have hired new leadership. They are going to be there in April. Meanwhile, if somebody has a brother or a son or someone who is at the trauma center today, what kind of care are they getting?

Secretary PEAKE. I think they are getting excellent care. As I understand it now, we are back up to full capacity. That was one of the issues.

Senator MURRAY. That was one of the issues.

Secretary PEAKE. They were down and they are up. There was some question about whether they were cherry picking. I think there is no suggestion that that is going on now, and so I have confidence. This is one of our four polytrauma centers.

Senator MURRAY. Right.

Secretary PEAKE. And so, it is really important to us that we do it right.

Senator MURRAY. I really appreciate that. I am going to continue to follow this and would love to have a chance to talk with you again in a few months when your new leadership is in place; because, as you know, with our Soldiers coming home with brain injury, we do not want to listen to any parent tell us that they got less than desirable care. Some of these stories were pretty horrible.

Secretary PEAKE. I went out to Bethesda. It was a soldier that had actually returned to Bethesda from Palo Alto. I spoke to his wife, so I have a first-hand view of her concerns, as well.

Senator MURRAY. Good. One of the things that I am hearing from parents or spouses of someone who has TBI is, that the sooner they get the good care to really help their brain function better is critically important. So, leaving anybody without care is really disheartening to all of us who want to make sure we do the right thing.

Secretary PEAKE. Part of it is being able to care for a family in distress; that is part of this, as well. Unfortunately, perception is reality; so we want to—need to—make sure that we make sure that we wrap our arms around them as well.

Senator MURRAY. OK. I really appreciate your direct attention to that.

I also wanted to ask you about the massive cuts to the major and minor construction programs in the President's budget that has been submitted. As you know well, the VA's infrastructure across the country is well over 50 years old. There are a lot of really serious upgrades that are needed.

I know in my home State we have four projects that are on the VA's priority list, two of them are in Seattle and ranked at No. 4 and No. 5 and they are not going to receive any money because of such a low number request in this year's budget.

We have important projects at American Lake, at Walla Walla VA where you are going to be visiting next week. How do we expect the VA to meet their goals when the Administration cuts the construction budget in half?

Secretary PEAKE. Well, we have to responsibly prioritize against the requirements as we see them. American Lakes, I understand that we are funding that at about $38 million as I recall the number.

You are right about there being an aging infrastructure. I think on average it is 57 years old. We have put money this year into the maintenance piece of it that will hopefully keep us eating into our backlog rather than just staying stable with it.

Senator MURRAY. Actually in the budget document it is zero for American Lake.

Secretary PEAKE. Let me get back to you for the record, ma'am.

Senator MURRAY. I really really appreciate that.

Secretary PEAKE. Because I believe we have money—at least in design—to move that project along.

Senator MURRAY. OK. On the documents we have it listed as zero.

Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Murray.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

We have another panel coming up that has representatives from the VSOs and I would love to get their opinion on the first question I have to ask. It deals with Priority 8 vets. These are veterans who have no service-connected injury. In Montana they are classified as Priority 8 if they make over $27,000 a year. I know that varies around the country.

My question is—it is an issue of fairness as far as I am concerned and I hear about it a lot when I go back to Montana—do you think when the guys or gals were recruited that they were told they were not going to get benefits if they made too much money?

Secretary PEAKE. Well, sir, I would tell you that our priority, I think, is appropriately for those with service-connected disabilities; those with special needs; and those who really have a significant economic need. Whether $27,000 is the right number—I do not really know if that is the right number—I do think that it is appropriate that we focus on those that really have the needs that were consequent to their service to this Nation.

Senator TESTER. I could not disagree with that, Mr. Secretary, and I think that is the right priority, so to speak. But in all fairness, and I will just say this for the record, that I think the Priority 8 vets ought to get the benefits, too. I do not care if they are making $100,000 a year. I think it is important that we live up to our promise to folks who protect this country, and it is just that simple for me.

I want to talk about budget construction for just a second. If you could very briefly—because I know you could go on for probably hours on this—but how do you construct a budget? Does the President give you a bottom line that you have to live under and then you go line-item by line-item and move money around? How do you construct this budget? And it was probably done before you got here; so, if you could tell me how your predecessor did it, it would be great. Or anybody?

Secretary PEAKE. Let me ask Mr. Henke to talk about the construction.

Senator TESTER. As concise as you can because budgets tend to get rather weighty. So, if you could just give me how you do it?

Mr. HENKE. Yes, sir. We began the process in the summer of last year bringing it to conclusion with OMB and the Administration in November. We do not have a fixed cap total. We model very accurately the demand for health care and bring that forward and have extended discussions with the Administration at the end of the year.

But, there is no "control total" to hit that we must live under. There is no fixed point under which we must come.

Senator TESTER. Sir, I understand the benefits portions—getting the money to the ground for the veterans is critically important—but oversight helps ensure that it happens, that the benefits actually get to the veterans on the ground.

There is a $4 million cut to the IG. What is the thought process on that? Because you have got a huge agency that, as I said before, does really good work. We want to make sure it does. I cannot oversee you. I oversee your budget. I cannot, other than what veterans tell me on the ground, know what is really going on.

Can you tell me why you cut the IG $4 million?

Mr. HENKE. Well, sir, the $4 million cut is from what was plussed up last year in the contingent emergency funding. Without the emergency funding it shows a bit of a growth. The IG has the ability to carry over some funding into 2009. We will have to understand what the funding impact might be in 2009, but it certainly is not because we do not believe the IG is a very important element.

Senator TESTER. So, what you are saying is that with the $4 million cut the IG is still going to have plenty of flexibility to go out and determine if the job is being done to the best of their ability?

Mr. HENKE. I will count on them to do that, and I believe they will have the resources to do that.

Senator TESTER. OK. In your opening comments, Secretary Peake, you talked about, in regard to the enrollment fees, you said that you were going to charge the fees because retired military had to pay the fees for TRICARE. Is that what I heard?

Secretary PEAKE. What I said is, one of the rationales for charging fees in the first place is an issue of equity. I pulled the pay table for Sergeant Major E9 with 28 years of service, and I think it is $3,999 a month. So, if you multiply that out, it is $48,000 a year. That soldier, who spent 28 years of his life serving his country—maybe multiple tours in Iraq or whatever—will pay $460 a year for his family as an enrollment fee for TRICARE for like services.

So, to say that a veteran who is a Priority 8, as an example, should not pay an enrollment fee who is making $50,000 (which is what it would be); this does not quite seem right.

Senator TESTER. But the Priority 8 is not eligible at all.

Secretary PEAKE. We have some in our system, Priority 7s and 8s. They are the only people that will be affected by this enrollment fee.

Senator TESTER. The Priority 8s?

Secretary PEAKE. Yes, 7s and 8s.

Senator TESTER. Thank you. I am out of time. I will pass it on.

Chairman AKAKA. Thank you, Senator Tester. We will have another round.

Senator Sanders.

STATEMENT OF HON. BERNARD SANDERS, U.S. SENATOR FROM VERMONT

Senator SANDERS. Thank you, Mr. Chairman. I apologize for being late but I was presiding.

First, Dr. Peake, let me thank you. I know that in the Veterans' Affairs Committee we put a sum of money to make sure that travel reimbursement rates went up. Senator Tester and I and others wrote you asking to implement that policy and you did. And I can tell you that in the State of Vermont there is a lot appreciation for that. So, I am glad we were able to move quickly on that.

My line of questioning is going to be pretty simple and that is to say that any objective look at what is going on in terms of the needs of our veterans right now suggests that we cannot pursue a course of policy which is normal—because these are not normal times.

We have some 29,000 soldiers who have been wounded in Iraq, many of them seriously. We have—God only knows how many—soldiers who are going to come home with TBI, but we expect that tens of thousands of those returning will need to be diagnosed and treated.

Senator Murray and others have talked about the rates of suicides which are appallingly high and all of us are concerned about how we do a better job in preventing that.

On top of all of that we have a situation with our older veterans, where our waiting lines are extremely long and people are not getting into the hospitals or clinics in a timely manner. It takes far too long for many of the claims to be processed for our veterans. That is what we are facing.

And I do not have to tell you, Mr. Secretary, although you are new to your job, that Members on this Committee feel that there is something very very wrong when we have a President who thinks it is OK to give hundreds of billions of dollars in tax breaks to the wealthiest 1 percent, but we cannot find a few billion dollars to begin to address these issues.

I am disturbed. We made some real progress, Mr. Chairman—and I thank you very much for your leadership on this—in producing the largest increase in funding for the VA in the history of that agency. And as you know—I do not mean to be terribly political here—we had to do this fighting the Administration.

Now, we are back this year with all of these problems out there, with PTSD, with TBI, with waiting lists, with claims backlog; and the President has come forth with a 3.9 percent increase for the year knowing that all of these problems are looking at us; staring us in the face. We also know the cost of medical inflation is very high. We know you are going to have to hire thousands of doctors and nurses and psychologists and other people.

So, my first question is, given the enormous problems facing the VA, why has the President given us a budget that calls for only a 3.9 percent increase?

Secretary PEAKE. Well, sir, if you look at the medical aspect of it in terms of the increase, it is more like 5.8 percent. Medical inflation is about 4.63 percent. So, it is a real growth of maybe close to 1.2 percent. I understand that that is where we are.

We were fortunate to have the plus up that we had this last year because it gave us a chance to do some one timers that needed to be done. And we got the ability, I think, with the budget that we have to sustain those, as well as, to move forward in the area of

outreach, as an example. And I owe the chairman a more detailed breakdown of that.

But I think it starts to sustain the important advances that we have made and allows us to consolidate. I think we will continue to do the hiring that we talked about and the budget is on target for that goal.

Senator SANDERS. But you talked about the medical side of your budget getting an increase. But, everything being equal, if last year's load was the same as this year's load, we are talking about not only the old—and I think we are all in agreement that we are not going to forget about the older veterans——

Secretary PEAKE. Right.

Senator SANDERS. But, you have all the guys and women coming home with PTSD and TBI. I think common sense would suggest that in order to address that need, you are going to need a budget a heck of a lot larger.

I would point out that we are spending, Mr. Chairman, about $12, $14 billion a month—a month—in Iraq fighting that war; and it disturbs me that we cannot come up with a fraction of what we spend in a month to make sure that we take care of the people who fought that war.

Do you have any additional thoughts on that?

Secretary PEAKE. Except to say, sir, that we are looking at a 14 percent increase in the number of OEF/OIF people that we think are going to come to us; and we have been very careful not to underestimate that. But, we have already programmed a 21 percent increase in what we expect to expend on that group of people.

So, I think we are, again, sir, we are trying to put the money where the priority is appropriately; and make sure we do not drop the ball on this important cohort of people; and we will still take care of our older veterans.

Senator SANDERS. And you think this budget will enable us to appropriately take care of our older veterans and deal with the huge increase in caseload that the VA is going to experience?

Secretary PEAKE. Overall our caseload increase we expect to be about 1.6 percent above what our current 2008 estimate is.

Senator SANDERS. Is there not some dispute about the accuracy of those estimates?

Secretary PEAKE. Sir, my understanding is that we have in the past—some years ago—been as much as 5 or 6 percent off, and I know that some of it was out of model. Probably because of the scrutiny of this Committee, I think we have gotten a lot better at that. And, as I look at the variances, it really is starting to get tighter.

I think we are doing a better job of forecasting and, you know, I believe that—and we should be held accountable that way.

Senator SANDERS. I think it would be a tragedy if, for whatever reason, the VA underestimated the kind of caseload that it would get and then requested less money than, in fact, you will end up needing.

So, again, do you think that you have the money to adequately treat our older veterans and the people coming home from Iraq and Afghanistan?

Secretary PEAKE. I do, sir.

Senator SANDERS. OK. We may have a disagreement on that, but let me ask you this then about the fees and the co-pays. My understanding is that one of the goals, frankly, of increasing fees is essentially to drive veterans away from the VA system; to lower the caseload; to say, you are going to be paying more for your prescriptions or if you are a veteran with a family income of $50,000 to $75,000; you are either going to pay $250, or if you have a higher income, your fee will be up to $500. I think it is quite obvious that a lot of veterans who are hard-pressed financially will say, I am not going to go into the VA. Is that the goal: to drive away—and by the way I understand this is not your invention. This has been going on year after year. And year after year, of course, the Congress throws this in the garbage can where it should be thrown.

It is an absurd proposal. And I have to say that the idea of raising revenue from veterans who have put their lives on the line defending this country to pay off our deficit—when at the same time giving tax breaks to billionaires—is literally beyond comprehension.

Do you have any comment on that, Secretary Peake? Sir, the estimates are that about 144,000 Priority 8 folks in our system would choose to not pay the fee.

So, I think, yes, there are some that would go out and our estimate also is that those are people that already have health insurance elsewhere. And I know that is an older study, but I think the number was about 90 percent would have other health insurance.

Senator SANDERS. Some may but some may not. And I think just to push people outside of the system, to push one veteran outside the system because he cannot afford the fee is really outrageous. But we do not have to discuss that too much because that proposal is going to go nowhere, and it should go nowhere.

I want to get back to Senator Tester's observation about Priority 8s; and it is, again, the same principle. We have in the State of Vermont many veterans who served their country who expected to be able to access VA health care who make more than $27,000 a year. And as you know, 3 or 4 years ago President Bush threw these people off of VA health care.

Secretary PEAKE. It was 2003. Secretary Principi made the decision because of——

Senator SANDERS. Because of what? We cannot afford tax breaks for the rich and keep veterans in our health care system?

Secretary PEAKE. Well, sir, actually part of the issue is the ability to make sure that we can take care of priority veterans: those with service-connected disabilities; those with special needs; those with really means-tested shortfalls.

Senator SANDERS. Mr. Secretary, I understand that. We have heard that very often. And the question is, can we do both? I think we can. It is not a question of prioritizing. Sure. Everybody here understands that we want to pay rapt attention, do everything we can, for those who are coming back.

I do not know necessarily that it has to be an either/or. Some of us believe that we have the capability and you are seeing a Committee that wants to do both. We are telling you we have the money to do that and I will. And I know, Mr. Chairman, we have

had success in this Committee trying to bring Priority 8s back into the VA system. We intend to do that.

My last question, if I might. There has been a tension, to be very frank—trying not to be political but being very frank—between the White House and many of us in Congress. And we have, last year, given you a very ample budget against—I have to say it—what the White House had requested.

So, you are in this difficult position of being forced to accept more money than your boss wanted you to have. [Laughter.]

Many people would very happy to be in that situation, but you are in a difficult position. I would simply hope, and maybe get a thought from you. We have given you the money. We want that money to be spent cost effectively and we want it to do the job that we have outlined. The needs are so, so great out there—with the older veterans and the newer veterans—it is not easy because you are going to have to hire so many people and do a lot of reorganization.

Can you tell us very briefly how you are going to be doing that?

Secretary PEAKE. Yes, sir. Well, you are right that when you are ramping up, as was brought up earlier, that presents some challenges. I think some of the opportunities that we have been given with the physicians' pay bill and so forth allow us to be more competitive so we are able to see that.

The other good thing about that is that we are seeing an increase retention. So instead of a 9 percent loss, we wind up with a 4 percent loss in terms of attrition. So those are all positive things that I think are going to allow us to move forward with this money that we have been getting.

Senator SANDERS. Are you making, and this is a difficult issue for the whole health care system not just the VA, but are you making progress in getting the nurses you need, psychologists, psychiatrists, physicians?

Secretary PEAKE. Yes, we are. We are making progress and I was just looking at some of the other tools that we have in relation to the personnel and that includes loan forgiveness and by 2012 we will have like $100 million in loan forgiveness.

We have some scholarship programs that we have been able to do and we have quite a number of folks in various scholarship programs.

Senator SANDERS. I would love the opportunity. I will give you a ring and maybe we can chat.

Secretary PEAKE. Very good.

Senator SANDERS. Thank you, Mr. Chairman, whoever the chairman may be.

Senator Webb, you are the Chair.

Senator WEBB [presiding]. We may have a GI Bill by the time he gets back. [Laughter.]

STATEMENT OF HON. JIM WEBB,
U.S. SENATOR FROM VIRGINIA

I apologize for the late entry here. I have had a Foreign Relations Committee meeting with Secretary Rice in Armed Services and another event and then a vote. This is a very important Committee to be on and these issues I care a lot about.

I obviously note that the funding in this bill for enhanced educational benefits is not what we would have expected. I do not know if you had a question on that before I arrived or not?

Secretary PEAKE. I have not.

Senator WEBB. Would you address that issue?

Secretary PEAKE. Well, with our voc rehab and education programs, you will see a drop in manpower of about six, I think, that really is our headquarters. We have another 53 people going out into the field in our voc rehab that, in fact, with some of the restructuring that Admiral Cooper is doing, we will have another 40, I think, out into the field in terms of our voc rehab counseling and so forth.

Senator WEBB. What about educational benefits writ large, for instance, an enhanced GI Bill? Do you have any planning for that in this budget?

Secretary PEAKE. Well, not in this budget and we need to work with DOD on that. It is where the resources would actually come from for that.

Senator WEBB. You mean in terms of manpower resources to do it? You are assuming this would come out of Title 10 funding?

Secretary PEAKE. We wind up administering that benefit, as I understand it, rather than entirely funding that benefit ourselves.

Senator WEBB. Has that traditionally been true, staff?

Mr. TOWERS. Yes, sir, that is correct.

Senator WEBB. I am talking about GI Bills in the past?

Mr. TOWERS. Typical GI Bill.

Senator WEBB. Typical GI Bill.

Mr. COOPER. The GI Bill that we have now——

Senator WEBB. For instance, the World War II GI Bill.

Mr. TOWERS. Yes, sir. I understand.

Senator WEBB. Who paid for the World War II GI Bill?

Mr. COOPER. I cannot answer that question.

Senator WEBB. How about the Vietnam GI Bill?

Mr. COOPER. The GI Bill we have right now—the Montgomery GI Bill—that is in mandatory funding. The money under the current GI Bill the individual pays, as you know, $1200 in the first year to become eligible. And then DOD tells us those who are eligible to execute that bill.

Senator WEBB. Right. I mean, DOD tells you who is eligible to get a veteran benefit, per se, by the character of the discharge. It does not necessarily mean that DOD will fund veterans benefits.

Mr. COOPER. Yes, sir.

Senator WEBB. It has been my experience in the past that the VA pays for the title 38 benefits.

Mr. COOPER. We pay for title 38 benefits, yes.

Senator WEBB. This would be a title 38 benefit.

Mr. COOPER. That is correct.

Senator WEBB. Then you would pay.

Mr. COOPER. There is nothing in the budget.

Senator WEBB. Secretary Peake, I would like your thoughts on the Dole-Shalala formula for characterizing disability. I had some questions about that when Senator Dole and Secretary Shalala were testifying. Specifically, how you would work together with

DOD if they are simply characterizing someone as no longer being fit for active duty service. How is that going to work?

Secretary PEAKE. We have a pilot that is going on now; and, again, this is just a pilot, not a full implementation of what Dole-Shalala has recommended.

The issue is that the pilot says that the Department of Defense will determine—and the service specifically will determine—fitness for duty. That fitness, when that determination is going to be made, then we would do a full examination. The VA would do the full examination to find whatever claimable conditions might be there and adjudicate those.

One of those claimed conditions would be the unfitting condition that then we would give that number, how we adjudicated that particular unfitting condition and that would be the percent that DOD would use to determine whether that servicemember was either medically retired or separated with a severance payment. That is the 30 percent issue.

What Dole-Shalala would say is that any soldier that is determined to be unfit would get an annuity based on their time, grade, years of service and so forth, regardless of what the percentage would be.

We would then pay the benefit based on whatever percentage we wind up adjudicating. So it would be totally separate. So the pilot program is kind of a hybrid right now. The Dole-Shalala would pay a transition.

Senator WEBB. So you are talking present law, pilot and where this might go. You are talking about three separate issues.

Secretary PEAKE. Exactly.

Senator WEBB. There is present law, DOD will adjudicate a percentage and the VA makes a separate determination basically?

Secretary PEAKE. Right.

Senator WEBB. So where are you going to go on this?

Here is a thought that I have. Someone is either going to be given a severance from the military without knowing the percentage that they are going to receive or they are going to be adjudicated by the VA before they are discharged?

Secretary PEAKE. If we can break it down. The way it currently works is, you go to a medical board. They theoretically use the VA schedule of rating to make that determination on only the unfitting condition. That then determines whether you are retired medically or whether you get a severance pay and are separated.

In the future with Dole-Shalala if it were to go the full Dole-Shalala approach—you would go before the Board and you would be determined whether you are fit or unfit regardless of the rating. And if you are unfit, you get an annuity based on your time in service and grade.

Then you get your full adjudication of all of your potentially claimable conditions by the VA and you get your benefits from the VA based on that. Those benefits would be really three different kinds. One is quality of life that would need to be sorted out. Another would be an earnings; and then another would be a transition payment that could be either 3 months' worth of pay, or like a stipend for a year in training or education.

Senator WEBB. So, you would receive an annuity based on your time in the military. Let us say you are 100 percent, you are fully disabled it would not——

Secretary PEAKE. It would not make any difference.

Senator WEBB. It would not show up in the annuity that you would receive?

Secretary PEAKE. That is correct.

Senator WEBB. Or, if you were 10 percent you are going to get an annuity for the rest of your life based on time and grade.

Secretary PEAKE. It has nothing to do with the percent.

Senator WEBB. I understand. Let us say if you have someone who is getting out after 5 years and they have a condition that eventually is going to be adjudicated as 10 percent. As long as they have been characterized as unable to perform their military duties, they are going to get an annuity based on 5 years?

Secretary PEAKE. Correct.

Senator WEBB. Have you priced that out?

Secretary PEAKE. I have not seen the full pricing of that.

Senator WEBB. It would be interesting to see. Do you have any percentages on the number of people now coming out of, say, Iraq/Afghanistan who are getting some small percentage?

Secretary PEAKE. Yes.

Senator WEBB. What would be the percentage of that force?

Secretary PEAKE. Let me ask Admiral Cooper. We just looked at that the other day. There are about 290,000 people, I think, that had been adjudicated, that have a claim and the numbers that were less than 10 percent. We have that number for you, sir.

Mr. COOPER. The total number of people coming out of Iraq and Afghanistan who have filed a claim is 258,000 out of 800,000 that are now veterans. Out of 800,000 veterans, 258,000——

Senator WEBB. Approximately one-third?

Mr. COOPER. Approximately one-third, yes, sir.

Senator WEBB. And of those, how many of those—what percentage of those are being adjudicated as having a claim of at least 10 percent, having a disability of at least 10 percent?

Mr. COOPER. About 80 percent that are 10 percent and above.

Senator WEBB. So, basically one-quarter of those who have become veterans have claims that have been adjudicated favorably at 10 percent or higher?

Mr. COOPER. Yes, sir. But that does not necessarily qualify them as fit or unfit.

Secretary PEAKE. They may be fit.

Mr. COOPER. As a matter of fact, the No. 1 disability that we have adjudicated is tinnitus.

Senator WEBB. Tendinitis.

Mr. COOPER. Tinnitus—ringing in the ear.

Senator WEBB. I have that problem. That is why I cannot understand the word.

[Laughter.]

Mr. COOPER. Sir, the fact is of all those GWOT veterans that we have adjudicated, about 80 percent are 10 percent or above, but very few of those will have the condition that is limiting.

Senator WEBB. You are not estimating that up to 25 percent of the people serving are going to be adjudicated as unfit for further military service by DOD before you make the determination?

Mr. COOPER. That is correct.

Secretary PEAKE. Many of these folks are reservists still. You come out, you get a DD–214. You can claim, and if you go back into the service, you stop getting paid while you are in the service and then it starts up again when you come back out if you have a compensable condition.

Senator WEBB. I understand under present—in fact, I have a close family friend who just had that happen to him. Four years in the Marine Corps, was adjudicated 20 percent. He has just been called back in the recent call-up and I think he is probably going to re-enlist, but he has been adjudicated.

I am really curious as to how this transition is going to work in terms of when you go to an annuity. If you have some projections—I do not want to take anymore time with this, but if you have some projections, it would be interesting to look at those.

Secretary PEAKE. Let me go back for the record and report on that in terms of the scoring.

Senator WEBB. Senator Murray, I am happy to yield the gavel back to you.

Senator MURRAY [presiding]. Yes, Mr. Chairman. Absolutely. Thank you very much.

Mr. Secretary, thank you. I think Chairman Akaka is on his way back here. He will be here in a minute, but I did have a couple of other questions.

Last year, as you know, we did pass the Wounded Warriors Act as part of the Defense Authorization Bill. It has been signed into law. A bill, that as you know, made a lot of very important improvements for our servicemembers as they transition from the military into the VA including extending the period of automatic VA eligibility for returning servicemembers from 2 to 5 years.

However, as I looked through the budget, I did not see any requests from the VA for additional funding for that extension or any other legislative requirements that were included in the Wounded Warrior Act.

Can you tell me how the Administration is proposing to pay for the cost of extending the VA eligibility?

Secretary PEAKE. We are estimating overall a 21 percent increase in what we believe we would need to expend on the 14 percent increase in those that we think will seek our care. So, we think that we have that covered within our numbers now.

Senator MURRAY. Are you taking it from something else?

Secretary PEAKE. Well, it is within the budget if that is what you mean particularly. We are not taking it from—it is part of the health care budget. We were not disenrolling any of those. Even those we were seeing for 2 years, we were not disenrolling them. We are treating them as Priority 6s.

Senator MURRAY. What about the other recommendations of the Dole-Shalala Commission that you are implementing? Where are you going to get the money to cover those costs?

Secretary PEAKE. As an example, for the Federal Recovery Coordinators, they are hired and they are built into our budget.

Senator MURRAY. You believe you have enough resources to enact all provisions of the Dole-Shalala Commission as well?

Secretary PEAKE. Well, we will need some other legislative authority to do all the provisions of Dole-Shalala. But, those things that we can do administratively; we have the resources.

Senator MURRAY. Do you anticipate asking us for additional resources as we see what the cost of those are as those things are implemented?

Secretary PEAKE. If we have to, in terms of changing the disability system, as an example, I think we would need to. As Senator Webb was talking about, we need to get that squared out and understand. Once we get the studies in, which we have started, we have contracted to do two studies so that we can try to understand better what the issues of quality of life would be, and the issues of the transition payments, and the earnings issues.

Senator MURRAY. OK. We had several high-profile cases of data breach, as you will recall, in 2006; and after that, we passed a law laying out how we expect the Department to handle those kinds of events. The requirements of that included an analysis of the breach by an outside expert or the IG and the provision of services such as credit monitoring and victim assistance if individuals were deemed to be at risk, and reporting back to Congress.

Can you tell me how many breaches have been reported since this law was enacted? Does anybody have that?

Secretary PEAKE. Let me ask General Howard if he has that specific data. I do not.

Mr. HOWARD. Ma'am, there have been several large ones. For example, you recall the Birmingham incident.

Senator MURRAY. Yes.

Mr. HOWARD. That for sure is one. There have been a lot of them, but most of them have been very small.

With respect to the provision in the law, we now have a contract on the shelf that can be used, if we need to, in order to comply with the law for independent risk assessment. We have not done that to date, though.

Senator MURRAY. OK. Are we following the provisions of the law that require credit monitoring for anybody?

Mr. HOWARD. Yes, we are.

Senator MURRAY. And reporting back to Congress.

Mr. HOWARD. We do two things. First, when we have an incident, we immediately assess, you know, whether or not individuals may have been harmed. If there is any inclination at all that has happened, we immediately notify them. And then under further review if we believe they should be awarded credit protection, we also send a letter out to them and they can opt in for that if they desire.

Senator MURRAY. Thank you very much. One final question.

Dr. Peake, in the President's State of the Union address, he called on Congress to allow U.S. troops to transfer their unused education benefits to family members. But I noticed in the budget he did not ask for any money for it. We are being told that it will cost anywhere between $1 and $2 billion dollars. So I am left wondering where the President's sincerity is in requesting us to do something when he did not ask the money for it or not. I am wondering if you could share with us why there is no additional re-

quest for the cost of that in the budget proposal. That would be helpful.

Secretary PEAKE. My understanding is that would be a DOD cost as opposed to VA cost. However, we have been doing this for the Army. We have done some 300 families. And from our perspective, we will be able to implement that whenever the time comes; and we think it is a good thing.

Senator MURRAY. OK. Very good, thank you.

Mr. Chairman.

Chairman AKAKA [presiding]. Thank you very much.

Mr. Secretary, this question builds on what Senator Murray and I talked about a moment ago.

You state that the President's top priority is to enact the recommendations of the Dole-Shalala Commission. You added that Congress needs to pass the President's legislation. I continue to have reservations about the President's proposal regarding the disability compensation system.

I can assure you that Congress is doing its due diligence, but we will not pass legislation until we are satisfied that such legislation is appropriate for all veterans.

This Committee has held two hearings on veterans' disability compensation already this session. Another one is scheduled for later this month.

I also will add that VA has initiated its own studies to determine appropriate payment levels for quality of life, transition assistance, and loss of earnings. I believe that Congress would be in dereliction of its duty to pass legislation to reform the disability compensation system without knowing the outcome of these studies.

I want to continue on the topic of compensation and what can be accomplished in the short term.

We have high expectations for VBA to improve upon the quality and timeliness of claims decisions. Last year, Congress was able to increase staffing for this.

Can you tell us when veterans can expect to see results from this significant investment in manpower? Is there something more that Congress can provide?

Secretary PEAKE. Sir, I think you will, given the training program and the efforts that Admiral Cooper has made in bringing people on board, we are already starting to see, I think, a change in those numbers. We expect that it will be down to 169 days by the end of this year, 145 by the end of 2009. I think we need to move forward with the paperless process.

We have put an RFI out to get industry input on rules-based engines. We have a systems integrator that will be hired to help us look at restructuring how we are doing business.

If you walk through the BVA mail room, I mean, it is like stepping back into the 1950's and it is not the way we can do it in an industrial age. And so we are going to need to figure that out and make the investment to get to a paperless environment.

I think also, sir, that this issue, we do need to figure out how to simplify our disability system. When it takes 2 years, 3 years to train somebody adequately to be able to adjudicate a claim, it is not because they are not bad people or not smart or anything like that, it means our system is too complex.

And so I think it is a combination of things, but we have to get moving on it.

Chairman AKAKA. Thank you.

Secretary Peake, I would like to revisit the issue of Priority 8 veterans. You mentioned that you were unsure if the current threshold is high enough or not enough. You have the authority to raise this threshold.

So my question to you is, is this something that you are considering?

Secretary PEAKE. Sir, I would tell you that I am certainly willing to look at it and consider it and I will do so and work with the Committee on it.

Chairman AKAKA. Thank you. I have further questions, but let me call on Senator Burr.

Senator BURR. Thank you, Mr. Chairman. I only have one additional question and it is specifically on the VA proposed budget which requests additional staff to decide disability claims, process education claims, to litigate, and decide appeals. But, General, it does not seek additional staffing for vocational rehab and employment programs. As I mentioned previously in my statement, I think the focus of the VA should be on recovery, rehabilitation and returning veterans with disabilities to the most productive lives we can offer.

So, I would ask whether you think the VA has placed enough emphasis on this VBA program which, in my view, most closely aligns with what I think are the goals of the agency and this Committee.

Secretary PEAKE. Sir, I agree with your assessment that the voc rehab and education is one of the things that we really need to be moving forward. We have too many people that drop out of it once we get started.

To your first point, sir, there is a headquarters reduction, but there is a field increase of about 53 people. I think that we need to make sure that our veterans have more access to that; and that we look at ways to keep people in those programs and measure the outcomes in terms of careers and employment, and not just measure people in the process.

So, it is one of the first briefings I asked to have when I got to the VA, and it is one that will take an increasing priority in terms of focus.

Senator BURR. General, I want to take this opportunity to thank you for responding to the President's request. More importantly, for the team that you have got assembled around you of incredibly talented folks that, in many cases, have to come up here and listen to us rant and rave—some legitimate; some rantings, quite honestly, none of us will ever figure out the exact reasons.

But, the fact is that not a day goes past that I do not think that everyone that is assembled at the VA is focused on exactly what each is there for, and that is: to serve the veteran in the most effective way possible.

We ask you to do an impossible thing, and that is: to project what the future is going to look like—the future caseload, the future patient mix, the future disabilities that VA beneficiaries are going to have. It is impossible. We do not expect it to be perfect.

I hope, collectively, we can begin to make the types of reforms that I think we would all agree have to be made in any health care delivery system. And I think it is vitally important that we understand what it costs us and the length of time to do a colonoscopy at the VA and what it costs and how long it takes to do a colonoscopy in the private sector. And if there is a discrepancy that is major or minor, then we ought to ask ourselves, are they doing it wrong or are we doing it wrong?

Maybe we can find some things to replicate and that is what I am encouraged about is that in every area of the Veterans Administration, I am seeing people who are searching for what the answer is to providing that quality care at the most efficient, effective cost they can find.

I think clearly, as we go forward, you know I am passionate about looking at the disability system and trying to collectively come up with something that is understandable, not just for us, for veterans.

But also to work with Dr. Kussman as we begin to map out what the VA health care delivery system will look like in the future and what makes sense based upon the way we treat people today and a sensitivity as to where they live and how they can best access the services as more and more of our Guard and Reserve happen not to come from urban areas but from rural areas.

This is going to be a challenge. My hope is that there is not as much pressure on the transportation needs of veterans in the future because we have been able to redefine how we deliver medical services in a way that they do not have to go that far. And my hope is that the Congress will be a partner with the Veterans Administration for this.

I thank each one of you for your willingness to be here today and I thank the Chairman for his leadership on this Committee.

Chairman AKAKA. I thank our Ranking Member here; and he did not have to say it, for his passion about VA issues. And I certainly am glad he is here, and I look forward to working with him.

I would now like to ask Under Secretary Tuerk a question. You came to Hawaii last year to advise Senator Inouye and me on a planned expansion to the Columbarium space at Punchbowl.

My question to you is, is that still on track?

Mr. TUERK. Yes, Mr. Chairman, I am glad to have the opportunity to update you on that. The first phase of that project, where we intend to spend some $3.7 million to add 3,385 new niches to the Columbarium at the Punchbowl, is on track. We anticipate awarding a contract this September, committing 2008 funds to this project. Subsequently, we will proceed up the existing Columbarium, up toward the rim of the crater. So my short answer, Senator, is, yes, we are on track. We are moving right now to begin the first phase of the expansion. And I am here to assure you again there will not be any interruption of service at the Punchbowl.

Chairman AKAKA. Well, thank you so much for that.

Mr. Secretary, I want to thank you profusely for your testimony, your answers to our questions, and thank you for what you are doing as Secretary of VA.

I also want to thank your Under Secretaries who are present here for what they are doing. There is a difference now in how we are facing the budget here today.

So, I am looking forward to working with you and with the Committee on this, and together I know we can do a good job in providing the best services we can to our veterans.

So, I want to thank you all very much.

Secretary PEAKE. Thank you very much, Mr. Chairman.

[Pause.]

Chairman AKAKA. The hearing will come to order.

I want to welcome the second panel and I want you to know that I appreciate each of you being here today.

First, I welcome the representatives of the Independent Budget: Carl Blake, National Legislative Director of Paralyzed Veterans of America.

Kerry Baker, Associate National Legislative Director for Disabled American Veterans.

Raymond Kelley, National Legislative Director for AMVETS.

Christopher Needham, Senior Legislative Associate for the National Legislative Service of Veterans of Foreign Wars.

I also welcome Peter Gaytan, Director of the National Veterans Affairs and Rehabilitation Commission of the American Legion.

Finally, I welcome our dear friend over the years, John Rowan, National President of Vietnam Veterans of America.

Again, I thank all of you for joining us today. Your full statements will appear in the record of the Committee.

Mr. Blake, will you please begin with your testimony.

STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Mr. Chairman, Ranking Member Burr, on behalf of the four coauthors of the Independent Budget, I would like to thank you for allowing us the opportunity to testify today on the health care recommendations for the Department of Veterans Affairs for fiscal year 2009.

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

Although we recognize this is another positive step forward in achieving adequate funding for the VA, we believe still more can be done.

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

The one lead difference between our recommendation and the VA's recommendation this year is in the increase in patient workload. Our increase in patient workload is based on a projected increase of approximately 120,000 new unique veterans. This includes Category 1 though 8 veterans and non-veterans who also have coverage under the VA.

We estimate the cost of these new unique patients to be approximately $792 million. The increase in patient workload also includes

a projected increase of about 85,000 new Operation Enduring Freedom and Operation Iraqi Freedom veterans at a cost of approximately $253 million. This alone puts a difference of about $600–plus million between our recommendation and the Administration's recommendation.

Our policy and initiatives include additional funding for improved mental health and TBI services, long-term care services, funding for homeland security and emergency preparedness and prosthetics.

Also, for medical facilities, the Independent Budget recommends approximately $4.6 billion. This includes an additional $250 million to address non-recurring maintenance needs of the VA. We are pleased to see that this year the President's budget does include a significant plus up in funding for non-recurring maintenance.

Although not proposed to have a direct impact on veterans health care, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription co-payments and index enrollment fees based on income.

Although the VA does not overtly explain impact of these proposals in its budget submission, similar proposals in the past have estimated that nearly 200,000 veterans will chose to disenrolling from the system and nearly one million veterans will chose not to enroll.

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

Mr. Chairman, as you know, the whole community of national veterans service organizations strongly supports an improved funding mechanism for VA health care. However, if the Congress cannot support mandatory funding, there are alternatives which could meet our goals of timely, sufficient, and predictable funding.

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

Furthermore, by adding transparency to VA's health care enrollee projection model, we can focus the debate on the most actuarially sound projection of veterans' health care costs to ensure sufficiency. Under this proposal Congress would retain its discretion to approve appropriations, retain all of its oversight authority, and most importantly, there would be no PAYGO implications.

We look forward to the opportunity to talk to both your staff and Senator Burr's staff about this proposal.

We would also ask that this Committee in your views and estimates for fiscal year 2009 recommend to the Budget Committee either mandatory funding or this new advanced appropriation approach to take the uncertainties out of funding for health care for our Nation's wounded, sick, and disabled veterans.

Finally, Mr. Chairman, I would end with two points. First, I would like to thank both your Committee staff and the Staff of Senator Burr, as well as legislative aides for all of the members of the Committee, for allowing the Independent Budget the opportunity, the week before the President's Budget was released, to

come and brief our budget recommendations in advance and give them an idea of where we intended to go before the President's budget actually came out.

I would like to believe that this actually fosters a better working relationship with all the staff on the Committee and it re-enforces the point that we make that we have nothing really to hide and only everything to gain in this process.

And finally, Mr. Chairman, I would like to thank you for your kind words about Richard Fuller. With the exception of his family and a few really close friends, I am not sure that anyone has been more impacted by his loss than me. Richard was my mentor when I started at PVA and I would suggest that he taught me the responsibility that comes with this job and what we do everyday for veterans.

So, Mr. Chairman, again, I would like to thank you. I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Committee, as one of the four co-authors of *The Independent Budget*, Paralyzed Veterans of America (PVA) is pleased to present our views regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for fiscal year 2009.

PVA, along with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, is proud to come before you this year to present the 22nd edition of *The Independent Budget*, a comprehensive budget and policy document that represents the true funding needs of the Department of Veterans Affairs. *The Independent Budget* uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year, the document is endorsed by 54 veterans' service organizations, and medical and health care advocacy groups.

Last year proved to be a difficult year for the appropriations process. The year started with an incomplete appropriation for fiscal year 2007. Congress eventually completed the fiscal year 2007 funding bills in February, placing VA in a very difficult position. While the funding levels provided for fiscal year 2007 were very good, the fact that the bill was not completed for nearly 5 months after the start of that fiscal year is wholly unacceptable. Congress then followed that action up by providing more than $1.8 billion in supplemental funding for the VA.

Unfortunately, the fiscal year 2008 appropriations process did not go any smoother. Due to political wrangling over the Federal budget, the VA did not receive its appropriation until December. We were very disappointed that the VA was forced to endure this situation for the 13th time in the last 14 years. This was particularly disappointing in light of the fact that the Administration guaranteed that the bill would be signed into law and because the bill was completed before the start of the fiscal year on October 1.

The appropriations bill was eventually enacted, but it included budgetary gimmicks that *The Independent Budget* has long opposed. While the maximum appropriation available to the VA would match or exceed our recommendations, the vast majority of this increase was contingent upon the Administration making an emergency funding request for this additional money. Fortunately, the Administration recognized the importance of this critical funding and requested it from Congress. This emergency request provided the VA with $3.7 billion more than the Administration requested for fiscal year 2008.

For fiscal year 2009, the Administration requests $41.2 billion for veterans' health care. This included approximately $2.5 billion from medical care collections. Although this represents another step forward in achieving adequate funding for the VA, it still falls short of the recommendations of *The Independent Budget*.

For fiscal year 2009, *The Independent Budget* recommends approximately $42.8 billion for total medical care budget authority, an increase of $3.7 billion over the fiscal year 2008 operating budget level established by Public Law 110–161, the Omnibus Appropriations bill, and approximately $1.6 billion above the Administration's fiscal year 2009 request. It is important to note that our budget recommendations reflect a distinct change from past years as it reinforces the long-held policy that

medical care collections should be a supplement to, not a substitute for real dollars. The Administration, year-after-year, chooses to include medical care collections as part of its overall funding authority for Medical Services. However, we believe that the cost of medical care services should be provided for entirely through direct appropriations. In order to develop this recommendation, we used the maximum appropriation amount included in Public Law 110–161 for VA medical care and added the projected medical care collections to that amount to formulate our baseline.

The medical care appropriation in past years has included three separate accounts—Medical Services, Medical Administration, and Medical Facilities—that comprise the total VA health care funding level. However, for fiscal year 2009, the Administration's Budget Request recommends consolidating Medical Services and Medical Administration into a single account. In order to properly reflect this change in our recommendations, the separate accounts for Medical Services and Medical Administration must be added together. For fiscal year 2009, *The Independent Budget* recommends approximately $38.2 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$32,574,528,000
Increase in Patient Workload	1,045,470,000
Policy Initiatives	1,000,000,000
Medical Administration	3,625,762,000
Total fiscal year 2007 Medical Services	$38,245,760,000

In order to develop our current services estimate, we first added the estimated collections for fiscal year 2008 to the Medical Services appropriation for fiscal year 2008. This best reflects the total budget authority that the VA will use to provide health care services. This amount was then increased by relevant rates of inflation. We also use the Obligations by Object in the President's Budget submission in order to set the framework for our recommendation. We believe this method allows us to apply more accurate inflation rates to specific subaccounts within the overall account. Our inflation rates are based on 5-year averages of different inflation categories from the Consumer Price Index—All Urban Consumers (CPI–U) published by the Bureau of Labor Statistics every month.

Our increase in patient workload is based on a projected increase of 120,000 new unique patients—Category 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $792 million. The increase in patient workload also includes a projected increase of 85,000 new Operation Iraqi Freedom and Operation Enduring Freedom (OEF/OIF) veterans at a cost of approximately $253 million.

The policy initiatives include $325 million for improvement of mental health services and Traumatic Brain Injury care. This amount represents the growing trend both within the Administration and the Congress to enhance the mental health services within the VA. Furthermore, it reinforces our belief that resources should be provided to the VA to allow them to be the lead for providing these specialized services, not outside health care organizations. We also recommend $250 million for long-term care services. The policy portion of *The Independent Budget* further explains the shortfall that the VA has in meeting the Average Daily Census mandated by the Millennium Health Care Act. We also recommend that the VA be appropriated $325 million for funding the fourth mission which encompasses homeland security and emergency preparedness initiatives. Currently, the VA already spends approximately this amount, but this funding is drawn directly out of the Medical Services account. Finally, we recommend $100 million to support centralized prosthetics funding.

As mentioned previously, our Medical Administration recommendation must be added to our Medical Services recommendation to properly reflect the format of the fiscal year 2009 budget submission. As such, *The Independent Budget* recommends approximately $3.6 billion for Medical Administration for fiscal year 2009.

Finally, for Medical Facilities *The Independent Budget* recommends approximately $4.6 billion. This amount includes an additional $250 million for non-recurring maintenance for the VA to begin addressing the massive backlog of infrastructure needs.

Although *The Independent Budget* health care recommendation does not include additional funding to provide for the health care needs of Category 8 veterans being denied enrollment into the system, we believe that adequate resources should be provided to overturn this policy decision. During fiscal year 2008, the VA estimated that a total of over 1,500,000 Category 8 veterans would have been denied enrollment into the VA health care system. Despite the fact that we have not seen any

solid empirical data to substantiate this continued growth rate in denied Category 8 veterans, the VA continues to project higher and higher numbers of Category 8 veterans denied enrollment into the health care system. Based on the projected increase in this population of veterans over the last 5 years, *The Independent Budget* estimates that more than 1,870,000 will have been denied enrollment by fiscal year 2009. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, *The Independent Budget* estimates that the actual total cost to reopen the system will be approximately $1.4 billion in order to meet this new demand. For the sake of discussion, if the projected collections for this group of veterans were to be considered in this estimation, the actual cost in appropriated dollars would be approximately $456 million. We believe that the system should be reopened to these veterans and that adequate funding should be provided in addition to our Medical Care recommendation.

Although not proposed to have a direct impact on veterans' health care, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription drug co-payments from $8 to $15 and an indexed enrollment fee based on veterans' incomes. These proposals will simply add additional financial strain to many veterans, including PVA members and other veterans with catastrophic disabilities. Although the VA does not overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans will leave the system and more than 1,000,000 veterans will choose not to enroll. It is astounding that this Administration would continue to recommend policies that would push veterans away from the best health care system in the world. Congress has soundly rejected these proposals in the past and we call on you to do so once again.

For Medical and Prosthetic Research, *The Independent Budget* is recommending $555 million. This represents a $75 million increase over the fiscal year 2008 appropriated level established in the Omnibus Appropriations Act and $113 million over the Administration's request for fiscal year 2009. We are particularly pleased that Congress has recognized the critical need for funding in the Medical and Prosthetic Research account, and we urge Congress to again overrule VA's request, one that will seriously erode VA's crucial biomedical research programs. Research is a vital part of veterans' health care, and an essential mission for our national health care system. VA research has been grossly underfunded in contrast to the growth rate of other Federal research initiatives. At a time of war, the government should be investing more, not less, in veterans' biomedical research programs.

The Independent Budget recommendation also includes a significant increase in funding for Information Technology (IT). For fiscal year 2009, we recommend that the VA IT account be funded at approximately $2.165 billion. This amount includes approximately $121 million for an Information Systems Initiative to be carried out by the Veterans Benefits Administration. This initiative is explained in greater detail in the policy portion of *The Independent Budget*.

We remain concerned that the Major and Minor Construction accounts are significantly under funded in the fiscal year 2009 Budget Request. The Administration's request slashes funding for Major Construction from the fiscal year 2008 appropriations level of $1.1 billion to $582 million. The Minor Construction account is also significantly reduced from the appropriated level of $631 million to only $329 million. These funding levels do little to help the VA offset the rising tide of necessary infrastructure upgrades. Without the necessary funding to address minor construction needs, these projects will become major construction problems in short order. For fiscal year 2009, *The Independent Budget* recommends approximately $1.275 billion for Major Construction and $621 million for Minor Construction. The Minor Construction recommendation includes $45 million for research facility construction needs.

Finally, Mr. Chairman, as you know, the whole community of national veterans service organizations strongly supports an improved funding mechanism for VA health care. However, if the Congress cannot support mandatory funding, there are alternatives which could meet our goals of timely, sufficient, and predictable funding.

Congress could change VA's medical care appropriation to an advance appropriation which would provide approval 1 year in advance, thereby guaranteeing its timeliness. Furthermore, by adding transparency to VA's health care enrollee projection model, we can focus the debate on the most actuarially sound projection of veterans' health care costs to ensure sufficiency. Under this proposal, Congress would retain its discretion to approve appropriations; retain all of its oversight authority; and most importantly, there would be no PAYGO problems.

We ask this Committee in your views and estimates for fiscal year 2009 to recommend to the Budget Committee either mandatory funding or this new advance

appropriations approach to take the uncertainties out of health care for all of our Nation's wounded, sick and disabled veterans.

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

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

Chairman AKAKA. Mr. Baker.

STATEMENT OF KERRY BAKER, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

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

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

The claims backlog is undeniably growing. By the end of January there were over 816,000 pending claims including appeals.

In the 4 years since the end of 2004, pending claims rose by an average of 63,000 per year. Also the number of cases with eight or more disabilities increased well over 100 percent from 2000 to 2006. Such complex cases further slow down the claims process.

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

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

One example deals with VA's policy of requiring medical opinions in cases where a claimant has already submitted an opinion adequate for rating purposes. Congress rescinded VA's prior policy of verifying a private physician's opinion with a VA examination prior to awarding benefits.

Yet VA continues to refuse to render decisions in cases where a claimant secures a private opinion until after VA obtains its own opinion. We believe these actions are an abuse of discretion, delay decisions and prompt needless appeals.

Congress should mandate that VA must decide cases based on a veterans' private medical evidence when it is adequate for rating purposes. This small change will preserve VA's manpower and budgetary resources, reduce the backlog, prevent needless appeals and, most importantly, better serve disabled veterans and their families.

On another note, the law requires VA to accept lay evidence as proof of service connection for a disability if a veteran is a combat veteran. VA accepts certain military declarations as proof of combat but only a fraction of combat veterans received one of these qualifying medals.

Military records usually do not document individual combat experiences. As a result, veterans who suffer a disability in combat

are forced to wait a year or more while VA conducts research to determine whether a veteran's unit engaged in combat as claimed. This results in difficulty, even impossibility, in proving a veteran's personal participation in combat by official military records.

Congress should clarify its intent by defining a combat veteran for all purposes under Title 38 as one who, during active military service, served in a combat zone for purposes of Section 112 of the Internal Revenue Code of 1986 or predecessor of law. This amendment would reinforce the original intent of Congress in liberalizing service connection for sick and disabled veterans who served in combat.

Also, on behalf of the Independent Budget Veterans Service Organizations, I am going to call the Committee's attention to issues involving the Federal Court of Appeals for Veterans Claims.

The greatest challenge facing the court today is similar to the VA's, the rising backlog of appeals. However, staffing is not the court's primary dilemma, rather the court has shown a propensity to remand cases to the Board of Veterans Appeals based on errors alleged by VA's counsel for the first time on appeal, notwithstanding the VA has no right to appeal a decision by the Board.

In this, the court suggests that a veteran is free to present those assignments of error to the Board even though that appellant may have already done so. This leads the Board to repeat the same mistakes that it made previously. Such remands reopen the appeal to unnecessary development and further delays, overburden an already backlogged system and exemplify a far too restrictive judicial process.

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

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

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

Thank you.

[The prepared statement of Mr. Baker follows:]

STATEMENT OF KERRY BAKER, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

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

As you know Mr. Chairman, the *IB* is a budget and policy document that sets forth the collective views of DAV, AMVETS, Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars of the United States (VFW). Each organization accepts principal responsibility for production of a major component of our Independent Budget—a budget and policy document on which we all agree. Reflecting that division of responsibility, my testimony focuses primarily on the variety of Department of Veterans Affairs' (VA) benefits programs available to veterans.

In preparing this 22nd *Independent Budget*, the four partners draw upon our extensive experience with veterans' programs, our firsthand knowledge of the needs of America's veterans, and the information gained from continuous monitoring of

workloads and demands upon, as well as the performance of, the veterans benefits and services system. Consequently, this Committee has acted favorably on many of our recommendations to improve services to veterans and their families. We ask that you give our recommendations serious consideration again this year.

THE VETERANS BENEFITS ADMINISTRATION IS STILL UNDERSTAFFED AND OVERWHELMED

To improve administration of VA's benefits programs, the *IB* recommends Congress provide the Veterans Benefits Administration (VBA) with enough staffing to support a long-term strategy for improvement in claims processing and for other programs under jurisdiction of the VBA. Included in our recommendations are new resources needed for training programs and information technologies; however, this testimony primary focuses on solving VA's staffing shortages as well as other initiatives to manage the increase in new claims and reduce the out-of-control claims backlog. In total, if Congress accepts our recommendations, VBA will be better positioned to serve all disabled veterans and their families.

UNDERSTAFFING AND CLAIMS BACKLOG

Mr. Chairman, the claims' backlog is unquestionably growing. Rather than making headway and overcoming the protracted delays in the disposition of its claims, VA continues to lose ground on its claims backlog. According to VA's weekly workload report, as of January 26, 2008, there were 816,211 pending compensation and pension (C&P) claims, which include appeals. Putting this number into perspective, at the end of 2004, 2005, 2006, and 2007, the total number of pending claims was 620,926; 680,432; 752,211; and 809,707, respectively. Therefore, in the 3 years from the end of 2004 to the end of 2007, the total number of pending C&P claims rose by 188,781 for an average of 62,929 additional pending claims per year. The VA's pending claims rose by 6,504 just from the end of 2007 to January 26, 2008—less than 1 month. At this rate, VA's caseload will pass one million claims in 3 years. With the wars in Iraq and Afghanistan still raging, together with the mass exodus from military service that usually occurs following cessation of combat operations, new and re-opened claims received by VA are more likely to increase than decrease. A caseload topping one million claims will truly be a demoralizing moment for America—the time to act is now.

Throughout the foregoing years, many promises were made in public; yet VBA staffing has essentially remained nearly flat at between 9,200 to 9,500 full-time employees (FTE)—9,287 in fiscal year 2006; 9,445 in fiscal year 2007; and 9,559 in fiscal year 2008. (The fiscal year 2008 figure does not currently take into account increased staffing levels authorized in the most recent appropriations bill for 2008.) While we do not suggest additional resources as the solitary answer to the claims backlog, the current VBA staffing levels have proven year after year to be significantly below the levels needed to halt the growth in the claims backlog, much less sufficient to begin reducing the backlog. There is no proverbial silver bullet to solving VA's challenges. Various policy changes can and should be implemented that may collectively have a positive impact on reducing VA's claims backlog, while also improving services to VA's clientele. Nonetheless, implementing any policy change will utterly fail without a significant increase in VBA staffing that is at least on parity with VA's increased receipt of new and reopened claims as well as its ever-growing claims backlog.

Based on an estimated receipt of 920,000 claims in fiscal year 2009, Congress should authorize 12,184 FTE for fiscal year 2009. That number equates to 83 cases per year per each direct program FTE. The *IB* veterans' organizations realize that 83 claims per FTE are below VA's historical projections per FTE. Nonetheless, an infusion of new personnel into VBA's workforce will inevitably result in a reduced output per FTE for a significant length of time. These newly allotted employees will be unable to process claims at rates equal to experienced employees. Additionally, senior staff within VBA will be forced to frequently halt production of their own workload in order to provide necessary training to inexperienced employees. We, nonetheless, strongly encourage the VA to provide adequate training to ensure that claims are decided properly the first time. Therefore, the reduction in workload per FTE is unavoidable.

Additionally, VBA's new claims per year continue to increase from 1 year to the next despite VA's 2008 budget assertion that such claims were going to decline. For example, VBA received 771,115 new rating claims in fiscal year 2004 and 838,141 new claims in fiscal year 2007, equaling an average increase of 16,756 additional claims per year. During this same period, VA received the following Benefits Delivery at Discharge (BDD) claims: 39,885 in fiscal year 2004; 37,832 in fiscal year

2005; 40,074 in fiscal year 2006; and 37,370 in fiscal year 2007, for a total of 155,164 new beneficiaries that had never before been on VA rolls. At this rate, the average number of new BDD claims per year is 38,791 for a total of 232,746 new claims through the BDD process by the end of fiscal year 2009. These figures do not include servicemembers filing claims through either the military's physical disability evaluation systems, or those discharging via end-of-service contracts who then come to VA on their own to file claims after discharge.

The significance of these new beneficiaries is that large portions of VA's workload increase via new claims each year are re-opened claims rather than claims from veterans who have never filed for VA benefits. Therefore, the increase in brand new beneficiaries into the system will inevitably increase further the number of re-opened claims, ultimately causing the total number of claims received by VA each year to continue growing, contrary to VA's fiscal year 2008 budget estimate. VA's 2009 budget submission reveals the VA added 277,000 beneficiaries to its C&P rolls in 2007, which further proves this point.

The complexity of the workload has also continued to grow. Veterans are claiming greater numbers of disabilities and the nature of disabilities such as Post Traumatic Stress Disorder (PTSD), complex combat injuries, diabetes and related conditions, and environmental diseases are becoming increasingly more complex. For example, the number of cases with eight or more disabilities increased 135 percent from 21,814 in 2000 to 51,260 in 2006.[1] Such complex cases will only further slow down VBA's claims process.

We believe that adequate staffing is essential to any meaningful strategy to get claims processing and backlogs under control. In its budget submission for fiscal year 2007, VBA projected its production based on an output of 109 claims per direct program FTE. We have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, resulting in compromised decisions, higher error and appeal rates, and ultimately more overload on the system. In addition to recommending staffing levels more commensurate with the workload, we have maintained that VA should invest more in training adjudicators and that it should hold them accountable for higher standards of accuracy. Nearly half of VBA adjudicators responding to survey questions from VA's Office of Inspector General admitted that many claims are decided without adequate record development. (The Board of Veterans' Appeals (Board) and the Court of Appeals for Veterans Claims' (Court's) remand rate clearly demonstrate this.) The Inspector General saw an incongruity between their objectives of making legally correct and factually substantiated decisions, with management objectives of maximizing output to meet production standards and reduce backlogs. Nearly half of those surveyed reported that it is generally, or very difficult, to meet production standards without compromising quality. Fifty-seven percent reported difficulty meeting production standards while attempting to ensure they have sufficient evidence for rating each case and thoroughly reviewing the evidence. Most attributed VA's inability to make timely and high quality decisions to insufficient staff. In addition, they indicated that adjudicator training had not been a high priority in VBA.

Therefore, we believe it prudent to recommend staffing levels based on an output of 83 cases per year for each direct program FTE. With an estimated 920,000 incoming claims in fiscal year 2009, that effort would require 11,084 direct program FTEs in fiscal year 2009. With support FTE added, this would require C&P authorization of 12,184 total FTE for fiscal year 2009.

Adjudicating veterans' claims is a labor-intensive system of personal decision-making, with lifelong consequences for disabled veterans. During Congressional hearings, VA is routinely forced to defend VBA budgets that it knows to be inadequate to the task. The priorities and goals of Congress, the Administration, and the VA must be on par with the necessity for a long-term strategy to fulfill VBA's mission and confirm the Nation's moral obligation to disabled veterans.

OVERDEVELOPMENT OF CLAIMS

Numerous developmental procedures in the VA claims' process collectively add to the enormous backlog of cases. While many of these procedures are mandatory, they are often over-utilized. This unnecessarily delays claims for months—when this occurs in, or leads to the appeals process, claims are delayed for many years. There is no single answer to solving the claims backlog. Therefore, in addition to staffing

[1] Fiscal year 2008 Budget Submission, Volume II, "National Cemetery Administration, Benefits Programs, and Departmental Administration," Benefits Summary, Department of Veterans Affairs, Pg. 6A–2 (Retrieved Feb. 2, 2008, from *http://www.va.gov/budget/summary/index.htm*).

increases, Congress and VA must attack the problem using alternative methods, particularly when those alternative methods are parallel with the intent of the law, work to save departmental resources, and protect the rights of disabled veterans.

For example, rather than making timely decisions on C&P claims when evidence development may be complete, the VA routinely continues to develop claims. These actions lend validity to many veterans' accusations that whenever VA would rather not grant a claimed benefit, VA intentionally overdevelops cases to obtain evidence against the claim. Despite these accusations, a lack of adequate training is just as likely the cause of such overdevelopment.

Such actions result in numerous appeals, followed by needless remands from the Board and/or the Court. In many of these cases, the evidence of record supports a favorable decision on the appellant's behalf yet the appeal is remanded nonetheless. These unjustified remands usually do nothing but perpetuate the hamster-wheel reputation of veterans' law. Numerous cases exemplify this scenario; a list can be provided upon request. One such example is summarized in the *IB* submission. For the sake of brevity, we will not repeat the summary here, but urge the Committee to review the example titled "Improvements in the Claims Process," which can be found in the Compensation and Pension section of the General Operating Expenses Chapter.

This example deals with VA requesting unnecessary medical opinions in cases where the claimant has already submitted one or more medical opinions that are adequate for rating purposes. VA claimants desiring to secure their own medical evidence, including a fully informed medical opinion, are entitled by law to do so. If a claimant does secure an adequate medical opinion, there is no need in practicality or in law for VA to seek its own opinion. Congress enacted title 38, United States Code (U.S.C.), section 5125 for the express purpose of eliminating the former 38 Code of Federal Regulations (CFR), section 3.157(b)(2) requirement that a private physician's medical examination report be verified by an official VA examination report prior to an award of VA benefits. Section 5125 States:

> For purposes of establishing any claim for benefits under chapter 11 or 15 of this title, a report of a medical examination administered by a private physician that is provided by a claimant in support of a claim for benefits under that chapter *may* be accepted without a requirement for confirmation by an examination by a physician employed by the Veterans Health Administration if the report is sufficiently complete to be adequate for the purpose of adjudicating such claim. [Emphasis added]

Therefore, Congress codified section 5125 to eliminate unnecessary delays in the adjudication of claims and to avoid costs associated with unnecessary medical examinations. Notwithstanding the elimination of title 38 CFR, section 3.157, and the enactment of title 38 U.S.C., section 5125, VA consistently refuses to render decisions in cases wherein the claimant secures a private medical examination and medical opinion until a VA medical examination and medical opinion are obtained. Such actions are an abuse of discretion, which delay decisions and prompt needless appeals. When claimants submit private medical evidence that is adequate for rating purposes, Congress should mandate that VA must decide the case based on such evidence rather than delaying the claim by arbitrarily and unnecessarily requesting additional medical examinations and opinions from the agency. Such enactment will preserve VA's manpower and budgetary resources; help reduce the claims backlog and prevent needless appeals; and most importantly, better serve disabled veterans and their families.

STANDARD FOR DETERMINING COMBAT VETERAN STATUS

Title 38 U.S.C., section 1154(b) requires VA to accept lay or other evidence as sufficient proof of service connection of a disease or injury if a veteran alleges that disease or injury occurred in or was aggravated during combat. While VA recognizes the receipt of certain medals as proof of combat, only a fraction of those who participate in combat receive a qualifying medal. Further, military personnel records usually do not document actual combat experiences. As a result, veterans who suffer a disease or injury resulting from combat are forced to provide evidence that may not exist or wait a year or more while the VA conducts research to determine whether a veteran's unit engaged in combat.

Congress should amend title 38 U.S.C., section 1154(b) to clarify military service as treatable service in which a member is considered to have engaged in combat for purposes of determining combat-veteran status. Such clarification would properly allow for utilization of nonofficial evidence as proof of in-service occurrence for service connection of combat-related diseases or injuries.

This type of legislation would remove a barrier to the fair adjudication of claims for disabilities incurred or aggravated by military service in combat zone. Under existing law, veterans who can establish that they "engaged in combat" are not required to produce official military records to support their claim for disabilities related to such service. This legislation would not alter the law's current requirement that a veteran confirm a disability through official diagnosis. Further, it would not alter the requirement that a veteran show a nexus between a claimed disability and military service. The only alteration from current law would be a relaxed standard of proof, consistent with Congress' original intent, required to establish a veteran as one who engaged in combat. This relaxed standard of proof would then only apply to those who serve in a combat zone.

Many veterans disabled by their service in Iraq and Afghanistan, and those who served in earlier conflicts are unable to benefit from liberalizing evidentiary requirements found in the current version of section 1154(b). This results because of difficulty, even impossibility, in proving personal participation in combat by official military documents.

Impositions put forth by VA General Counsel opinion 12–99 require veterans to establish by official military records or decorations that they "personally participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality." Oversight visits by Congressional staff to VA regional offices found claims denied under this policy because those who served in combat zones were not able to produce official military documentation of their personal participation in combat via engagement with the enemy. The only possible resolution to this problem without amending section 1154(b) is for the military to record the names and personal actions of every single soldier, sailor, airman, and Marine involved in every single event—large or small—that constitutes combat and/or engagement with the enemy on every single battlefield. Such recordkeeping is impossible.

Numerous veterans have been and continue to be harmed by this defect in the law. In numerous cases, extensive delays in claims processing occur while VA adjudicators attempt to obtain official military documents showing participation in combat: documents that may never be located.

The Senate noted in 1941, in the report on the original bill, that the absence of an official record of care or treatment in many of such cases is explained by the conditions surrounding the service of combat veterans. Congress emphasized that the establishment of records for non-combat veterans was a simple matter compared to the combat veteran—either the veteran carried on despite his disability to avoid having a record made lest he or she be separated from his or her organization or, as in many cases, the records themselves were lost. Likewise, many records are simply never generated.

Congress should clarify its intent by amending title 38, United States Code, section 1154(b), with respect to defining a veteran who engaged in combat for all purposes under title 38, as a veteran who, during active service, served in a combat zone for purposes of section 112 of the Internal Revenue Code of 1986 or a predecessor provision of law.

INFORMATION TECHNOLOGY

Mr. Chairman, in addition to boosting its staffing, we believe VBA must continue to upgrade its information technology infrastructure and revise its training tools to stay abreast of modern business practices, to maintain efficiency, and to meet increasing workload demands. With the continually changing environment in claims processing and benefits administration, anything less is a recipe for failure.

In recent years, however, Congress has actually reduced significantly the funding for such VBA initiatives. In fiscal year 2001, Congress provided $82 million for VBA initiatives. In fiscal year 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and, in 2006, $23 million, despite VBA's undeniable challenges.

With restored investments in its initiatives, VBA could complement staffing increases for higher workloads with a support infrastructure designed to increase operational effectiveness. VBA could resume an adequate pace in its development and deployment of information technology solutions, as well as upgrade and enhance training systems, to improve operations and service delivery.

COURT OF APPEALS FOR VETERANS CLAIMS

The Congressional mandate that VA claimants receive the benefit of the doubt in appropriate cases is the cornerstone of veterans' benefits derived from military service. Yet, the Court has ignored the intent of Congress by creating a judicial road-

block that completely isolates claimants from their statutory right to the benefit of the doubt.

Title 38 U.S.C., section 5107(b) grants claimants the benefit of the doubt as a matter of law with respect to any benefit under laws administered by the Secretary of Veterans Affairs (Secretary) when there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter. Yet, the Court has been affirming any BVA denial when the record contains only minimal evidence necessary to show a "plausible basis" for such finding. This renders a claimant's statutory right to the benefit of the doubt futile because claims can be denied and the denial upheld when supported by far less than a preponderance of the evidence.

Congress tried to correct this situation by amending the law with the enactment of the Veterans Benefits Improvement Act of 2002 [2] to require the Court to consider whether Board findings were consistent with the benefit-of-the-doubt rule. The intended effect of section 401 of the Veterans Benefits Act of 2002 has not been upheld by the court.[3]

Prior to the enactment of Veterans Benefits Act, the Court's case law provided (1) that the court was authorized to reverse a finding of fact when the only permissible view of the evidence of record was contrary to that found by the Board, and (2) that a finding of fact must be affirmed where there was a plausible basis in the record for the board's determination. However, Congress added new language to section 7261(b)(1) that mandates the Court to review the record before the Secretary pursuant to section 7252(b) of title 38 and "take due account of the Secretary's application of section 5107(b) of this title * * *."[4] The Secretary's obligation under section 5107(b), as referred to in section 7261(b)(1), is as follows:

> (b) BENEFIT OF THE DOUBT—The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.

Prior to enactment of Veterans Benefits Act section 401, the Court characterized the benefit-of-the-doubt rule as mandating that "when * * * the evidence is in relative equipoise, the law dictates that [the] veteran prevails" and that, conversely, a VA claimant loses only when "a fair preponderance of the evidence is against the claim."[5] Nonetheless, such characterizations have historically proven to be nothing more than meaningless rhetoric.

Reading amended sections 7261(a)(4) and 7261(b)(1) together, which must be done in order to determine the effect of the Veterans Benefits Act section 401 amendments, reveals the Court is now directed, as part of its scope-of-review responsibility under section 7261(a)(4), to undertake three actions in deciding whether adverse Board findings are clearly erroneous and, if so, what the court should hold as to that finding. The plain meaning of the amended subsections (a)(4) and (b)(1) require the Court (1) to review all evidence before the Board; (2) to consider the application of the benefit-of-the-doubt rule in view of that evidence; and (3) if after carrying out actions (1) and (2), the Court concludes that an adverse Board finding is clearly erroneous and therefore unlawful, to set it aside or reverse it.

Therefore, as the foregoing discussion illustrates, Congress intended the Veterans Benefits Act section 401 amendments to fundamentally alter the Court's review of Board decisions. This is evident by the plain meaning of the amended language and the amendment's unequivocal legislative history. Congress intended the court to take a more proactive and less deferential role in its judicial review. For example, Congress specifically intended the Court "to examine the record of proceedings—that is, the record on appeal—before the Secretary and BVA. Section 401 also provides special emphasis during the judicial process to the 'benefit of the doubt' provisions of section 5107(b) as the Court makes findings of fact in reviewing BVA decisions. The combination of these changes is intended to provide for more searching appellate review of BVA decisions, and thus give full force to the benefit-of-the-doubt pro-

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[2] Pub. L. No. 107–330, 401, 116 Stat. 2820, 2832.

[3] Section 401 of the Veterans Benefits Act, effective December 6, 2002, amended title 38, United States Code, sections 7261(a)(4) and (b)(1).

[4] *See* 38 U.S.C. §7261(b)(1).

[5] *Gilbert* v. *Derwenski*, 1 Vet.App. 49, 54–55 (1990).

vision."[6] [7] This language is consistent with the existing section 7261(c), which precludes the Court from conducting trial de novo when reviewing VA decisions—receiving evidence not part of the record before the Board.

Perhaps the most dramatic of the three court actions directed by section 401 was the mandate that the court "take due account of the Secretary's application of section 5107(b)," i.e., the "benefit-of-the-doubt rule." It is against this more relaxed standard of review that, through the Veterans Benefits Act section 401, Congress has now required the Court to review the entire record on appeal and to examine the Secretary's determination as to whether the evidence presented was in equipoise on a particular conclusion. The foregoing notwithstanding, the Court's equipoise review is no better after the Veterans Benefits Act section 401 than it was before section 401 was enacted. The Court has ignored Congress' intent.

In light of this background, the section 401 mandate supersedes the previous Court practice of upholding a factual finding unless the only permissible view of the evidence is contrary to that found by the Board. Likewise, section 401 overrules the requirement that a Board finding of fact must be affirmed where there is a "plausible basis" in the record for the determination. Yet, the nearly impenetrable "plausible basis" standard continues to prevail to this very date as if Congress never amended section 7261. The former Ranking Minority Member of this Committee, spoke in strong support of this amendment and explained that "the bill * * * clarifies the authority of the [Court] to reverse decisions of the [BVA] in appropriate cases and requires the decisions be based upon the record as a whole, taking into account the pro-veteran rule known as the benefit of the doubt."[8]

Ultimately, the Board sits in near splendid isolation to arbitrarily weigh evidence and unfairly determine its probative value. Such determinations are the lynchpin in claims for benefits by disabled veterans. Regardless of the quantity and quality of evidence in favor of a claimant's case, a Board's conclusion that an infinitesimal amount of unfavorable evidence, however much lacking in quality, outweighs and is more probative than an immeasurable amount of high-quality evidence is practically untouchable by the Court. Worse yet, it is the Court's own doing. Essentially, when the Board renders this type of decision that turns on the weighing of such evidence, the Court is precluded from even considering the benefit-of-the-doubt rule. Evidence must first be in equipoise, or balance, for the benefit-of-the-doubt to apply. As soon as the Board finds the slightest plausible basis that a claimant's evidence preponderates against the claim, the favorable and unfavorable evidence is no longer in balance. Unless the Court finds such a ruling to be clearly erroneous—meaning there is no plausible basis regardless of how trivial such basis may be—the Court cannot overturn the ruling. Consequently, if the Court cannot overturn the ruling, it can never reach a review of the Board's application of the benefit of the doubt. The Court has therefore created a barrier between itself and a VA claimant's statutory right to the benefit of the doubt—a barrier moveable only by Congress.

Congress should not allow any Federal court to ignore its legislative power, particularly one charged with the protection of rights afforded our Nation's disabled veterans and their families. To ensure the Court enforces the benefit-of-the-doubt rule, Congress should replace the clearly erroneous standard with a requirement that the court will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

SOLVING THE COURT'S BACKLOG

The Board and the Court add substantially to the claims backlog by needlessly and frequently remanding numerous cases on appeal. In many of these appeals, the evidence of record fully supports a favorable decision on the appellant's behalf, yet the appeal is remanded nonetheless. These unjustified remands deprive the appellant, usually for many additional years, of benefits awardable based on facts already of record.

The greatest challenge facing the Court is identical to the VA—the backlog of cases. The Court has shown a reluctance to reverse errors committed by the Board. Rather than addressing an allegation of error raised by an appellant, the Court has a propensity to vacate and remand cases to the Board based on an allegation of error made by the VA's counsel for the first time on appeal, such as an inadequate Statement of reasons or bases in a Board decision. Another example occurs when

[6] 148 CONG. REC. S11334 (remarks of Sen. Rockefeller).

[7] 148 CONG. REC. S11337, H9003 (daily ed. Nov. 18, 2002) (explanatory Statement printed in Congressional Record as part of debate in each body immediately prior to final passage of compromise agreement).

[8] 148 CONG. REC. H9003.

the VA argues, again for the first time on appeal, for remand by the Court because VA failed in its duty to assist the claimant in developing the claim notwithstanding an express finding by the Board that all development is complete and where the appellant accepts, and does not challenge such finding by the Board. Such actions are particularly noteworthy because the VA has no legal authority to appeal a Board decision to the Court.[9]

Consequently, the Court will generally decline to review alleged errors raised by an appellant that actually serve as the basis of the appeal. Instead, the court remands the remaining alleged errors on the basis that an appellant is free to present those errors to the Board even though an appellant may have already done so, leading to the possibility of the Board repeating the same mistakes on remand that it had previously. Such remands leave errors properly raised to the Court unresolved; reopen the appeal to unnecessary development and further delay; overburden an already backlogged system; exemplify far too restrictive judicial restraint; and inevitably require an appellant to invest many more months and perhaps years of his or her life in order to receive a decision that the court should have rendered on initial appeal. As a result, an unnecessarily high number of cases are appealed to the Court for the second, third, or fourth time.

In addition to postponing decisions and prolonging the appeal process, the Court's reluctance to reverse Board decisions provides an incentive for VA to avoid admitting error and settling appeals before they reach the Court. By merely ignoring arguments concerning legal errors rather than resolving them at the earliest stage in the process, VA contributes to the backlog by allowing a greater number of cases to go before the Court. If the Court would reverse decisions more frequently, VA would be discouraged from standing firm on decisions that are likely to be overturned or settled late in the process.

To remedy this unacceptable situation, Congress should amend title 38 U.S.C., section 7261 to require the Court on a de novo basis to: (1) decide all relevant questions of law; (2) interpret constitutional, statutory, and regulatory provisions; and (3) determine the meaning or applicability of the terms of an action of the Secretary. The Court's jurisdiction should also be amended to require it to decide all assignments of error properly presented by an appellant.

GENERAL

The benefit programs are effective for their intended purposes only to the extent VBA can deliver benefits to entitled veterans and dependents in a timely fashion. However, in addition to ensuring that VBA has the resources necessary to 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. We invite your attention to the *IB* itself for the details of those issues, but the following summarizes a number of recommendations to adjust rates and improve the benefit programs administered by VBA:

- cost-of-living adjustments for compensation, specially adapted housing grants, and automobile grants, with provisions for automatic annual increases in the housing and automobile grants based on increases in the cost of living;
- a presumption of service connection for hearing loss and tinnitus for combat veterans and veterans who had military duties involving high levels of noise exposure who suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma;
- removal of the provision that makes persons who first entered service before June 30, 1985, ineligible for the Montgomery GI Bill, along with other improvements to the program;
- no increase in, and eventual repeal of, funding fees for VA home loan guaranty;
- increase in the maximum coverage and adjustment of the premium rates for Service-Disabled Veterans' Life Insurance;
- increase in the maximum coverage available in policies of Veterans' Mortgage Life Insurance;
- legislation to restore protections for veterans' benefits against awards to third parties in divorce actions; and
- legislation to increase Dependency and Indemnity Compensation for certain survivors of veterans, and to no longer offset DIC with Survivor Benefit Plan payments.

We hope the Committee will review these recommendations and give them consideration for inclusion in your legislative plans and will support their funding in the

[9] 38 U.S.C.A., § 7252(a) (West 2002) ("The Court of Appeals for Veterans Claim shall have exclusive jurisdiction to review decisions of the Board of Veterans' Appeals. The Secretary may not seek review of any such decision.")

Congressional Budget Resolution for fiscal year 2009, as well as subsequent appropriations.

Mr. Chairman, thank you for inviting DAV and other member organizations of the *Independent Budget* to testify before you today.

Chairman AKAKA. Thank you very much, Mr. Baker.

Mr. Kelley.

STATEMENT OF RAYMOND C. KELLEY, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

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

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

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

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

In contrast, the Independent Budget recommends Congress provide $251.9 million for the operational requirements of NCA, a figure that includes $50 million toward the national shrine initiative.

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

The national cemetery system continues to be seriously challenged. Adequate resources and developed acreage must keep pace with the increased workload.

Currently, there are 13 national cemeteries in some phase of development or expansion. The Administration's budget provides funding for only three of these projects, while NCA expects to perform nearly 115,000 internments in 2009, an 8.7 percent increase over the current year.

Congress must also address the need for gravesite renovation and upkeep. Although there has been no orderly progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. To date, $99 million has been invested in restoring the appearance of our national cemeteries, completing nearly 300 of the 928 deficiencies identified in the 2002 study on improvements of veterans cemeteries.

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

The State Cemetery Grant Program is an important component of NCA. It greatly assists States increasing the burial services to veterans especially those living in areas where national cemeteries are under served.

NCA admits only 80 percent of those requesting interment meet the 170,000 veterans within 75 miles radius threshold the NCA has set for itself. This re-emphasizes the importance of the State grants program.

Since 1978 the VA has more than doubled the acreage available to accommodate more than a 100 percent increase in burials through these grants. In this year, States have indicated they plan on establishing 14 new cemeteries over the next 4 years. Therefore, to provide for these cemeteries and to reach NCA's threshold goals, the Independent Budget requests $42 million for the State Cemetery Grant Program in fiscal year 2009.

Also, the Independent Budget strongly recommends Congress to review the current burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full cost of burial, they now pay for just 6 percent of what they covered when the program was started in 1973.

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

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

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

[The prepared statement of Mr. Kelley follows:]

PREPARED STATEMENT OF RAYMOND C. KELLEY,
NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Chairman Akaka, Ranking Member Burr, and members of the Committee: AMVETS is honored to join our fellow veterans service organizations and partners at this important hearing on the Department of Veterans Affairs budget request for fiscal year 2009. My name is Raymond C. Kelley, National Legislative Director of AMVETS, and I am pleased to provide you with our best estimates on the resources necessary to carry out a responsible budget for VA.

AMVETS testifies before you as a co-author of *The Independent Budget*. This is the 22nd year AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars have pooled our resources to produce a unique document, one that has stood the test of time.

In developing the *Independent Budget*, we believe in certain guiding principles. Veterans should not have to wait for benefits to which they are entitled. Veterans must be ensured access to high-quality medical care. Specialized care must remain the focus of VA. Veterans must be guaranteed timely access to the full continuum of health care services, including long-term care. And, veterans must be assured accessible burial in a State or national cemetery in every State.

The VA health care system is the best in the country and responsible for great advances in medical science. VHA is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected ailments. The delivery care system provides a wide array of specialized services to veterans like those with spinal cord injuries, blindness, Traumatic Brain Injury, and Post Traumatic Stress Disorder.

Looking at the numbers alone, the VA budget would appear to be one that would garner only praise and be a model for years to come. However, the budget was signed into law 5 months after the start of the new fiscal year, marking the 13th time in 14 years the VA had to work from continuing resolutions to maintain the system. Also, the budget was contingent on $3.7 billion in emergency funding that

was signed into law less than 1 month ago. This is an unacceptable way of funding a department that is as fluid in nature as the VA.

Mr. Chairman, as you know, we strongly support mandatory funding for VA health care. However, if the Congress cannot support mandatory funding, there are alternatives which could meet our goals of timely, sufficient, and predictable funding.

Congress could change VA's medical care appropriation to an advance appropriation which would provide approval 1 year in advance, thereby guaranteeing its timeliness. Furthermore, by adding transparency to VA's health care enrollee projection model, we can focus the debate on the most actuarially sound projection of veterans health care costs to ensure sufficiency.

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

We ask this Committee in your views and estimates to recommend to the Budget Committee either mandatory funding or this new advance appropriations approach to take the politics out of health care for all of our Nation's wounded, sick and disabled veterans.

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

THE NATIONAL CEMETERY ADMINISTRATION

The Independent Budget acknowledges the dedicated and committed NCA staff who continue to provide the highest quality of service to veterans and their families despite funding shortfalls, aging equipment, and increasing workload. The devoted staff provides aid and comfort to grieving veterans' families in a very difficult time, and we thank them for their consolation.

The NCA currently maintains more than 2.8 million gravesites at 131 national cemeteries in 39 States and Puerto Rico. VA estimates that about 24 million veterans are alive today. They include veterans from World War I through the Global War on Terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from more than 105,000 in 2008 to 115,000 in 2009.

The NCA is responsible for five primary missions: (1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, State, or private cemeteries upon appropriate application; (3) to administer the State grant program in the establishment, expansion, or improvement of State veterans cemeteries; (4) to award a Presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

NCA BUDGET REQUEST

The administration requests $181 million for the NCA for fiscal year 2009. The members of *The Independent Budget* recommend that Congress provide $252 million and 51 additional FTE for continuing operations and workload increases of NCA. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the U.S. Armed Forces.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the Nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

In accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress to fully fund the National Shrine Initiative by providing $50 million in fiscal year 2009 budget and a commitment of $250 million over a period of 5 years to restore and improve the condition and character of NCA cemeteries.

It should be noted that the NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but critical under funding does not

allow NCA to remove the backlog of improvements that need to be met. To date, NCA has invested $99 million to the initiative, making nearly 300 improvements. Additionally, $28.2 million will be invested in restoration in 2008. This money is the full amount of supplemental funding that was given to NCA in fiscal year 2008, a fact that should be a wake-up call of the importance of the National Shrine Initiative. Even with the funding that has been spent on these improvements, new areas requiring restoration are identified. By enacting a 5-year program with dedicated funds and an ambitious schedule, the national cemetery system can provide veterans and their families with the utmost dignity, respect, and compassion.

THE STATE CEMETERY GRANTS PROGRAM

The State Cemetery Grants Program (SCGP) complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist States in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials through this program.

To help provide reasonable access to burial options for veterans and their eligible family members, *The Independent Budget* recommends $42 million for the SCGP for fiscal year 2009. The availability of this funding will help States establish, expand, and improve State-owned veterans' cemeteries.

States have intentions of beginning construction of 24 new State cemeteries in 2008. Many States have difficulties meeting the requirements needed to build a national cemetery in their respective State. The large land areas and spread out population in these areas make it difficult to meet the "170,000 veterans within 75 miles" national veterans cemetery requirement. Recognizing these challenges, VA has implemented several incentives to assist States in establishing a veterans cemetery. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration.

BURIAL BENEFITS

There has been serious erosion in the value of the burial allowance benefits over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a small fraction of what they covered in 1973, when the Federal Government first started paying burial benefits for our veterans.

In 2001 the plot allowance was increased for the first time in more than 28 years, from $150 to $300, which covers approximately 6 percent of funeral costs. *The Independent Budget* recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973.

In the 108th Congress, the burial allowance for service-connected deaths was increased from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. *The Independent Budget* recommends increasing the service-connected burial benefit from $2,000 to $4,100, bringing it back up to its original proportionate level of burial costs.

The non-service-connected burial allowance was last adjusted in 1978, and also covers just six 6 percent of funeral costs. *The Independent Budget* recommends increasing the non-service-connected burial benefit from $300 to $1,270.

The NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 2.8 million soldiers who died in every war and conflict are honored by burial in a VA national cemetery. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans; they are hallowed ground to those who died in our defense, and a memorial to those who survived.

Mr. Chairman, this concludes my testimony. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Chairman AKAKA. Thank you very much, Mr. Kelley.

Mr. Needham.

STATEMENT OF CHRISTOPHER NEEDHAM, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. NEEDHAM. Chairman Akaka, Ranking Member Burr and Members of the Committee.

On behalf of the members of the Veterans of Foreign Wars, I would like to thank you for the opportunity to testify today. As a co-author of the Independent Budget, the VFW is primarily responsible for the construction section, so I will limit my remarks to that area.

The President's request for construction funding will not meet the needs of America's veterans. As part of its budget submission, the VA has provided hundreds of pages of construction priorities that require millions of dollars of investment. Despite this, the Administration has essentially halved the major and minor construction budgets. We look to you in Congress, as you have done in the past, to increase the construction budget and live up to the needs of our veterans.

With respect to the major construction account, the Administration has requested $582 million, far below the $1.1 billion appropriated this year. This is also far behind the $1.275 billion called for by the Independent Budget.

Further, the Administration is proposing just $476 million for hospital construction, less than half of the $1.1 billion recommended by the IB.

We appreciate that the Administration's request covers eight medical facilities including three completely new projects, two of those would expand VA's polytrauma efforts. We believe, however, that VA can and must do more.

The funding provided for these eight projects is tiny compared to their total cost. If this budget is enacted, VA will have a construction backlog of $2 billion in projects. At the pace of the Administration's request, it would take five fiscal years for these projects to be fully funded and even more for construction to be completed.

We need to move forward to keep up with the promise of CARES. Former VA Secretary Anthony Principi testified before the House that CARES would require $1 billion a year for 5 years. Since that time, total CARES funding is about $3 billion when you discount emergency hurricane repairs.

Clearly, more needs to be done and we urge action to live up to the Secretary's words. You must make a steady investment in VA's capital infrastructure to bring the system up to date with the 21st century needs of veterans.

Turning to minor construction, VA's request is just $329 million which is about $300 million less than the current year's funding level. The IB has recommended $621 million with the majority of that going to VHA construction and renovation. For VHA, the Administration's request is just $273 million. This will not meet the needs laid out in their budget documentation.

For fiscal year 2009 VA, in its capital plan, lists 145 construction projects. Although VA does not provide cost estimates for these, the fiscal year 2008 cost per project was over $5 million per project. Simple multiplication shows that VA's minor construction budget is

not sufficient, and for the sake of argument even if you halve the cost per project, it still would not meet the needs.

Fully funding minor construction is important because it plays a key role in the maintenance of VA's facilities. VA says that 30 percent of all minor construction funding is used to offset the deficiencies of the facilities condition assessments or FCAs.

In fiscal year 2007 VA estimated that there was a $5 billion backlog in FCA maintenance. Although Congress has targeted funding for these essential projects, most of the backlog remains. The main way in which VA clears the backlog is through non-recurring maintenance or NRM. To that end, we were pleased to see the $802 million request for NRM. This is in line with what The IB has called for in the past.

Industry standard is for a medical facility to spend between 2 and 4 percent of its plant replacement value on NRM funding. In VA's case this corresponds with $800 million to $1.6 billion, an amount VA agrees with and is included in their asset management plan.

While we were pleased with the request, given the $5 billion backlog in maintenance, it represents the low end of what VA needs. Accordingly, we would like Congress to increase funding, again as you have in the past, to reduce this backlog and ensure that VA delivers health care in clean, safe and well maintained environments.

Mr. Chairman, this concludes my testimony and I would be happy to answer any questions you or the members may have.

[The prepared statement of Mr. Needham follows:]

PREPARED STATEMENT OF CHRISTOPHER NEEDHAM, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of this Committee: On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today. The VFW works alongside the other members of the *Independent Budget* (*IB*)—AMVETS, Disabled American Veterans and Paralyzed Veterans of America—to produce a set of policy and budget recommendations that reflect what we believe would meet the needs of America's veterans. The VFW is responsible for the construction portion of the *IB*, so I will limit my remarks to that portion of the budget.

The administration's fiscal year 2009 budget request for major and minor construction is woefully inadequate, especially in light of the administration's own supporting documents. Despite hundreds of pages of budgetary documents that show a need for millions of dollars in construction projects, the administration saw fit to halve the major and minor construction accounts from the fiscal year 2008 levels, failing to meet the future needs of our veterans. We look to you in Congress to correct this, and to advance VA's construction priorities so that future generations of veterans—those currently serving in the deserts of Iraq and the mountains of Afghanistan—can have a first-rate VA health care system that lives up to their needs.

MAJOR CONSTRUCTION

The President's request for major construction is a paltry $581.6 million for fiscal year 2009. This is a dramatic cut from last year's funding level of $1.1 billion. While we appreciate that this level covers eight medical facility projects, including three new previously unfunded projects, the total level of funding does not come close to meeting the *IB*'s recommendation of $1.275 billion in construction projects. $476.6 million of the administration's request covers Veterans Health Administration projects, significantly lower than the $1.1 billion that the *IB* has called for.

In determining our recommendations, we follow VA's prioritization process as VA discusses in its annual 5-Year Capital Plan, which is included in Volume III of the Department's budget submission.

VA determines its budget year priorities in two phases. First, partially funded projects from previous years are ordered by fiscal year and priority order. Second, newly evaluated projects from the current budget year are listed in priority order. These are combined, with the first category receiving priority over the second.

For the current year's process, VA had seven partially unfunded projects at the top of the list and chose to provide funding for five of those projects. They also began to provide funding for the top three new projects as ranked in the current fiscal year: Bay Pines, FL; Tampa, FL; and Palo Alto, CA. We certainly appreciate the progress on new construction projects as last year's funding request did not call for any new projects. We also appreciate the focus on construction and improvements to VA's polytrauma centers. We believe, however, that more can and must be done.

While the eight major construction projects might sound like a lot, the funding levels recommended for them are a tiny blip in the overall costs of those projects. If we look at just the partially unfunded projects—the backlog, if you will—even the $320 million aimed at them barely scratches the surface. Only the Lee County, FL, outpatient clinic is funded to completion. The other four projects still require a total future funding level of $1.26 billion. The funding for the three new projects totals $76.8 million out of a total construction estimate of $771 million. This is important because it means that there will be a total construction backlog of over $2 billion when the administration prepares its request for the following fiscal year. It is increasingly unlikely that the top priority construction projects—likely to include this year's number 4 priority project in Seattle, WA, or improvements in Dallas, TX, or Louisville, KY—will be funded in future years while VA's meager construction budget is earmarked only to prior projects, as was the case with last year's funding request.

I would refer you to the table on Page 7–12 of VA's 5-Year Capital Plan for the full list of projects VA considered funding in the current year. The increase in funding that we are calling for could be applied to those prior year projects we referred to previously, or to the fiscal year 2009 scored projects. Both categories desperately need funding beyond the administration's request. Even an increase of about $31 million would allow VA to begin the first stages of construction on priority projects 4–6, which typically requires 10 percent of the total cost estimate.

These projects are necessary to ensure that VA properly reinvests in its aging physical infrastructure. VA's facilities average over fifty years old, and VA has historically recapitalized at a rate far below hospital industry standards. From 1996–2001, for example, VA recapitalized at a rate of just 0.64 percent per year. This corresponds with an assumed building life of 155 years, far beyond any reasonable expectations. VA has made progress since then, but more clearly must be done, especially if we are to live up to the promise of CARES and modernize the system so that veterans now and into the future will have first-rate health care in clean, safe, modern and comfortable facilities.

We remain concerned about the unfulfilled promise of CARES. Upon completion of the CARES decision document, former VA Secretary, Anthony Principi, testified before the Health Subcommittee of the House Committee on Veterans' Affairs in July 2004. His testimony noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care."

According to VA's November 2007 testimony before that same Committee, Congress has appropriated just $2.83 billion for CARES projects, far below the need to which the Secretary had testified. Further, this includes a sizable amount for rebuilding facilities after the Gulf Coast Hurricanes—amounts we have argued that Congress should have provided as separate emergency funding, outside of VA's regular planning process. With the fiscal year 2008 appropriation, the total is up to $3.9 billion—better, but still lagging.

With just $581 million requested for major construction in fiscal year 2009, which is far below VA's demonstrated needs, it is clear that VA is falling short. After that 5-year de facto moratorium on construction while CARES was ongoing and without additional funding coming forth, VA and veterans have an even greater need than they did at the start of the CARES process. Accordingly, we urge action to live up to the Secretary's words by making a steady investment in VA's capital infrastructure to bring the system up to date with the 21st century needs of veterans.

MINOR CONSTRUCTION

We also are greatly concerned with the administration's proposed slashing of the minor construction budget. As with the major construction account, this cut is contrary to the information the Department provides in the total budget document. For

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

$273 million of the request is targeted for VHA facilities and $18 million—about 5 percent of the total—is allocated for staff offices to accommodate the consolidation of VA's information technology programs.

VA has a long list of minor construction projects targeted for fiscal year 2009. There is a list of 145 minor construction projects listed on page 7–95 of the 5-Year Capital Plan. Although there is no cost specifically associated with them, we can estimate the cost using the average cost of the scored projects from fiscal year 2008, which can be found on page 7–90. For the fiscal year 2008 projects listed, the average price per project is $5.6 million. If you multiply that cost per project by the 145 proposed fiscal year 2009 projects, VHA would require a budget of $812 million, nearly $500 million more than they have actually requested. We understand that VA has some carryover funding for minor construction to offset some of that balance, but even if all $267 million of that were applied to this list of projects, VHA would still require $545 million in funding instead of the $273 the administration has requested.

The minor construction request seems even more deficient when you factor in its role with respect to the maintenance of VA's facilities. Every medical center is surveyed at least once every 3 years and given a thorough assessment of all component systems. These reviews comprise the Facility Condition Assessment (FCA), and the scores are used, in part, to produce the condition index of the facility, one of the benchmark statistics in VA's Real Property Scorecard. The majority of funding for projects and systems found to be deficient through the FCA is nonrecurring maintenance (NRM), but VA says that 30 percent of all minor construction is targeted to correct documented FCA deficiencies. In fiscal year 2007, VA notes that its FCA backlog was well over $5 billion in projects. Congress has done a good job to improve some of these deficiencies—notably the $550 supplemental that was targeted toward FCA problems—but more must be done if VA is going to properly maintain its facilities.

NONRECURRING MAINTENANCE

Those FCA reviews show the importance of nonrecurring maintenance (NRM), and the $5 billion backlog shows how woefully deficient past NRM requests and appropriations have been. It is sad that it took the unconscionable situation at Walter Reed—a non-VA facility—to demonstrate the importance of the account. We certainly applaud VA's efforts post-Walter Reed to assess the maintenance of its infrastructure and Congress' immediate response, but it should not have come to that. The problems with the lack of NRM funding have been repeatedly pointed out in the *Independent Budget*, and we continue to ask Congress and the administration to do more.

For fiscal year 2009, we are pleased to see that the President has requested $802 million for NRM funding. This is in line with what the *IB* has called for in the past. For justification of our number, we continue to cite the Price Waterhouse review of VA's facility management programs that cited industry standards to claim that VA should be spending between 2 and 4 percent of its plant replacement value on NRM. VA accepted this recommendation and adopted it as part of its Asset Management Plan. That VA document noted that VA's plant replacement value was approximately $40 billion, and accordingly, the NRM budget should be between $800 million and $1.6 billion.

With the near-$5 billion backlog in FCA-observed maintenance needs, the proposed $802 million is surely on the low end. That amount would allow VA to perform maintenance at current levels, but not to dip into the backlog. Accordingly, we would like Congress to increase funding for this account, as has been done in the past. We need to eliminate the backlog to ensure that veterans have health care in clean, safe, and efficient locations, and that VA properly cares for its infrastructure to ensure that it lasts for years into the future.

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

Chairman AKAKA. Thank you very much, Mr. Needham.

Mr. Gaytan.

STATEMENT OF PETER S. GAYTAN, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION

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

Last September, the National Commander, Marty Conatser, presented the American Legion's budget recommendations for the Department of Veterans Affairs in fiscal year 2009.

Since our complete written testimony is submitted for the record, I will only address a few key concerns with the President's budget requests.

Also, on behalf of the American Legion, I thank you and your colleagues for the fiscal year 2007 and fiscal year 2008 VA budgets last session.

The initial fiscal year 2008 budget agreed to by both bodies met or exceeded the recommendations of the American Legion and we appreciate the hard work of this Committee. Approval of the emergency funding provided in Pubic Law 110–161 was also a welcome addition to the VA budget.

While the fiscal year 2009 VA budget request does, indeed, raise health care funding slightly, it does not appear that this request takes into consideration several critical factors that will impact the actual value of the fiscal year 2009 VA budget, such as the normal rate of inflation, the recent downturn in the economy and increased unemployment, the successful surge of troops in Iraq and their pending re-deployments, the extension of health care for returning OIF and OEF veterans from two to 5 years, and the increased medical research and treatment needed on Traumatic Brain Injury and Post Traumatic Stress Disorder.

The American Legion does not believe that now is the time to cut funding for medical and prosthetic research. The American Legion believes each of these factors will increase demand for services within VA and will strain an already overburdened system.

The veterans' community is all too familiar with the adverse impact and miscalculations in usage of VA services. We continue to urge Congress to provide medical care funding that is timely, predictable and sufficient each year. The American Legion looks forward to working with you and your colleagues to achieve this goal.

Additionally, the American Legion is very concerned with the unfunded major construction projects identified in the CARES final report. These locations have been identified as priority construction projects that will allow VA to fulfill its mission of providing quality health care to America's veterans and they must be funded at a level that will allow them to achieve that goal.

The American Legion adamantly opposes 2009 policy proposals contained in the fiscal year 2009 budget submission that seek to impose an annual enrollment fee and practically double the current co-payment for pharmaceuticals.

The American Legion has opposed these proposals in the past and we once again call on the Members of this Committee to join us in defeating any proposal that seeks to balance the VA budget on the backs of America's veterans.

Mr. Chairman, that concludes my remarks and I am available for any questions you may have.

[The prepared statement of Mr. Gaytan follows:]

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

Mr. Chairman and Members of the Committee: The American Legion would like to begin this hearing by expressing our gratitude to you and your colleagues for your work on the fiscal year 2008 budget for the Department of Veterans Affairs (VA). From the very beginning of the 110th Congress, there was a great deal of fiscal work to be accomplished. In essence, you and your colleagues had to put together two VA appropriations budgets during the First Session.

The American Legion supported the Budget Resolution for the first time in many, many years. The American Legion supported the original version of the Military Construction, Veterans' Affairs, and Related Appropriations for fiscal year 2008, passed overwhelmingly with bipartisan support in both chambers; however, we were also very pleased when President Bush requested the additional $3.7 billion provided in Public Law 110–161. Needless to say, last year was an unusual appropriations cycle.

The veterans' community continues to request an annual VA appropriation that is timely, predictable, and sufficient to meet the growing demands on VA. Every VA program is specifically designed to address the various needs of America's veterans and their families. Some programs date back to past proprieties of an earlier era of veterans such as the greatest piece of social legislation ever enacted, the Servicemen's Readjustment Act of 1944 (the GI Bill of Rights). Newer areas of concern include improved diagnosis and treatment of Traumatic Brain Injury. Some programs are individual entitlements that are funded through mandatory appropriations, while the balance are subject to the annual discretionary appropriations battle in Congress. But all represent the thanks of a grateful Nation.

The American Legion does not support the 2009 policy proposals contained in the fiscal year 2009 Budget submission that seek to impose an annual enrollment fee and practically double the current co-payment for pharmaceuticals. The American Legion has opposed these proposals in the past and we once again call on the Members of this Committee to join us in defeating any proposal that seeks to balance the VA Budget on the backs of America's veterans.

Mr. Chairman, The American Legion welcomes the opportunity to present recommendations on the fiscal year 2009 VA appropriations and other appropriations that fall under the jurisdiction of this Committee. The American Legion appreciates the efforts of the Secretary of Veterans Affairs and his capable leadership staff to produce a budget request that reflects the fiscal needs of VA to provide timely access to the earned benefits provided to those who served in the Armed Forces of the United States. In a Nation of over 300 million citizens and a host of visitors, only 24 million veterans have accepted the challenge of military service. Some veterans were placed in harm's way, but all accepted the oath of enlistment. All were prepared to give "the last full measure of devotion."

Last September, The American Legion National Commander Marty Conatser testified before you and your colleagues to outline budget recommendations for fiscal year 2009 and address some legislative concerns as well. To briefly recap, here is a table that reflects the final VA appropriations for fiscal year 2008, The American Legion's budget request for fiscal year 2009, and the President's budget request for fiscal year 2009:

Discretionary Funding Programs	Final Fiscal Year 2008 Pub. L. 110–161	Legion's Request Fiscal Year 2009	President's Request Fiscal Year 2009
Medical Services	$29.1 billion	.....	
Medical Administration	$3.2 billion	.....	$34 billion
Medical Facilities	$4.1 billion	.....	$4.6 billion
Total Medical Care	$36.7 billion	$38.4 billion	$38.7 billion
Medical/Prosthetics Research	$480 million	$476 million	$442 million
Major Construction	$1.1 billion	$560 million	$582 million
Minor Construction	$579 million	$485 million	$329 million
CARES	.....	$1 billion	.....

Discretionary Funding Programs	Final Fiscal Year 2008 Pub. L. 110–161	Legion's Request Fiscal Year 2009	President's Request Fiscal Year 2009
State Extended Care Facilities Grants Program	$165 million	$275 million	$85 million
State Veterans' Cemetery Construction Grants Program	$39 million	$45 million	$32 million
National Cemetery Administration	$195 million	$228 million	$181 million
General Operating Expenses	$1.6 billion	$2.8 billion	$1.7 billion
Information Technology	$2 billion	$2.3 billion	$2.4 billion

VETERANS AFFAIRS AND REHABILITATION

The American Legion breaks down its Veterans Affairs and Rehabilitation testimony into three sections that mirror the major organizational segments of the Department of Veterans Affairs (VA). In these separate sections The American Legion will discuss our legislative budget priorities regarding the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA).

Veterans Health Administration

The distinction of the VA as the Nation's leader in providing safe, high-quality health care in the health care industry (both public and private), has been recognized by several reputable sources:

• The medical journal *Neurology* commented, "The VA has achieved remarkable improvements in patient care and health outcomes, and is a cost-effective and efficient organization" (2007).

• Harvard University's Kennedy School of Government presented VA with the highly coveted "Innovations in American Government" for its advanced electronic health records and performance measurement system (2006).

• The *Journal of the American Medical Association* (JAMA) noted VA's 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" (2005).

• The recent book by Phillip Longman entitled "Best Care Anywhere: Why VA Health Care is Better Than Yours" (2007).

Veterans' Health Care Benefit Enrollment Discrimination

All veterans eligible to receive benefits from VA should have access to the VA health care system. The American Legion opposes any enrollment policy that disallows any eligible veteran, who was prepared to give his or her life for this country, access to what is often described as the best health care in the Nation. Honorable military service, whether for a single enlistment period or for a 30-year career, is not merely another period of employment in an individual's personal history. It is a defining portion of one's life.

Maintaining the quality of care that VA is currently known for should be a national priority. But that quality of care is being denied to an ever-increasing number of America's veterans. Fiscal year 2009 budget request continues the suspension of enrollment of new Priority Group 8 veterans due to the increased demands for services. According to VA, the number of Priority Group 8 veterans denied enrollment in the VA health care system at the end of fiscal year 2007 was 386,767. The American Legion believes this number is significantly higher because it does not include those veterans who have not attempted to use the VA because they are aware of the suspension. Given the recruiting and retention problems the Armed Forces face, it is clear that denying earned benefits to eligible veterans does not solve the problems created by an inadequate Federal budget.

As the Global War on Terrorism wages on, fiscal resources for VA will continue to be stretched and this Nation's veterans will continue to beg elected officials for monies to sustain a viable VA. A viable VA is one that cares for all veterans, not just the most severely wounded. More importantly, VA is often the first experience veterans have with the Federal Government after leaving military service. This Nation's veterans have never let this country down; it is time for Congress to do its best not to let them down.

All veterans, who are eligible to receive benefits from VA, should have timely access to the VA health care system. Honorable military service is evidence of an individual's commitment to this Nation. In return for honorable military service, the thanks of a grateful nation should not simply be a conditional benefit that can easily

be restricted or denied by political or bureaucratic whim, but should be regarded as an earned right in recognition for faithful service to this country.

Quality, timely and accessible VA health care is the ongoing cost of war. It is unconscionable to send the young men and women in the Armed Forces to every corner of the globe and then limit the funding to take care of their injuries suffered in service to this country. VA was created to take care of the unique needs of a very specific population, those veterans that wore the uniforms of the Armed Forces. Once those uniforms are off, these veterans should be able to depend upon the VA health care system for their health care needs—regardless of the type or severity of their injuries. Many veterans will need health care for the rest of their lives. The American Legion expects the VA health care system to ensure and provide the very best health care for this Nation's heroes. The American Legion strongly supports the reinstatement of enrollment for Priority Group 8 veterans.

Mandatory Funding of VA Medical Care

The American Legion believes the time for mandatory funding for veterans' health care is now. Congress should act to ensure that we, as a Nation, will always provide the funding necessary to ensure veterans, who seek timely access to quality health care through the VA health care delivery system, are provided the health care they earned.

A new generation of young Americans is now deployed around the world, answering the Nation's call to arms. Like so many brave men and women who honorably served before them, these new veterans are fighting for freedom, liberty and security of us all. Also like those who served before them, today's veterans deserve the respect of a grateful nation when they return home.

Previous generations of wartime veterans were welcomed at VA medical facilities until the 1980's. Unfortunately, without urgent changes in health care funding, these new veterans will soon discover their battles are not yet over. This Nation's newest heroes will be fighting for the life of the VA health care system. Just as the veterans of the 20th century did, they will be forced to fight for the care they are eligible to receive.

The American Legion believes that the Veterans Health Administration's (VHA) recurring fiscal difficulties will only be solved when its funding becomes a mandatory appropriation item. As a mandatory appropriation, law would guarantee VA health care funding for all eligible enrollees—and it will be a patient-based, rather than a budget-driven, annual appropriation.

The American Legion continues to support legislation that establishes a system of capitation-based funding for VHA. This new funding system would provide all of VHA's funding, except that of the State Extended Care Facilities Construction Grant Program which would be separately authorized and funded as a discretionary appropriation.

Although VHA continues to struggle to maintain its global preeminence with a 21st Century integrated health care delivery system, it is handicapped by funding methods that were developed in the 19th Century for a now antiquated inpatient delivery system. No modern health care organization can be expected to survive with such an inconsistent and inadequate budget process. The American Legion's position on VA health care funding is that health care rationing for veterans must end. It is time to guarantee health care funding for all veterans seeking VA health care.

Third-Party Reimbursements

The Balanced Budget Act of 1997, Pub. L. 105–33, established the VA Medical Care Collections Fund (MCCF). The law requires that money collected or recovered from third-party payers after June 30, 1997, be deposited into this fund. The MCCF is a depository for collections from third-party insurance, outpatient prescription co-payments and other medical charges and user fees. The funds collected may be used to provide VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Federal Government.

The American Legion supported legislation to allow VA to bill, collect and reinvest third-party reimbursements and co-payments. However, The American Legion has adamantly opposed the scoring of MCCF as an offset to annual discretionary appropriations because almost all of these funds derive from the treatment of non-service-connected medical conditions. Historically, these collection goals far exceed VA's ability to collect accounts receivable.

Once again, the President's budget request for fiscal year 2009 raises the bar on MCCF from $2.3 billion to $2.5 billion. VA's ability to capture these funds is critical to its ability to provide quality and timely health care to veterans. Miscalculations of VA required funding levels results in real budgetary shortfalls. Seeking an an-

nual emergency supplemental appropriation is not the most cost-effective means of funding the Nation's model health care delivery system.

Government Accountability Office (GAO) reports have described the continuing problems in VHA's ability to capture insurance data in a timely and accurate manner and have raised concerns about VHA's ability to maximize its third-party collections. GAO visited three VA medical centers and found the following concerns: VA lacked the ability to verify insurance; VA could not accept partial payment as full payment; VA had inconsistent compliance with collections follow up; VA failed to ensure documentation by VA physicians was sufficient; VA had insufficient automation; and, VA had a shortage of qualified billing coders. All of these concerns are key deficiencies contributing to the collections shortfalls. VA should implement all available remedies to maximize its collections of accounts receivable.

The American Legion opposes offsetting annual VA discretionary funding by the arbitrarily set MCCF goal, especially since VA is prohibited from collecting any third-party reimbursements from the Nation's largest federally-mandated health insurer, Medicare.

Medicare Reimbursements

Veterans contribute to the Medicare Trust Fund, as do most American workers, without choice, throughout their working lives. Veterans also paid these contributions when they served on active-duty. However, when a veteran is treated at a VA medical facility, VA is prohibited from collecting Medicare reimbursements for the treatment of allowable, nonservice-connected medical conditions. Since over half of VA's enrolled patient population is Medicare-eligible, this prohibition constitutes a multi-billion dollar annual subsidy to the Medicare Trust Fund. No other Federal health care provider is prohibited from receiving Medicare reimbursements. The American Legion supports allowing Medicare reimbursement to VHA to pay for the treatment of allowable, nonservice-connected medical conditions of enrolled Medicare-eligible veterans.

Medical Construction and Infrastructure Support

Major Construction

The CARES process identified more than 100 major construction projects in 37 States, the District of Columbia, and Puerto Rico. Construction projects are categorized as 'major' if the estimated cost is over $10 million. Now that VA has a plan to deliver health care through 2022, it is up to Congress to provide adequate funds.

The CARES plan calls for, among other things, the construction of new hospitals in Orlando, FL, and Las Vegas, NV, and replacement facilities in Louisville, KY, and Denver, CO, for a cost estimated to be well over $1 billion for these four facilities. VA has not had this type of progressive construction agenda in decades. Major construction money can be significant and proper utilization of funds must be well planned. Recently, Congress approved funding for a new Veterans Affairs Medical Center in Denver. It is our hope that funding will be provided for Louisville and Las Vegas as well.

In addition to the cost of the proposed new facilities are the many construction issues that have been virtually "put on hold" for the past several years due to past inadequate funding and the moratorium placed on construction spending by the CARES process. One of the most glaring shortfalls is the neglect of the buildings sorely in need of seismic correction. This is an issue of safety. The delivery of health care in seismically unsafe buildings cannot be tolerated and funds must be allocated to not only construct the new facilities, but also to pay for much needed upgrades at existing facilities. Gambling with the lives of veterans, their families and VA employees is absolutely unacceptable.

The American Legion believes that VA has effectively shepherded the CARES process to its current State by developing the blueprint for the future delivery of VA health care—it is now time for Congress to adequately fund the implementation of this crucial undertaking.

The American Legion recommends $560 million for Major Construction in fiscal year 2009. Although the President's budget request for fiscal year 2009 calls for Major Construction to be $582 million, The American Legion also recommends an additional $1 billion specifically designated for approved CARES major construction.

Minor Construction

VA's minor construction program has also suffered significant neglect over the past several years. Maintaining the infrastructure of VA's buildings is no small task. Because the buildings are old, renovations, relocations and expansions are quite common. When combined with the added cost of the CARES program rec-

ommendations, it is easy to perceive that a major increase over the previous funding level is crucial and overdue.

The American Legion recommends $485 million for Minor Construction in fiscal year 2009.

Veterans Benefits Administration

The President's annual budget request is a detailed outline of the mandatory and discretionary funding needed by the Veterans Benefits Administration (VBA). Given VBA's many challenges and responsibilities, which include the annual expenditures for compensation, pension, and related benefit payments, it is imperative that Congress ensure that VBA's programs have the personnel and other resources necessary to operate efficiently and can provide quality and timely service. The budget debate process and oversight hearings provide opportunities to evaluate how well VBA is, in fact, performing its missions and whether the needs and expectations of its stakeholders are being met.

For several years, VBA has endeavored to implement its long-term strategic plans to hire and train a new cadre of adjudicators, to continue the computer modernization program, and to institute a variety of procedural and programmatic changes intended to improve the claims adjudication process. However, external factors, such as the enactment of legislation providing new benefits and medical care services and precedent setting legal decisions by the Federal courts, continue to play a major role in changing VBA's plans, policies, and operations. VBA's efforts to address these varied and complex issues have profound budgetary and operational implications.

One of the most significant challenges plaguing VBA is the sheer size of the backlog of pending disability claims and appeals. These claims are usually multi-issue cases arguing complex medical and legal issues that must be resolved. The American Legion believes the backlog is a symptom of unresolved systemic problems that adversely affect the adjudication and appeals process. These unresolved problems further contribute to the ever-growing backlog. These problems include: frequent decisionmaking errors at all levels of the decisionmaking process; failure by VA personnel to comply with the Veterans' Claims Assistance Act of 2000 (VCAA); lack of personal accountability by VA employees and managers; ineffective quality control and quality assurance programs; inadequate personnel training; and, an unreliable work measurement system. VBA is faced with a serious dilemma. While endeavoring to address these thorny issues, it is also aggressively trying to process claims faster. From the results, it does not appear VBA has found a way to successfully balance these competing priorities.

As of January 5, 2008, there were more than 406,000 rating cases pending in the VBA system. Of these, 105,693 (26 percent) have been pending for more than 180 days. There are more than 163,000 appeals pending at VA regional offices, with more than 147,000 requiring some type of further adjudicative action. Additionally, there are currently more than 30,000 appeals pending at the Board of Veterans' Appeals and more than 19,000 remands pending at the Appeals Management Center.

As previously noted, The American Legion remains deeply concerned by the problems arising from the VBA's general lack of compliance with its "duty to notify" and its "duty to assist" requirements directed by the VCAA. This legislation is one of the most significant, pro-veteran improvements in the VA claims adjudication system in the past decade. However, VBA continues to give only lip service to this law. While claimants receive what VBA terms a VCAA letter, this letter, in fact, is generally not very informative about what particular evidence is needed by VBA to grant the benefit sought by the veteran. In addition, these VCAA letters are usually long and confusing, not very specific to the evidence needed from claimants, and written in bureaucratic language instead of "plain English." Rather than helping claimants with the development of the claim, these letters frequently generate more questions, more telephone calls, and more correspondence to veterans' service officers or the VA regional office. Clearly, the VCAA letter currently in use by VBA today only serves to delay rather than facilitate the claims process.

The VBA's work measurement system may directly or indirectly affect the VBA's failure to reduce the claims backlog. The VBA's work measurement system is the means by which both individual employee and station performance is tracked and evaluated. This system is also relied upon in determining staffing needs at the station, region, and service levels in support of VBA's annual budget request. A serious problem can arise if the data developed by the work measurement system is neither accurate nor reliable in reporting the actual amount of work accomplished. This produces a distorted view of the way the VBA adjudication process is operating and what the true staffing needs are, both locally and system-wide.

The American Legion believes VBA's current work measurement system is seriously flawed. It does not provide VBA and Congress the needed information on how

long it actually takes to properly process a claim and how many staff are required to perform this process in a timely manner. The American Legion advises that this work data is also subject to frequent manipulation and abuse, thus, its accuracy and reliability is open to serious question as are the conclusions and decisions drawn from this work data. In the view of The American Legion, the development and implementation of a new work measurement system should be one of VBA's highest priorities. The American Legion fully understands and appreciates the major challenges facing VBA in the upcoming year, but as a major stakeholder in VBA's benefit programs we are committed to ensuring that VBA provides the best quality and timely service to our Nation's veterans and their families.

National Cemetery Administration

Approximately 24 million veterans are living today. Nearly 690,000 veteran deaths are estimated to occur in 2009. VA estimates that approximately 111,000 will request interment in national cemeteries. Considering the growing cost of burial services and the excellent quality of service the National Cemetery Administration (NCA) provides, The American Legion foresees that this percentage will be much greater. Congress must therefore provide sufficient Major Construction appropriations to permit NCA to accomplish its Stated goal of ensuring that burial in a national or State cemetery is a realistic option for our Nation's veterans by locating cemeteries within 75 miles of 90 percent of eligible veterans. The American Legion recommends $228 million be appropriated for the National Cemetery Administration for fiscal year 2009.

National Cemetery Expansion

According to VA, it takes approximately 20 to 30 Full Time Equivalents (FTEs), to operate a national cemetery (depending on the size and workload at a particular facility) and it takes approximately 8 to 10 FTEs to operate a newly-opened cemetery (cemeteries are opened to interments long before completion of the full site). Thus, it seems reasonable that at least 50 new FTEs will be needed to operate the six new cemeteries NCA is planning to bring online in fiscal year 2008. It is likely, therefore, that these new cemeteries will need the full 20 to 30 FTEs in fiscal year 2009. The average VA employee salary with benefits is $63,709. The American Legion recommends that funding for an additional 120–150 employees be included in the fiscal year 2009 budget.

National Shrine Commitment

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning veterans' headstones and markers to renovate their gravesites. The work that has been done by VA so far has been outstanding; however, adequate funding is the key to maintaining this very important commitment. The American Legion supports NCA's goal of completing the National Shrine Commitment within 5 years. This commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must be increased to reflect the true requirements of the NCA to fulfill this commitment.

VA has assessed burial sections and sites, roadways, buildings, and historic structures and has identified 928 potential improvement projects at an estimated cost of $280 million. October 2007 marked the end of the 5-year plan, but still much work needs to be done. With the addition of six new cemeteries and the addition of six more cemeteries that are fast-tracked to come online this year, resources will be strained. The American Legion recommends that $52 million be appropriated to the National Shrine Commitment in order to fulfill this commitment to the Nation's veterans.

State Cemetery Construction Grants Program

This program is not intended to replace National Cemeteries, but to complement them. Grants for State-owned and operated cemeteries can be used to establish, expand and improve on existing cemeteries. There are 60 operational State cemeteries and two more under construction. Since NCA concentrates its construction resources on large metropolitan areas, it is unlikely that new national cemeteries will be constructed in all of the States. Therefore, individual States are encouraged to pursue applications for the State Cemetery Grants Program. Fiscal commitments from the States are essential to keep the operations of State cemeteries on track. NCA estimates it costs about $300,000 per year to operate a State cemetery.

Determining an "average cost" to build a new State cemetery or to expand an existing one is very difficult. Many factors influence cost, such as location, size and the availability of public utilities. The American Legion believes States will increas-

ingly use the State Cemetery Grants Program to fulfill the needs of their veteran populations that are still not well served by the "75-mile service area/170,000 veteran population" threshold that currently serves as the VA benchmark for establishing a new national cemetery. New State cemeteries and expansions and improvements of existing State cemeteries are therefore likely to increase. With increasing costs, especially given the high cost of land in urban areas, and with increasing demand, The American Legion recommends the amount of funding for the State Cemetery Grants Program be substantially increased. The American Legion recommends $45 million for the State Cemetery Grants Program in fiscal year 2009.

ECONOMICS

The GI Bill and Veterans' Education Benefits

The American Legion has a proud history of developing the Servicemen's Readjustment Act of 1944 (Public Law 78–346), also known as the GI Bill of Rights, which served to assist 18 million veterans of WWII in gaining employment after military service and assisting in the creation of the American middle class.

Accordingly, The American Legion supports passage of major enhancements to the All-Volunteer Force Education Assistance Program, better known as the Montgomery GI Bill (MGIB). The current make-up of the operational military force requires that adjustments be made to support all Armed Forces servicemembers. The American Legion supports legislation that will allow members of the Reserve Components to earn credits for education while mobilized, just as active-duty troops do, and be able to use those credits after they leave military service. Two of the top priorities of any veterans' education legislation are equity and portability of benefits. However, it is also clear that the current dollar value of benefits must be increased to meet the greater costs of today's higher education.

In the 20 years since the MGIB went into effect on June 30, 1985, the Nation's security needs have changed radically from a fixed cold war to a dynamic Global War on Terrorism. In 1991, the Active-Duty Force (ADF) of the military stood at 2.1 million; today it stands at 1.4 million. Between 1915 and 1990 the Reserve Force (RF) was involuntarily mobilized only nine times. Today the Nation's Reserve Forces are no longer a strategic force but are an operational force mobilized continuously and working side-by-side with active duty units all over the world.

The Department of Defense (DOD) reported as of August 2007 that in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) there have been:

- 2.4 million deployment events;
- 1.6 million servicemembers have been deployed;
- 540,000 servicemembers have had more than one deployment;
- 443,000 National Guard and Reserve soldiers have been mobilized and deployed to Iraq or Afghanistan since 2001, for an average of 18 months per mobilization;
- Out of 540,000 servicemembers with more than one deployment, 103,909 are members of the Reserve Components; and
- "Stop-loss" (a policy that prevents troops from leaving the service when their enlistment end date has arrived) has been imposed on more than 50,000 troops.

The American Legion recommends that the dollar amount of the entitlement should be indexed to the average cost of college education including tuition, fees, textbooks and other supplies for commuter students at an accredited university, college or trade school for which they qualify and that the educational cost index should be reviewed and adjusted annually.

The American Legion supports a monthly, tax-free subsistence allowance indexed for inflation as part of the educational assistance package.

The American Legion recommends reauthorizing and funding State Approving Agencies to assure current staffing and activities and to assure that there is no harm to veterans receiving education payments.

State Approving Agencies

The American Legion is deeply concerned with the timely manner that veterans, especially returning wartime veterans, receive their education benefits. Annually, approximately 300,000 servicemembers (90,000 of them belonging to the National Guard and Reserve) return to the civilian sector and use their earned education benefits from the VA.

Any delay in receipt of education benefits or approval of courses taken at institutions of higher learning can adversely affect a veteran's life. A recent GAO Report entitled "VA Student Financial Aid; Management Actions Needed to Reduce Overlap in Approving Education and Training Programs and to Assess State Approving

Agencies" (GAO–07–384) focuses on the need to "ensure that Federal dollars are spent efficiently and effectively."

GAO recommends that VA should require State Approving Agencies (SAAs) to track and report data on resources spent on approval activities, such as site visits, catalog review, and outreach in a cost-efficient manner. The American Legion agrees. Additionally, GAO recommended that VA establish outcome-oriented performance measures to assess the effectiveness of SAA efforts. The American Legion fully agrees. In response, VA Deputy Secretary Mansfield plans to establish a working group with SAA to create a reporting system for approval activities and develop outcome-oriented measures with a goal of implementation in the fiscal year 2009 budget cycle. Finally, GAO recommended that VA should collaborate with other agencies to identify any duplicate efforts and use the agency's administrative and regulatory authority to streamline the approval process. The American Legion agrees. VA Deputy Secretary Mansfield responded that VA would initiate contact with appropriate officials at the Departments of Education and Labor to help identify any duplicate efforts.

Sec. 301 of Pub. L. 107–330 created increases in the aggregate annual amount available for State approving agencies for administrative expenses from fiscal years 2003–2007 to the current funding level of $19 million. The American Legion fully supports reauthorization of SAA funding.

The American Legion strongly recommends keeping SAA funding at $19 million in fiscal year 2009 to assure current staffing and activities.

VA Home Loan Guaranty Program

Since the home loan program was enacted as part of the original Servicemen's Readjustment Act of 1944 (the GI Bill), VA has guaranteed more than 18 million home loans totaling nearly $914 billion for veterans to purchase or construct a home, or to refinance another home loan on more favorable terms. In the 5-year period from 2001 through 2006, VA has assisted more than 1.4 million veterans in obtaining home loan financing totaling almost $197 billion. About half of these loans, just over 730,000, were to assist veterans to obtain a lower interest rate on an existing VA guaranteed home loan through VA's Interest Rate Reduction Refinancing Loan Program.

The VA funding fee is required by law and is designed to sustain the VA Home Loan Program by eliminating the need for appropriations from Congress. Congress is not required to appropriate funding for this program; however, because veterans must now "buy" into the program, it no longer serves the intent of helping veterans afford a home. The funding fee makes the VA Home Loan program less beneficial when compared to a standard, private loan, in some aspects. The current rate for mortgages is approximately 5.7 percent. The funding fee would be in addition to the rate given by the lender. A $300,000 loan would generate a fee in addition to any rate the veteran would achieve. The funding fee mandates the participant to buy into the program; however, that goes directly against the intention of the law: to provide veterans a resource for obtaining a home. Approximately 80 percent of all VA Home Loan participants must pay the funding fee and the current funding fee paid to VA to defray the cost of the home loan has had a negative effect on many veterans who choose not to participate in this highly beneficial program.

The American Legion supports the elimination of the VA Home Loan funding fee and urges Congress to appropriate funding to sustain the VA Home Loan Guaranty Program.

The American Legion reaffirms its strong support for VA's Loan Guaranty Program. The American Legion also supports any administrative and/or legislative efforts that will improve and strengthen the VA Home Loan Guaranty Program's ability to serve America's veterans.

Homeless Providers Grant and Per Diem Program

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem Program under the Homeless Veterans Comprehensive Service Programs Act of 1992 (Pub. L. 102–590). Grants from the Grant and Per Diem Program are offered annually (as funding permits) by the VA to fund community agencies providing service to homeless veterans. VA can provide grants and per diem payments to help public and nonprofit organizations establish and operate supportive housing and/or service centers for homeless veterans.

Funds are available for assistance in the form of grants to provide transitional housing (up to 24 months) with supportive services, supportive services in a service center facility for homeless veterans not in conjunction with supportive housing, or to purchase vans.

The American Legion strongly supports funding the Grant and Per Diem Program for a 5-year period instead of annually and supports increasing the funding level to $200 million annually.

Department of Labor Veterans' Employment and Training Service (DOL-VETS)

VETS is and should remain a national program with Federal oversight and accountability. The American Legion is eager to see this program grow and especially would like to see greater expansion of entrepreneurial-based, self-employment opportunity training.

The mission of VETS is to promote the economic security of America's veterans. This mission is executed by assisting veterans in finding meaningful employment. The American Legion believes that by strengthening American veterans, we in turn strengthen America. Annually, DOD discharges approximately 250,000 servicemembers. Recently-separated service personnel will seek immediate employment or, increasingly, have chosen some form of self-employment.

In order for the VETS program to assist these veterans to achieve their goals, it needs to:

- Improve by expanding its outreach efforts with creative initiatives designed to improve employment and training services for veterans;
- Provide employers with a labor pool of quality applicants with marketable and transferable job skills;
- Provide information on identifying military occupations that require licenses, certificates or other credentials at the local, State, or national levels;
- Eliminate barriers to recently separated service personnel and assist in the transition from military service to the civilian labor market;
- Strive to be a proactive agent between the business and veterans' communities in order to provide greater employment opportunities for veterans; and
- Increase training opportunities, support and options for veterans who seek self-employment and entrepreneurial careers.

The American Legion believes staffing levels for DVOP specialists and LVERs should match the needs of the veterans' community in each State and not be based solely on the fiscal needs of the State government.

Contrary to the demands placed upon VETS, funding increases for VETS since 9/11 does not reflect the large increase in servicemembers requiring these services due to the Global War on Terrorism. In support of this fact, the inflation rate from January 2002 to January 2008 is 15.93 percent and yet for State Grants alone, funding has only increased a meek 2.5 percent ($158 million to $162 million) in the same time span.

The President's budget request for fiscal year 2009 will allow for an increase of 1 percent for State Grants, the mechanism for funding DVOPs and LVERs. However, this does not meet the inflation rate and approximately 100 positions have the potential to be eliminated again next year.

More services and programs are needed and yet since 2002 the VETS program has only received a modest 4 percent increase. Transition assistance, education, and employment are each a pillar of financial stability. They will prevent homelessness allow the veteran to compete in the private sector, and let our Nation's veterans contribute their military skills and education to the civilian sector. By placing veterans in suitable employment earlier, the country benefits from increased income tax revenue and reduced unemployment compensation payments, thus greatly offsetting the cost of Transitional Assistance Program (TAP) training. The American Legion recommends full funding for DOL-VETS.

Homelessness (DOL-VETS)

The American Legion notes that there are approximately 200,000 homeless veterans on the street each night. This number, compounded with 300,000 servicemembers entering the private sector each year since 2001 with at least a third of them potentially suffering from mental illness, requires intensive efforts. Numerous programs to prevent and assist homeless veterans are available.

The Homeless Veterans Reintegration Program (HVRP) is a competitive grant program. Grants are awarded to States or other public entities and non-profit organizations, including faith-based organizations, to operate employment programs that reach out to homeless veterans and help them become gainfully employed. The purpose of the HVRP is to provide services to assist in reintegrating homeless veterans into meaningful employment within the labor force and to stimulate the development of effective service delivery systems that will address the complex problems facing veterans. HVRP is the only nationwide program focused on assisting homeless veterans to reintegrate into the workforce.

The competition for these grants is intense as they have one of the highest cutoff score thresholds to be in the competitive range for any grant program. Amazingly, 243 grants did fall into the competitive range but there was only enough funding to award 145 submissions. The HVRP program could only award $39 million for fiscal year 2007 but had to deny 98 fully qualified nominations. These 98 additional qualified programs would require an additional $30 million. The American Legion recommends $70 million for this highly successful grant program.

Training

The National Veterans' Employment and Training Services Institute (NVTI) was established to ensure a high level of proficiency and training for staff that provide veterans employment services. NVTI provides training to Federal and State government employment service providers in competency based training courses. Current law requires all Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representatives (LVER) personnel to be trained within 3 years of hiring. The American Legion recommends that these personnel should be trained within 1 year. The American Legion further recommends $6 million in funding to NVTI.

Veterans Workforce Investment Program (VWIP)

VWIP grants support efforts to ensure veterans' lifelong learning and skills development in programs designed to serve the most-at-risk veterans, especially those with service-connected disabilities, those with significant barriers to employment, and recently separated veterans. The goal is to provide an effective mix of interventions, including training, retraining, and support services, that lead to long term, higher wage and career potential jobs. The American Legion recommends $20 million in funding for VWIP.

Employment Rights and Veterans' Preference

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects civilian job rights and benefits of veterans and members of the Armed Forces, including National Guard and Reserve soldiers. USERRA also prohibits employer discrimination due to military obligations and provides reemployment rights to returning servicemembers. VETS administers this law, conducts investigations for USERRA and Veterans' Preference cases, conducts outreach and education, and investigates complaints by servicemembers.

Since September 11, 2001, nearly 600,000 National Guard and Reserve soldiers have been activated for military duty. During this same period, DOL-VETS has provided USERRA assistance to over 410,000 employers and servicemembers.

Veterans' Preference is authorized by the Veterans' Preference Act of 1944. The Veterans' Employment Opportunity Act of 1998 (VEOA) extended certain rights and remedies to recently separated veterans. VETS was given the responsibility to investigate complaints filed by veterans who believe their Veterans' Preference rights have been violated and to conduct an extensive compliance assistance program.

Numerous Federal agencies and government contractors and subcontractors are unlawfully circumventing Veterans' Preference. The use of multiple certificates in the hiring process is unjustly denying veterans opportunity for employment. Whereas figures show a decline in claims by veterans of OEF/OIF compared to Gulf War I, the reality is that employment opportunities are not being broadcast. Federal agencies as well as contractors and subcontractors are required by law to notify OPM of job opportunities but more often than not these vacancies are never made available to the public. VETS program investigates these claims and corrects unlawful practices.

The American Legion also supports the strongest Veterans' Preference laws possible at all levels of government. The American Legion is deeply concerned with the protection of the veteran and the prevention of illegal and egregious hiring practices. Currently, veterans are filing corrective action claims after the non-compliance employment event occurs and therefore may become financially disadvantaged. Concurrent measures and continuous oversight must be emplaced to protect veterans from unfair hiring practices, not just reactionary investigations. The American Legion recommends funding of $61 million for program management that encompasses USERRA and VEOA.

Veteran-/Service-Connected Disabled Veteran-Owned Businesses

The American Legion views small businesses as the backbone of the American economy. It is the driving force behind America's past economic growth and will continue to be the major factor for growth as we move further into the 21st Century. Currently, more than nine out of every ten businesses are small firms, which produce almost one-half of the Gross National Product. Veterans' benefits have always included assistance in creating and operating veteran-owned small businesses.

The impact of deployment on self-employed National Guard and Reserve soldiers is severe with a reported 40 percent of all veteran-owned businesses suffering financial losses and in some cases bankruptcies. Many other small businesses have discovered they are unable to operate and suffer some form of financial loss when key employees are activated. The Congressional Budget Office in its report, "The Effects of Reserve Call-Ups on Civilian Employers," Stated that it "expects that as many as 30,000 small businesses and 55,000 self-employed individuals may be more severely affected if their Reserve soldier employee or owner is activated." Additionally, the Office of Veterans' Business Development within the Small Business Administration (SBA) remains crippled and ineffective due to a token funding of $750,000 per year. This amount, which is less than the office supply budget for the SBA, is expected to support an entire nation of veteran entrepreneurs. The American Legion feels that this pittance is an insult to American veteran business owners, undermines the spirit and intent of the Veterans Entrepreneurship (TVC) and Small Business Development Act of 1999 (Pub. L. 106–50) and continues to be a source of embarrassment for this country.

The American Legion strongly supports increased funding for the Small Business Administration's Office of Veterans' Business Development to provide enhanced outreach and community-based assistance to veterans and self-employed members of the Reserves and National Guard.

Additionally, the American Legion supports allowing the Office of Veterans' Business Development to enter into contracts, grants, and cooperative agreements to further its outreach goals. The Office of Veterans' Business Development must be authorized to develop a nationwide community-based service delivery system specifically for veterans and members of Reserve components of the United States military.

The American Legion further recommends that funding for the SBA Office of Veterans' Business Development be increased to $2.3 million in fiscal year 2009.

CONCLUSION

The American Legion is extremely concerned about the budgetary process when Congress does not pass appropriations bills before the start of the new fiscal year. The failure to pass a proper budget has a significant impact on the veterans' community and the health care delivery provided to veterans. As a result of the failure of Congress to pass VA appropriations in a timely manner, all long- and short-range planning is adversely affected. VA medical facility administrators are asked to use a "crystal ball" to make prudent management decisions—not knowing when and how much funding they will have available to finish the fiscal year. Such fiscal irresponsibility spawns gross mismanagement decisions, rationing of care, and unacceptable delays and backlogs across the program areas—medical care, facility maintenance, administration, construction, and State grants programs. It is our hope that Congress will move to quickly pass this budget so that we can properly take care of our troops and our veterans.

The American Legion appreciates the opportunity to present its views and estimates on programs that will affect veterans, servicemembers and their families. We ask that this Committee take into consideration the recommendations of The American Legion as your colleagues formulate the fiscal year 2009 Budget Resolution. We also ask the Committee not to forget the sacrifices and contributions made by America's veterans and their families as the budget priorities are determined for fiscal year 2009.

Chairman AKAKA. Thank you, Mr. Gaytan.

Mr. Rowan.

STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Mr. ROWAN. Good afternoon, Chairman Akaka and Ranking Member Burr.

You have our testimony and I do not want to go into too much, but it is interesting to be able to sit in the back and listen for the last two and one-half hours to people going back and forth between the Senators and the Secretary and his aides and some of the other comments made.

I would just like to say some reactions to some of the things I heard. First of all, let me say that the VVA supports the Independent Budget. They have done a lot of really good work; and the detail in their report is unbelievable. We really commend them for their work.

We also agree that the budget, while significantly increased over the last several years, is still not sufficient to do the work the VA needs to do; and we specify details in the statement.

We also want to thank this Committee for pushing the National Vietnam Veterans Longitudinal Study to finally get that work done, which is long overdue. Congress had mandated the VA to do it years ago. We certainly encourage you to now start a similar project with the new veterans coming home, so that they can be tracked over the years to see what happens to them as they progress further; to find out who knows what pops up 40 years later, as happened to Vietnam veterans.

Reacting to some things that Senator Burr said earlier with regard to students on the campuses: I remember the old days when the Feds used to fund money and they used to send money out to the campuses for the veterans' programs; and they used to reward campuses that increased the percentage of veterans applying and actively showing up on their campuses. If we did that with an overlay of maybe some extra business with Post Traumatic Stress Disorder, perhaps we might be able to put that back into action again—maybe some funding along those lines, as well.

Of course, a new GI Bill might be useful. That is something the school administrators would love to be able to have.

That money went to create a very interesting group of folks over the years; and, frankly, there is an old boy network of Vietnam veterans out there who started on the campuses many years ago, and they are still functioning today.

We also want to talk about the whole issue of PTSD that the Senator mentioned earlier and you are correct that there is an issue of getting people well rather than just giving them a check. It would be nice to do that.

The problem we have unfortunately with the Vietnam veterans, it is often too late and we have been just done for too many years and the reason why it keeps going from 30 to 60 to 30 to 70 to 100 is because of unfortunately just deterioration.

The construction issue has been mentioned earlier and we want to share our concerns with that, particularly with regards to Puerto Rico. I was there in December 2006. My secretary just came back from a tour December 2007, and the American Legion had a very nice article about that as well. And we all had the same concurrence.

You are trying to stuff a new project into an unusable situation. You are trying to build a new hospital in a place that just does not work. I think, really, they need to go back to the drawing boards and take a look at the whole thing. It is not functioning. They are not going to ever make it work. They are going to have a problem with parking and distribution; people getting in and out. It is just a horror.

Priority 8s. The one thing I would say about Priority 8s, in my opinion, today's Priority 8 is tomorrow's service-connected veteran

in many instances. One of the problems, we believe, is that many veterans are not aware, particularly Vietnam veterans, of their rights and their rights to compensation for certain disabilities that they are now getting in their 50's and 60's.

The prostate cancers, the cancers, the diabetics, all of those folks are now unfortunately not aware that they are entitled to compensation and I am sure all of my colleagues here have service officers who tell the sad story about how they are finally getting to talk to the widow of the guy who died from a cancer from 7 years ago who did not know it was service-connected.

I do not know how we rectify that, other than doing a massive outreach program, which we are frankly trying to do with the pharmaceuticals and other organizations in the health industry to try to get the health people out there and the private sector to understand veterans health.

I also want to throw in, contrary to Bill O'Reilly's presumptions, homeless veterans are real. They have been real. I have been working in that program for 28 years now. It is a real problem. It is continuing to be a problem. It will always be a problem. PTSD helps to create these folks, and unfortunately the inability to get decent housing in most areas today for reasonable amounts of money just only exacerbates the situation.

Last but not least, I am very glad to hear that we are finally moving ahead hopefully with an RFI with the computers at VBA. If we do not computerize VBA and bring it into the 21st century, all of the additional people in the world will not change that system and that is the bottom line.

So, again, we thank you for having these hearings. We hope you keep their feet to the fire and we know you will.

Thank you.

[The prepared statement of Mr. Rowan follows:]

PREPARED STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Chairman Akaka, Ranking Member Burr and distinguished Members of the Committee, on behalf of the Board of Directors, and members, I thank you for giving Vietnam Veterans of America (VVA) the opportunity to testify today regarding the President's fiscal year 2009 budget request for the Department of Veterans Affairs. VVA thanks each of you on this distinguished panel, on both sides of the aisle, for your strong leadership on issues and concerns of vital concern to veterans and their families.

I want to thank you for recognizing that caring for those who have donned the uniform in our name is part of the continuing cost of the national defense. Caring for veterans, the essential role of the VA and, for specific services other Federal entities such as the Department of Labor, the Small Business Administration, and the Department of Health and Human Services, must be a national priority. This is poignantly clear when we visit the combat-wounded troops at Walter Reed Army Medical Center and Bethesda Naval Hospital.

VVA wishes to note at the outset that the annual exercise of debating the merits of the President's proposed budget is flawed. Medical Center directors should not have to be held in limbo as Congress reworks and adjusts this budget and perhaps misses, yet again, the start of the next Federal fiscal year. These public servants can be more effective, more efficient, and better managers of the public trust if they can properly plan for the funding they need to carry out their mission of caring for their patients. We hope that this can be avoided this year and ask that you seriously consider an immediate alternative to the broken system we currently have and reaching our goal of assured funding.

To rectify this situation, VVA and the other members of The Partnership for Veterans' Health Care Budget Reform are developing a proposal that would give the

VA leeway its managers need to properly plan for the requisites of their patient load. We will have more for you as this proposal is tightened up.

OVERVIEW

Concerning the proposal at hand, the President's fiscal year 2009 budget for the VA, we must again take exception to the attempt by the Administration to tax Priority 7 and 8 veterans with an annual fee just for signing into the VA health care system; and for almost doubling the co-payment for prescription pharmaceuticals. To us this is further evidence of the attempt to rid the system of as many "higher income" veterans as possible. We trust that you will see the folly in this, and will reject outright any attempt to enact these measures into the law of the land.

We are pleased, however, that the Administration has again refrained from citing phantom "management efficiencies" in the numbers in this budget proposal. Managers are in general well-paid. Effective, caring managers should take rightful pride in the jobs they do. Inefficient managers need to be sanctioned and, if necessary, transferred or removed.

We are less than sanguine, however, about the claim that "one of VA's highest priorities in 2009 will be to continue an aggressive research program to improve the lives of veterans returning from service in [Iraq and Afghanistan by devoting $252 million] to research projects focused specifically on veterans returning" from service in these two hot spots. It is our understanding that data collecting on maladies and diseases troops are returning with is not happening. It's almost as if our government does not want to know about these ailments so that it won't be burdened with Dependency Indemnity Compensation (DIC) payments.

We are pleased that the spirit of cooperation between the VA and the Department of Defense may actually be bearing fruit. In 2009, VA and DOD will complete the pilot of a new disability evaluation system for wounded returnees at major medical facilities in the Washington, DC, area. We hope that what results from this effort "to eliminate the duplicative and often confusing elements of the current disability process of the two departments" will lead to less confusion and a single, viable disability rating determined by the VA.

We are concerned, however, that there still will not be enough resources to deal with the flood of troops and veterans returning to our shores and presenting with a range of mental health issues. The VA ramped down for several years the numbers of mental health professionals it employed. Now, seeing the error of its ways, it is hurriedly hiring clinicians. The question is: Will there be enough of them to meet the challenge?

We are more than a little skeptical that, at the VA touts, the budget will provide resources "to virtually eliminate the patient waiting list by the end of 2009." When have we heard this before?

On the benefits side of the ledger, we find it ludicrous to believe that this budget "will allow VA to improve the timeliness with which compensation and pension claims are processed." Are VA planners perhaps a bit overly optimistic that they can reduce the average time it takes to process a claim to 145 days, 32 days quicker than the average 177 days it currently takes? No, the Veterans Benefits Administration requires a complete overhaul, one that introduces a new way of thinking about vetting veterans who make claims for Compensation & Pension benefits.

On the whole, this budget proposal is a better start than we have had in many a year, but the overall request for additional resources are just too low. With concerted work however it can be the most viable budget and appropriations document we have had in many years, of which we all can be proud.

VETERANS HEALTH ADMINISTRATION

Last year, VVA recommended an increase of $6.9 billion to the expected fiscal year 2007 appropriation for the medical care business line. Congress was very generous and we actually came close to that figure if one includes the supplemental funding of about $1.8 billion for veterans' health care. We recognize that the budget recommendation VVA is making again this year is also extraordinary, but with troops still in the field, years of under-funding of health care organizational capacity, renovation of an archaic and dilapidated infrastructure, updating capital equipment, and several cohorts of war veterans reaching ages of peak health care utilization, these are extraordinary times.

VVA asks that you continue ramping up the resources available to rebuild the organizational capacity to the point where the VA can really meet the needs of an increasing workload. Frankly, we believe that VA has (again) underestimated the projected workload for the next fiscal year. Instead of a growth of about 40,000 new veterans of the Global War on Terror (GWOT), VVA estimates that the increase will

be at least equal to last year's increase of 90,000 new veterans entering the system, and probably will be in excess of 100,000 new GWOT veterans, particularly if the VA starts doing a better job of outreach, reduces wait times as called for in their plan, and continues to make gains in adding needed staff capacity.

In contrast to what is clearly needed, we believe the Administration's fiscal year 2009 request for $2.34 billion more than the fiscal year 2008 appropriation is not adequate.

The increase the Administration has requested for medical care does not quite keep pace with inflation (due to increased energy costs, rising pharmaceutical costs, and other costs VA cannot control), but it will not allow VA to continue the needed pace of enhancing its health care and mental health care services for returning veterans, restore needed long-term care programs for aging veterans, or allow working-class veterans to return to their health care system. VVA's recommendation of a $5.24 Billion increase over fiscal year 2008 would accommodate these goals.

The advances of VA in recent years in improving the veterans' health care system are well known, and often elucidated by all of us, particularly VA officials. However, these advances have come with a cost. For years, the veterans' health care system has been falling behind in meeting the health care needs of some veterans. At the beginning of 2003, the former Secretary of Veterans Affairs made the decision to bar so-called Priority 8 veterans from enrolling. In most cases, these veterans are not the well-to-do—they are working class veterans or veterans living on fixed incomes who earn as little as $28,000 a year. It is not uncommon to hear about such veterans choosing between getting their prescription drug orders filled and paying their utility bills. The decision to "temporarily" bar these veterans is still standing, and it is still troubling to thoughtful Americans. As of this week, VA officials estimated that as many as 250,000 additional veterans are shut out of the system until they become indigent or eventually are granted service connection for one or more of their conditions that originated in military service. No one knows the size of the "migration" from the wilderness of Priority 8 to a category where these veterans can enter the system at some point when they are much sicker and/or poorer, because the VA has not tried to track it (at least not in a public way that we know of). However, VVA believes that it is a significant number.

It is time to live up to the promise and obligation and to "Leave No Veteran Behind" by restoring access to so-called Priority 8 veterans who are now on the outside and looking in. Of the recommended increase, $1.3 billion is for restoration of the Priority 8 veterans by the end of the second quarter of fiscal year 2009. It will take VA at least 3 to 6 months to add the organizational capacity to ensure that the system is not overwhelmed all at once.

Congress is to be commended for turning back many legislative requests for enrollment fees and outpatient cost increases in the past, which would have jeopardized access to care for hundreds of thousands of veterans. Hard-fought Congressional add-ons, such as the $3.6 billion added to veterans' health care for fiscal year 2007, and the more than $11 billion all told in calendar year 2008, now place us at a position where it is not only feasible to re-open the system to all veterans who have earned the right to access to this care, but it would be wrong to continue to shut them out.

MEDICAL SERVICES

For medical services for fiscal year 2009, VVA recommends $44.3 billion including collections. This is approximately $3.1 billion more than the Administration's request for fiscal year 2009. VVA is making its budget recommendations based on reopening access to the millions of veterans disenfranchised by the Department's policy decision of early 2003 that was supposed to be "temporary." The former ranking member of the House Committee on Veterans Affairs, Lane Evans, discovered that a quarter million Priority 8 veterans had applied for care in fiscal year 2005. Similar numbers of veterans have likely applied in each of the years since their enrollment was barred. Our budget allows 1.5 million new Priority 7 and 8 veterans to enroll for care in their health care system. While this may sound like too great a lift for the system, use rates for Priority 7 and 8 veterans are much lower than for other priority groups. Based on our estimates, it may yield only an 8 percent increase in demand at a cost of about $1.9 billion to the system for additional personnel, supplies and facilities.

MENTAL HEALTH—NEED TO RESTORE ORGANIZATIONAL CAPACITY FOR SUBSTANCE ABUSE TREATMENT

VVA urges that language be inserted in the Appropriations bill before Congress to express concern that substance abuse disorders among our Nation's veterans are

not being adequately addressed by the Veterans Health Administration (VHA). The relatively high rate of drug and alcohol abuse among our Nation's veterans (much of which is self-medication to deal with untreated PTSD), especially those returning from service in Operation Enduring Freedom and Operation Iraqi Freedom, is causing significant human suffering for veterans and their families.

These folks can and will be stronger for their experience if we only will deliver the effective care they need when they need it in a way they will accept.

Further delay in moving to restore effective mental health and substance abuse services will lead to poorer health and more acute health care utilization in the out years, not to mention economic opportunity cost to the Nation and needless suffering by these veterans, and their families.

Specifically, VVA urges the Congress to direct the Secretary to make concerted efforts to reduce the overall incidence of drug and alcohol abuse and dependence among enrollees in the Veterans Health Administration by meeting the performance measurements included in "A Comprehensive VHA Strategic Plan for Mental Health Services," VA's current and adopted plan to reform its mental health programs, with the hallmark of recovery. To its credit, VA has developed a strategy to "restore VHA's ability to consistently deliver state-of-the-art care for veterans with substance abuse disorders," as a milestone within that reform plan, but to date has yet to fulfill the promise of its commitment to recovery, and establishing the goal of every veteran being able to obtain and sustain meaningful employment at a living wage as the ultimate goal for all VA mental health programs, including its substance use disorder programs.

Further, VVA urges the Congress to direct the Secretary to provide quarterly reports beginning with a baseline report by each Veterans Integrated Service Network (VISN) on the initiatives set forth in the VHA Strategic Plan for Mental Health Services, specifically to improve VA's treatment of substance use disorders. These reports will provide an ongoing indication of VHA's progress in the implementation of its adopted Strategic Plan as described in section 1.2.8 of "A Comprehensive VHA Strategic Plan of Mental Health Services", May 2, 2005. In addition to baseline information, at minimum these reports should include: the current ranking of networks on their percentage of substance abuse treatment capacity along with plans developed by the lowest quartile of networks to bring their percentage up to the national average; and, the locations of VA facilities that provide 5 days or more of inpatient/residential detoxification services, either onsite, at a nearby VA facility, or at a facility under contract to provide such care; and, the locations of VA health care facilities without specialized substance use disorder providers on staff, with a statement of intentions by each such facility director of plans to employ such providers or take other actions to provide such specialized care.

The decade long diminishment of VA mental health programs that we experienced in the 1990's did level out by 2001, and VA all too slowly started to rebuild capacity that has been accelerated in recent years. However, we must continue to restore capacity to deal with mental disorders, particularly with Post Traumatic Stress Disorder and the often attendant co-morbidity of substance abuse. In particular, substance abuse treatment needs to be expanded greatly, and be more reliant on evidence based medicine and practices that are shown to actually be fruitful, and be held to much higher standards of accountability, as noted above. The 21 day revolving door or the old substance abuse wards is not something we should return to, but rather treatment modalities that can be proven to work, and restore veterans of working age to the point where they can obtain and sustain meaningful employment at a living wage, and therefore re-establish their sense of self-esteem.

NATIONAL CENTERS FOR PTSD

VVA also urges that additional resources explicitly be directed in the appropriation for fiscal year 2009 to the National Centers for PTSD for them to add to their organizational capacity under the current fine leadership. The signature wounds of this war may well be PTSD and Traumatic Brain Injury and a complicated amalgam of both conditions. VVA believes that if we provide enough resources, and hold VA managers accountable for how well those resources are applied, that these fine young veterans suffering these wounds can become well enough again to lead a happy and productive life.

Up until recently, VA has not made enough progress in preparing for the needs of troops returning from Iraq and Afghanistan—particularly in the area of mental health care. In addition to the funds VVA is recommending elsewhere, we specifically recommend an increase of an additional $500 million dollars over and above the $3.9 Billion that VA now says they will allocate to assist VA in meeting the mental health care needs of all veterans. These funds should be used to develop or

augment with permanent staff at VA Vet Centers (Readjustment Counseling Service or RCS), as well as PTSD teams and substance use disorder programs at VA medical centers and clinician who are skilled in treating both PTSD and substance abuse at the CBOC, which will be sought after as more troops (Including demobilized National Guard and Reserve soldiers) return from ongoing deployments. VVA also urges that the Secretary be required to work much more closely with the Secretary of Health and Human Services, and the States, to provide counseling to the whole family of those returning from combat deployments by means of utilizing the community mental health centers that dot the Nation. Promising work is now going on in Connecticut in and possibly elsewhere in this regard that could possibly be a model. In addition, VA should be augmenting its nursing home beds and community resources for long term care, particularly at the State veterans' homes.

To allow the staffing ratios that prevailed in 1998 for its current user population, VA would have to add more than 15,000 direct care employees—MDs, nurses, and other medical specialists—at a cost of about $2 billion. This level, because the system can and should be more efficient now, would allow us to end the shame of leaving veterans out in the cold who want and are in vital need of health care at VA, and who often have no other option.

BLIND AND LOW VISION VETERANS NEED MUCH GREATER RESOURCES AND ATTENTION

The President's request contains a significant reduction in the efforts to strengthen services for blind veterans. With the number of blind and very low vision veterans of the Nation's latest wars in need of services now, VVA strongly recommends the Congress explicitly direct an additional $30 million for fiscal year 2009 to increase staffing and programming at the VA's Blind and Visually Impaired Service Centers, and to add at least one new center.

Further, VVA recommends that the Congress directs the Secretary to implement an employment and independent living project modeled on the highly successful "Project Amer-I-Can" that so successfully placed blind and visually impaired veterans into work and other situations that resulted in them becoming much more autonomous and independent. That program was a cooperative venture of the New York State Department of Labor, the Veterans Employment & Training Service (VETS), and the Blind Veterans Association.

VET CENTERS

VA received an additional $20 million dollars in the Supplemental Appropriation for the war that was signed into law on March 7, 2007 specifically to increase the number of staff in the Readjustment Counseling Service (RCS) by 250 FTEE. Whether it was VHA or OMB that held these funds back, the funds were not released to the RCS to hire additional staff for the VA Vet Centers until mid-August. The Vet Centers are the most cost effective, cost efficient program operated by VA, but which just plain does not have enough staff. Because of the late arrival of the money the RCS could not hire any new staff, but used the funds for other things, such as vehicles to do rural outreach.

The additional 250 staff members for the previously existing Vet Centers are still very much needed, over and above the 100 peer counselors and approximately 50 mental health professionals they have already hired as additional staff in the past 2 years.

MEDICAL FACILITIES

For medical facilities for fiscal year 2009, VVA recommends a level of commitment that is at least equal to fiscal year 2008. Maintenance of the health care system's infrastructure and equipment purchases are often overlooked as Congress and the Administration attempt to correct more glaring problems with patient care is good, but needs to be sustained and if anything increased above the fiscal year 2008 level of resources level. We urge the Congress to continue the process of upgrading the physical plant of medical facilities at least at the rate funding at the fiscal year 2008 level for the next several years.

In a system in which so much of the infrastructure would be deemed obsolete by the private sector (in a 1999 report GAO found that more than 60 percent of its buildings were more than 25 years old), this has and may again lead to serious trouble. We are recommending that Congress provide an additional $1.5 billion to the medical facilities account to allow them to begin to address the system's current needs. We also believe that Congress should fully fund the major and minor construction accounts to allow for the remaining CARES proposals to be properly addressed by funding these accounts with a minimum of the remaining $2.3 billion.

MEDICAL AND PROSTHETIC RESEARCH

For medical and prosthetic research for fiscal year 2008, VVA recommends $500 million. This is approximately $50 million more than the Administration's request for fiscal year 2009. VA research has a long and distinguished portfolio as an integral part of the veterans' health care system. Research funding serves as a means to attract top medical schools into valued affiliations and allows VA to attract distinguished academics to its direct care and teaching missions.

VA's research program is distinct from that of the National Institutes of Health because it was created to respond to the unique medical needs of veterans. In this regard, it should seek to fund veterans' pressing needs for breakthroughs in addressing environmental hazard exposures, post-deployment mental health, Traumatic Brain Injury, long-term care service delivery, and prosthetics to meet the multiple needs of the latest generation of combat-wounded veterans.

Further, VVA brings to your attention that VA Medical & Prosthetic Research is not currently funding a single study on Agent Orange or other herbicides used in Vietnam, despite the fact that more than 300,000 veterans are now service-connected disabled as a direct result of such exposure in that war. This is unacceptable.

Mr. Chairman, finally I thank this Committee and the Appropriations Committee for using the power of the purse in the fiscal year 2008 Appropriations act to compel VA to obey the law (Public Law 106–419) and conduct the long-delayed National Vietnam Veterans Longitudinal Study. VVA asks that you schedule a hearing and/or a Members briefing for the second half of March for VA to outline their plan as to how they are going to complete this much needed study for delivery of the final results to the Congress by April 1, 2010, as a comprehensive mortality and morbidity study of Vietnam veterans, the last large cohort of combat veterans prior to those now serving in OEF/OIF.

Further, VVA strongly urges the Congress to mandate and fund longitudinal studies to begin virtually immediately, using the exact same methodology as the NVVRS, for the following cohorts: (a) Gulf War of 1991; (b) Operation Iraqi Freedom; and (c) Operation Enduring Freedom.

Please take action now so that these young veterans are not placed into the same predicament Vietnam veterans find ourselves today.

HOMELESS VETERANS

Homelessness is a significant problem in the veterans' community and veterans are disproportionately represented among the homeless population. While many effective programs assist homeless veterans to become productive and self-sufficient members of their communities and Congress must ensure that the Department of Veterans Affairs has adequate funding to meet the needs of the over 194,000 homeless veterans who served this country so proudly in past wars and veterans of our modern day war. VVA recommends the following increase in VA fiscal year 2009 budget for homeless programs.

HOMELESS PROVIDER GRANT AND PER DIEM PROGRAM

The Department of Veterans Affairs Homeless Grant & Per Diem Program has been in existence since 1994. These programs address the needs of homeless veterans and support the development of transitional, community-based housing and the delivery of supportive services. Because financial resources available to HGPD are limited, the number of grants awarded and the dollars granted are restrictive and hence many geographic areas in need suffer a loss that HGPD could address.

The Consolidated Appropriations Act of 2008, Public Law 110–161 provides $130 million, the fully authorized level, to be expended for the GPD program. Based on GAO's findings and VA's projected needs for additional GPD beds, VVA is concerned about the $138 million authorization for fiscal year 2009 and believes a $200 million authorization is required. An increase in the funding level for the next several years would help ensure and expedite VA's program expansion targets. It would provide critical funding for service, or drop-in, centers—the primary portal that links veterans in need with the people who can help them. It would guarantee continued declines in veteran homelessness, and provide for scaling back the funding as warranted by the VA's annual Community Homelessness Assessment, Local Education and Networking Group (CHALENG) reports

HUD-VASH

The HUD-VASH program was established as a partnership between the Departments of Veterans Affairs and Housing and Urban Development to combine permanent housing with supportive medical services. VVA supported passage of Public

Law 110–161 which included $75 million for 7,500 Section 8 vouchers for homeless and disabled programs. Under this program, VA must provide funding for supportive services to veterans receiving rental vouchers. The fiscal year 2009 VA budget must reflect a significant increase in funding these services.

VVA believes the $7.8 million in the fiscal year 2009 VA budget proposal was agreed upon before the HUD-VASH vouchers were enacted into law. Based on historical data that shows each housing voucher requires approximately $5,700 in supportive services—such as case management, personal development and health services, transportation, etc.—we estimate approximately $45 million will be needed to adequately serve 7,500 or more clients in HUD-VASH housing units. Rigorous evaluation of this program indicates this approach significantly reduces the incidence of homelessness among veterans challenged by chronic mental and emotional conditions, substance abuse disorders and other disabilities.

VETERANS BENEFITS ADMINISTRATION

The Veterans Benefits Administration (VBA) continues to need additional resources and enhanced accountability measures. VVA recommends an additional 300 over and above the roughly 700 new staff members that are requested in the President's proposed budget for all of VBA.

COMPENSATION & PENSION

VVA recommends adding one hundred staff members above the level requested by the President for the Compensation & Pension Service (C&P) specifically to be trained as adjudicators. Further, VVA strongly recommends adding an additional $60 million dollars specifically earmarked for additional training for all of those who touch a veterans' claim, institution of a competency based examination that is reviewed by an outside body that shall be used in a verification process for all of the VA personnel, veteran service organization personnel, attorneys, county and State employees, and any others who might presume to at any point touch a veterans' claim.

VOCATIONAL REHABILITATION

VVA recommends that you seek to add an additional two hundred specially trained vocational rehabilitation specialists to work with returning servicemembers who are disabled to ensure their placement into jobs or training that will directly lead to meaningful employment at a living wage. It still remains clear that the system funded through the Department of Labor simply is failing these fine young men and women when they need assistance most in rebuilding their lives.

It is also unclear as to whether VA actually added several hundred of these employment placement specialists for disabled veterans specifically called for in last year's funding measure, and whether they are effective in assisting disabled veterans, particularly profoundly disabled veterans to obtain decent jobs.

VVA has always held that the ability to obtain and sustain meaningful employment at a living wage is the absolute central event of the readjustment process. Adding additional resources and much greater accountability to the VA Vocational Rehabilitation process is essential if we as a nation are to meet our obligation to these Americans who have served their country so well, and have already sacrificed so much.

ACCOUNTABILITY AT THE VA

There is no excuse for the dissembling and lack of accountability in so much of what happens at the VA. It is certainly better than it used to be, but there is a long way to go in regard to cleaning up that corporate culture to make it the kind of system that it can be with existing resources, and even largely the same personnel as they currently have on board. It can be cleaned up and done right the first time, if there is the political will to hold people accountable for doing their job properly.

Thank you again, Mr. Chairman, for allowing VVA to be heard at this forum. We look forward to working with you and this distinguished Committee to obtain an excellent budget for the VA in this fiscal year, and to ensure the next generation of veterans' well being by enacting assured funding. I will be happy to answer any questions you and your colleagues may have.

Chairman AKAKA. Thank you very much, Mr. Rowan.

Before we begin with the questions, I want to note that Secretary Peake and his top VA leaders remained to listen to this panel.

Mr. ROWAN. Yes, we thank them.

Chairman AKAKA. Yes. And I do really appreciate that attention to the views of the veterans service organizations.

So, my first question is to all of you on this panel. I know some of you have mentioned parts of this in your testimony. Is there enough funding in this budget to allow VA to wage a much more serious and aggressive outreach campaign to bring in all veterans who need VA care and services?

Mr. BLAKE. Well, Senator Akaka, I will be the first to admit that outreach is not my expertise. I concur entirely with John Rowan's points about outreach. PVA is actually taking on a similar program to reach out to a number of severely disabled veterans that are out there and we are also considering doing an outreach campaign as it relates to Traumatic Brain Injured veterans, as well.

I do not know that you could ever put a dollar figure on how much outreach should be done and how much it should cost, but I would hasten to say that it is probably not adequate in terms of the number of veterans that still do not come to the VA.

Chairman AKAKA. Mr. Baker.

Mr. BAKER. Well, like Mr. Blake, I am no expert on outreach, but I believe that you simply cannot put a dollar figure on the veterans that are still suffering out there that are getting no benefits.

As long as there are those, and there are numerous ones like that, I think we need to do everything we can to make sure they get into the system and they get the help that they need.

Chairman AKAKA. Mr. Kelley.

Mr. KELLEY. I concur also that outreach is the key in every aspect of transitioning servicemembers to becoming a veteran, whether that is for medical health care or for educational benefits. There needs to be better outreach so they understand what is out there for them and that they utilize it properly.

Chairman AKAKA. Mr. Needham.

Mr. NEEDHAM. I certainly would agree that more outreach needs to be done. There are two issues I would like to see addressed with respect to that. Outreach for women veterans, so that they fully understand their mental health issues; but also the health care that they are entitled to.

And along with that also, VA also provides some services for families as well, particularly through the Vet Centers. And as long as we have more outreach in a proper and stable family structure, we think that will help with the veterans and their transitioning as well.

Chairman AKAKA. Mr. Gaytan.

Mr. GAYTAN. It is the American Legion's hope that Secretary Peake and his staff do identify the need for increased outreach. The American Legion has taken steps to help fill that gap, to smooth that seamless transition, and cause that to become a reality.

In our "Heroes to Hometown" program, the American Legion has a staff member that works directly with the recovery coordinators and the service specific staff who help those transitioning servicemembers who go from active duty to civilian life, from DOD health care to VA health care.

So, the American Legion's Heroes to Hometown program picks them up right away when they are returning, and we help to ex-

plain what their benefits are. We help them address the needs that they have as newly-injured servicemembers and veterans who are coming back and having to navigate that often confusing landscape of benefits and understand how to access those through the Department of Veterans Affairs.

So, the American Legion identifies the problem and wants to be part of the solution as well.

Chairman AKAKA. Mr. Rowan.

Mr. ROWAN. There is no outreach program. Nobody is talking to anybody. The new kids may be getting some information when they come home in a fairly standard format now, and that is a good thing, and they are trying to do some programs with them. But for anybody else before then, nothing.

So, all of my Vietnam veterans, when they come down with prostate cancer, unless they happen to belong to one of us and read our magazines—which is another thing that would be nice if they did, though many of them do not—most of them do not go to the VA. They do not belong to us; and they do not know that they are entitled to things.

The VA presently, I believe, is compensating about a quarter million diabetics—Vietnam veterans primarily—from service in Vietnam and Agent Orange. That is about less than 10 percent of the folks that stepped foot in Vietnam who qualify. We believe that number is probably twice that, if not more.

So, that means a quarter million possibly or more people are out there who are diabetics today entitled to compensation who are not getting it. Nobody knows about it.

We are trying to work with the private sector medical community to get the necessary education programs out there so that when they come across people at their desk, they ask the question, are you a veteran, and then go from there. And we think that will have a major, major impact.

And it is not just the Vietnam veteran. Desert Storm veterans, too. You know that is a long time ago already since Desert Storm, 17 years ago already and people forget that. And they have the highest rate of disability of any group yet—I think it is 30-some-odd—38 percent, I think. I forget the exact percentage of their numbers who are already getting disability. And we believe that could be higher and they are coming up with all kinds of strange things over time, too.

So, unfortunately, you know, we allocate billions of dollars probably in the Army to be all you can be and Army strong. They do not tell you about veteran weak.

Chairman AKAKA. Thank you, Mr. Rowan.

I now turn to our Ranking Member, Senator Burr, for his questions.

Senator BURR. Thank you, Mr. Chairman, and more importantly, thank you to each one of you for not just your willingness to come and share with us what I think is some valuable information but to the commitment that all the organizations and you as individuals make as part of that organization.

John, I agree with most everything you said. I would love to think that we could go back to Vietnam veterans, change the course of treatment for mental health issues and reasonably expect

a different outcome tomorrow. And we all know that is probably unachievable, though the pharmaceutical industry has provided us with some tools that I believe the VA is incorporating that did not exist 20 years ago. That may help to make life a little bit better. I hope and I believe that we are doing that within the VA today.

As it relates to homelessness, I agree with you totally. The challenging thing is that we, as a country, provide a roof pretty effectively over somebody's head. From a standpoint of veterans and others we do not do a great job with the wrap-around services that we need to take a veteran to permanent housing.

We get the occasional help that is needed, but without those wrap-around services, they always slip back into a homelessness situation; and I think this is something, quite frankly, that we need to tackle together. And it is not just limited to veterans. It is a population of folks that, for a multitude of reasons, find themselves not able to stay in permanent housing even with what I think are some great programs targeted for them.

I see the VA of the future focused in two areas as it relates to the delivery of health care specifically. One focus: to maintain the services to a population that had been promised and has been in the system; enhancing the care that is delivered as it is appropriate and technologically available.

And then two: to focus on today's warrior, to learn from the past where, in fact, we might not have designed the treatment the most effective way, and to learn where technologies have now provided us things like prosthetics that accomplish a level of quality that 20 years ago, quite frankly, we never believed we could achieve.

I want to use the balance of my time not to ask a question, but I guess I will sort of be the guinea pig, not to defend the Administration, but to remind all of us of the past.

In 1996, the Senate Committee on Veterans' Affairs held a hearing on veterans health care eligibility priorities. I want to read for you some selective questions and responses of some or all of the VSOs that are represented here.

Chairman Simpson asked, "which veterans should receive free medical care?"

"Answer: I believe anyone who in the service of their country was injured or disabled in any way that needs medical treatment once they leave military service. If they were injured and disabled in the line of duty, which does not necessarily mean combat, it could be training accidents, should be entitled to some type of health care once they leave the service without any expense to themselves.

"Chairman SIMPSON. If you say expanded and improved VA health benefits will not open the flood gates, then are you saying to us that veterans will not seek free care?

"Answer: Although all these veterans may be eligible for care and they are all eligible for care now, our proposal does not in any way stipulate or even imply that their care would not be paid for by somebody.

"The service-connected veteran and the Category A veterans as defined in the bill would continue to be provided care with the appropriate dollars as it should be, but everyone else who comes to the system, Mr. Chairman, is going to have to pay their own way

as they would in any other system through either co-payments, deductibles or private insurance.

"So, if there is an assumption on the cost of this bill being predicated upon all these new veterans coming into the system and not paying for their care, then it is a faulty assumption and one that drives the cost up.

"Last question and last answer."

"Senator ROCKEFELLER. To what extent do you think it is important that access to VA care be provided (a) higher income veterans with no service-connected disabilities; (b) dependents of veterans?

"Two answers: In the Independent Budget, DAV proposes, along with AMVET, PVA and VFW, that the Secretary have the discretion to treat these parties at their own expense. We do not request that they be entitled to VA medical care. We believe that it would be in the best interest to veterans and the VA to allow these parties to use VA care at their own expense.

"Additional answer: The American Legion believes that higher income, non-service-connected veterans and certain dependents of eligible veterans should be permitted to access the VA health care system by paying premiums, co-pays and deductibles. These additional revenue streams would help to ensure the long-term viability of the VA health care system. The normal appropriations process would ensure funding for Category A veterans and the conversion of VA to a market-based managed care system would attract other paying customers."

Senator BURR [continuing]. Now, again, I am not here to object to what you are saying because I firmly believe the Congress will throw out the Administration's proposal. We have done so with great frequency and little conscience, but I want to make the record straight.

No group has always said, no, do not do this. And my only plea to each one of you is that if we want to go through this annual Kabuki dance that we do, where you ask for more money, the Administration tries to do something, we have political differences up here, and the outcome is the same for veterans, then we have all failed.

At the end of the day, the question is, coming out the other end are people better off? Have they gotten what we promised? More importantly, have we used all the tools that are available to us, whether they are technological or anything else, to enhance their future in a positive way?

So, though I am in agreement with you that now is not the time to talk about this, as we expand the system, one only has to believe that somebody has to pay for it. If we collectively believe that it should be the taxpayer, let me suggest to you, if you look at any system or any health care system in the world, as it begins to grow like that, it will implode at some point. If your belief—and there is some disagreements on this Committee, this is an observation I am sharing of my own. Bernie——

[Laughter.]

But I appreciate the chuckle.

And, the fact is that each one of you, as representatives of service organizations, will have to search back in your history and remember that you made statements based upon your belief that the

integrity of this delivery system long-term was the single most important thing.

I believe that is the responsibility we have. I believe the responsibility of our representatives, the Secretary and his colleagues from VA, is to take what we have provided, to understand their mission, and carry it out in a way that provides the highest quality to the most people. And when there is not enough, to say there is not enough.

I want to say this in ending. I have been in a lot of congressional hearings in the House and the Senate. Rarely do I see a Government witness testify and stay to hear what the next panel says. Not only is the Secretary here listening to what you are saying, every person he brought from the VA is here listening to your testimony, listening to our questions. I think that says, more than anything I can imagine, how interested they are at doing their job.

Mr. Chairman, I thank you.

Chairman AKAKA. Thank you very much, Ranking Member Burr.

And now, Senator Sanders.

Senator SANDERS. I apologize again, Mr. Chairman. It has been one of those days and I keep running in and out.

It seems to be fairly clear that if you ask the American people whether or not we have a moral obligation to make sure that all of the men and women who put their lives on the line defending this country should have the promises made to them kept—even though, of course, as Senator Burr indicates, it is going to cost us money. I think the answer is, yes.

I think that is what people will say. And, Senator, any time that you would like to debate the issue of whether or not we give tax breaks to billionaires or put money into the VA, I would love to do it any place in the country; and most people will agree with me. Because you are right, it costs money. There is no question about it. But the question is one of national priority.

The second point that I would make is, I believe there is a will in this country that we have a moral obligation to take care of those people who put their lives on the line defending this country.

The second point, we have made and both of you will remember, Secretary Nicholson was before us on more than one occasion talking about the cost-effectiveness of the VA. Am I correct on that?

He talked about it as a high quality system where study after study indicated that it was cost effective. And I think that is what the evidence is. I think the evidence is, obviously there are exceptions with this, that when these guys get the money to do their job—they cannot do it if they do not have the money—that they do it pretty well.

The argument that we keep hearing is, when people get into the system they are happy with the care that they get. The problem is that too often there are waiting lines; too often there is inadequate staffing because they do not have the money to do their job.

I apologize for not having heard the testimony. The last point that I would say to Senator Burr, the indication, there is a difference; there is a philosophical difference. The last time around under Senator Akaka's leadership, we worked with many of your organizations. And for the first time in recent history, we actually

implemented most of the measures that were in the Independent Budget. I think that was the right thing to do.

And as I mentioned to the Secretary, who is kindly here right now, my main concern right now is that with so much influx, with so many new people coming into the system with so many needs, are they going to have the organizational capability to make sure that money is spent wisely and that they are hiring the right people and doing that as efficiently and as quickly as possible.

May I ask a question, Mr. Chairman?

Chairman AKAKA. Yes.

Senator SANDERS. To whoever wants to answer, do you have concerns? Or how do you see progress being made? We gave the VA more money. We worked with many of your organizations. Are you satisfied with the beginning—and it is just the beginning, of course—utilization of that money to address long-standing needs; and also the very pressing problems for our Iraq and Afghanistan veterans?

Who wants to comment on that?

Mr. GAYTAN. On behalf of the American Legion, I do want to comment on some of the main concerns that we have in regards to spending the funds that are provided to the Department of Veterans Affairs. And one, which is outlined in our testimony, as you have seen, is concern over cutting the research, medical and prosthetic research when you have TBI and PTSD as a major concern of these veterans who are coming back.

VA needs to be prepared to provide that service, not just now, but PTSD can manifest itself years down the road. VA needs to be capable of doing that.

Another commitment that VA needs that will require budgetary increases is long-term care. You cannot ignore the era of veterans who are turning to long-term care needs right now and VA needs to be capable of doing that as well.

One other area I just want to mention is the construction, and that was mentioned in our testimony as well. We cannot ignore the recommendations of the CARES report in terms of construction and those needed VA medical facilities.

Senator SANDERS. Do you think that the budget that the President presented will be able to do all of those things?

Mr. GAYTAN. It is our hope that it will.

Senator SANDERS. Other people like to comment on that?

Mr. BLAKE. Senator, I would just like to say that—I think one of my colleagues mentioned—we certainly appreciate everything the Congress did during the first session of the 110th Congress with regards to the funding for the VA.

We certainly cannot argue with the fact that most, if not all, of the recommendations in the budget were met when it comes to budget figures for the fiscal year 2008 appropriation.

I do not think it can be emphasized enough, however, that certainly our concern is spending that money wisely; and the fact that the VA did not receive its money or was not enacted from the President until January, puts the VA at quite a disadvantage at ensuring that it is wise with its dollars. Notwithstanding the fact that the VA has learned to live with this for 13 or 14 years now and knows how to plan around it, the simple fact is: you cannot

put the VA in that kind of a position and expect them to spend $40 billion plus just on the discretionary side appropriately and not have some heartache with some things they do.

Senator SANDERS. Anybody else want to comment on it?

Yes, sir.

Mr. ROWAN. Yes. I would concur. I think the whole issue of lag time is a real problem—no question—with regard to the budget, which is why we would like to see the whole process changed and brought into something a little bit more effective.

And yes, there have been changes in staffing, but probably not enough. We are concerned about the losses, particularly in the VBA side. There are a lot of people retiring in the VA system. A lot of my Vietnam veteran colleagues have taken their pensions and leaving, which is creating problems of a brain drain as much as anything else. It is enough to say, yes, we are going to hire a bunch of FTEs, but if it takes you 2 years to train somebody or 3 years to get people up to snuff, it is going to take a while.

We are concerned, too, about salaries. We are concerned about the ability—the whole health care system in this country is, you know, in a crisis; and we do not have anywhere near enough doctors and nurses or anything for anybody, never mind the VA.

So, if we are competing against everybody else, frankly, the only saving grace we have got is the VA hospital's affiliation with all of these wonderful medical schools, which have provided us with a lot of folks.

I just happened to recently use the emergency room at the Manhattan VA Hospital and everybody I talked to was an NYU doctor, which was fine by me. They have some of the best medical people in the country.

But, unfortunately, also other systems—when I go to clinics, for example, it takes a little while and I am a person who bounces in and out of both systems. I use the VA and I still have a private system from my retirement as a city employee. And, frankly, they are in the same strain we are. Let me tell you. They are all under the same system. Again, they do not have enough doctors. When you go to a regular private doctor, you better be prepared to wait because you may take 2 hours before he sees you and that is normal.

Senator SANDERS. Unfortunately it is normal.

Mr. ROWAN. We need more doctors.

Senator SANDERS. We just had a hearing on that, a 3-hour hearing on that issue yesterday as a matter of fact.

And I know it is very early in the game, and it is hard to make a judgment. But do you have a sense that the VA is moving aggressively, in the midst of that very difficult national climate, to hire of doctors, nurses, psychiatrists, psychologists? Do you think they understand the severity of the problem?

Mr. BAKER. I cannot answer that question with respect to the health care side. But with respect to the claims processing on the VBA side, having not been in the legislative business very long, I know that there has been a lot of increase in staffing in the VBA side, and I think that is going to help tremendously. And we certainly hope that it serves its purpose.

I do not think staffing is the only problem. I hope VA gets up to speed with their staff, but at the same time we put forth a lot of policy initiatives. Some of them are small, some of them are inexpensive, some of them will save money.

But, they all will chip away at the claims backlog. They will all improve the claims process. And I hope that, you know, those can be looked at in the future by VA and by the Committee. I hope that we do not have a sense to make so much change to a system that has evolved little bit by little bit into a very good system, that we scrap it and start over and have none of those safeguards in place that took so long to get.

I would just like the Committee to consider that.

Mr. ROWAN. I would just like to add that I think that the division directors are trying to do as much as they can as quickly as they can, but it is a tough system out there, generally. And so, they are under the same strains as everybody else.

And again, as far as the VBA is concerned, I can only state that until they get the computers up and running, all the FTEs in the world are not going to solve that problem.

Senator SANDERS. My last question. I am a fan of—I do not know what the formal title is—but the outreach clinics. We have four of them, I think, in the State. My impression is they work quite well and it has been one of the very positive innovations that we have seen at the VA in recent years.

Is it your impression that these outreach clinics are doing what they are supposed to be doing, Peter?

Mr. GAYTAN. Yes, sir. Actually, I am glad you brought that up. If we look at the improvements over the past couple of decades in VA health care, the quality of care that VA is providing, in hearing that praise for VA by the actual veterans who are going there and receiving the care, how it has changed from the Vietnam era of warehousing patients and how it has increased in terms of quality and delivering that access, it has a lot to do with not only the CBOCs, as you mentioned, the Community-Based Outpatient Clinics providing that care, but also the change in VA health care from inpatient to outpatient.

That change has been dramatic and we have seen it in results of quality and delivery of health care. And the veterans that are walking in and out of those VA hospitals are the first ones to tell you that the quality of care that they are receiving at VA is outstanding.

What the American Legion wants to do is ensure that VA is provided with a budget that will allow them to continue that quality and delivery of care.

Senator SANDERS. That is my impression that the veterans feel very positively about the CBOCs.

Mr. GAYTAN. The only negative, if there is a negative, is the fact that oftentimes when we get into specialties—when we get beyond clinical place and somebody asks to go for a specialty issue—and I have a friend of mine who went through a whole hip thing and had to get a hip replacement.

When you start getting into that system, then it can bog down a bit because, again, you are really hitting the crunch now with

way too many patients and not near enough medical care. It is ability; it is not that the doctors are not any good.

I mean, I had a guy and he just said I had enough and he went and got it done somewhere else because he just did not want to wait 6 months to get it done in the VA. That is going to take a long time before they build it back up in that part of the system.

I would also like to take a shot at, while you mentioned clinics, mention the other outreach programs, the veterans outreach centers which were created back in my day and helped a lot of Vietnam veterans survive, frankly.

Those programs are so great. They need to get to these new kids and I think that is going to be an interesting thing; and maybe some of us Vietnam vets who have been through the process can help them out a little bit.

But, if we look elsewhere, you know, we are not the only ones that deal with veterans in this world. My colleagues in Australia for years who have had similar outreach centers where veterans go for mental health counseling, they take the whole family and they take the kids, and they will treat them, because there is such a thing called secondary PTSD (which nobody ever wants to talk about), which is still going on today.

When we talk about the guy and the girl who comes home and beats up the husband or wife or whatever and the kids get into the middle of it all. And with all of these folks coming back today who have families, many of them with children that we never had in my generation in the numbers they have today.

So, I think they need to expand that program to include the family to do real family counseling which is what any good psycho-social service would definitely want to do.

Senator SANDERS. You would be interested to know in Vermont, we got some money for the VA and for the National Guard to do just that, to do an outreach program which involves the whole family.

I have gone over my time, Mr. Chairman, I apologize. Do you want to comment, sir?

Mr. KELLEY. Yes. I just wanted to build off of what Mr. Rowan was saying about the Vet Centers. And I think, particularly the Expanded Family Access, because what we are seeing with a lot of these issues is that the families are impacted. And the key challenge that we have seen with the Vet Centers over the last few years is not so much the location of them, but the staffing. We are concerned that the staffing levels are not sufficient to fully meet the demands, particularly as we have seen with the increasing numbers of OEF/OIF veterans returning. So, that is certainly something we have got our eye on and something that probably needs to be addressed.

Senator SANDERS. Let me conclude by thanking all of you. I think by working together we have made some real progress. Obviously there are some enormous challenges facing us. These are very, very difficult times—not just in health care, in terms of the number of people coming back, sick or wounded.

We have got a lot of work in front of us that I look forward, Mr. Chairman, that we will be able to continue working with these service organizations to make some real progress.

Thank you.

Chairman AKAKA. Thank you very much, Senator Sanders.

We have many more questions. I know some of the Committee Members do also. Let me end with two questions.

This question is for all of you. Earlier I told Secretary Peake and Admiral Cooper that there are high expectations for VBA to increase the quality of claims decisions. And this has to do with timing, not only for claims, but also for health—to provide care in a timely manner. I now turn to you for your quick views.

The question is, what more could Congress do for VBA to decrease the backlog and increase timeliness and accuracy?

Mr. BAKER. It sounds like a benefits question. It is a very good question and it is one that simply does not have one answer.

Congress has done a great thing already, I believe, in providing enough staffing for more employees at VBA almost to the point that we suggested in the Independent Budget. Though a little bit short, I believe we were fairly close.

Now, I believe the key is to utilize that staffing to its best advantage. It is going to take some time to get some training to the brand new people, and I think that is one area the VA has to focus on a lot—training.

I believe quality is an area that VBA has to focus on. The STAR program right now, I believe, is insufficient. It does not hold individuals accountable. It looks at about 10 cases per large VA regional office and I think that they have some plans to increase that. Yet, if you have an office that is putting out 1,000 claims a month, that is not even 1 percent; and you cannot even track a trend with that.

I believe we need to tie accountability to quality, at least as much as you do production, on an even level. I believe Congress could look at what we suggested in the Independent Budget. We tried to structure some things around the benefit side, like I said earlier, that are not expensive or that actually save resources.

We would be more than welcome to work with the agency to hone any differences that there may be in some of those recommendations.

That is probably the best answer I can give you off the cuff.

Mr. GAYTAN. If I can speak for the American Legion. In terms of addressing the backlog, what Mr. Baker said is true, and I want to emphasize the fact that focus needs to be given to the quality of the rating, as opposed to the quota.

You cannot expect the quota to be met and expect the quality to be met as well, because that is just recycling the claim back into the system. Quality has to be a focus, and not so much a stress on the quota and the amount that are being done. If the quality of that claims review is met, then we will address the backlog through that process.

Chairman AKAKA. Mr. Rowan.

Mr. ROWAN. Yes. First, I think the Congress needs to be prepared in that they are going to be hit with a fairly substantial bill somewhere down the line—hopefully sooner rather than later—for the computer system that they are going to need. And that is going to be a super budget dollar number. Whatever that comes out to,

that is going to have to be probably a one-shot deal or maybe a couple of year deal.

The Disability Commission talked about a lot of different things, too. They need regulations and laws to change some of the way we look at things. And I am not so sure how they do it. It has been, unfortunately, a couple of years since I have actually been in the grind doing service rep work, so I am not sure how they reorganized it on the ground.

But, one of the challenges you are asking people to meet: you are asking people to do musculoskeletal stuff; you are asking them to do endocrinology; you are asking them to become psychologists in their ratings. And, trying to get all that stuff in a reference book that says, you got this and you do not move this much, you get "X" percentage. If you do not move that much, you get a bigger percentage. It gets a lot more difficult than dealing with PTSD cases.

And I think the problem may be that the raters are not necessarily able to specialize as well as they could, so that, maybe, the more difficult cases could go to the senior rater, the person who would understand that stuff better.

I also think that we talked earlier about getting rid of some of this stuff—that if the doctor comes in and writes on his note paper, that I am a diabetic; take that and run with it and do not bother to bring me in for a C&P exam. And I am not saying they do, but when it comes to other things, we can speed that process up significantly in the early stages of some of those really slam-dunk claims, as many of my colleagues would say.

I mean, when we get into some other cases and we have to dig out things, the idea of getting into this whole issue of: if you served in a combat zone, you served in a combat zone whether you were a cook or a grunt. And, you know, maybe your disability is not as severe or whatever—your PTSD may not be as bad—but, you probably got some of it. We ought to just write that off; and I agree with the idea that you are in a combat zone, you are in a combat zone, period.

And, you know, let us stop trying to create 43 new medals. The Air Force just came out with one. The Army came out with a combat action badge, but not everybody is going to get it. Oh, please. I mean, we get into all this nonsense. Which is not to denigrate anything that the folks with the point of the spear do; but, those of us who have sat in the back and got bombed regularly or mortared regularly or whatever, it was just a little disconcerting to say the least.

And so, you know, we should be considered having served in a combat zone. And, today we noted that the worst job in the world now is the truck driver; and that was the truth in Vietnam, as well. But the truck drivers did not get medals; and try to prove their PTSD claim.

Chairman AKAKA. Thank you for those responses.

Let me just say, before I ask my final question—Mr. Baker, since you mentioned it, too—I want you to know I appreciate your thoughts on the need for a presumption for combat service. My bill, S. 2309, would do just that, and I hope to bring that measure to the full Senate later this year.

My final question to each of you is, I strongly believe that cutting the IG is not wise. Do you believe the Department can adequately police itself while funding for the IG is cut at the same time?

Mr. ROWAN. I will jump in.

Chairman AKAKA. Mr. Rowan.

Mr. ROWAN. No, I do not think they should cut the IG budget. However, we must understand something: the IG budget talks about corruption; the IGs worry about people stealing things. They do not necessarily tell you whether our division director is a very good manager, or whether your clinician is a good clinician, or the nurses are actually good nurses.

They go in and they look at systems, and they look at certain things; but they are more concerned about whether or not people are walking out the door with something than they are about the effectiveness of delivery of services. And that is, unfortunately, the job of the Congress. Maybe GAO can get more involved in looking at some of the operations in the VA, as far as oversight is concerned.

But I still do not think the IG budget should be cut because there are real concerns when you are talking about a $90 billion budget. I come from an old investigator's background so I have a real problem with that.

Mr. GAYTAN. The American Legion does not support the cut in the IG budget, sir.

Chairman AKAKA. Any other comments?

Mr. Blake.

Mr. BLAKE. Senator, I would say that we certainly, our recommendations reflect the fact that we believe that the IG's budget should actually be increased.

It is interesting that there was a line of questions along this idea in the House Committee hearing last week. While I will not comment one way or the other on some of the ideas brought up, it kind of makes you squirm when you consider what was being projected for what the IG should be responsible for, and outcomes that occurred because they did or did not conduct a particular investigation.

I think their role is too important to cut their budget, though. I think they can always use a little bit more, especially with a department this big.

Chairman AKAKA. Thank you very much.

Any further thoughts on that?

Mr. BAKER. I was going to say, Mr. Chairman, one, thank you for mentioning my testimony. My time in the field has brought me close to way too many people that have fallen through that loophole—that we were in combat and could not prove a specific incident—and so I appreciate your mentioning that.

As to your question, I think all we really have to do is look at the incidents that are going in Marion, IL, at the VA medical center. That will tell us we cannot cut the IG budget. If we do that, those very things could go on in other centers and there just might not be enough staff to investigate them fully, to prevent those things from happening in the future. I think that is a good example.

Chairman AKAKA. Thank you. I have many more questions for you, but I will submit them for the record at this time.

So, in closing, I want to again thank all of our witnesses for appearing today. And I want to thank the Secretary and his leaders who are still here. Thank you so much for doing this. Your input on these issues is valuable to the Committee as we consider our budget recommendations.

With that, let me say, thank you very much; and this hearing is now adjourned.

[Whereupon, at 12:58 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF THE NATIONAL COALITION FOR HOMELESS VETERANS

The National Coalition for Homeless Veterans (NCHV) appreciates the opportunity to submit testimony to the House Veterans' Affairs Committee regarding the U.S. Department of Veterans Affairs (VA) budget request for fiscal year 2009.

Established in 1990, NCHV is a nonprofit organization with the mission of ending homelessness among veterans by shaping public policy, promoting collaboration, and building the capacity of service providers. NCHV is the only National organization wholly dedicated to helping end homelessness among America's veterans.

The majority of NCHV members, which includes nearly 280 organizations in 48 States, the District of Columbia, Puerto Rico and Guam, provide the full continuum of care to homeless veterans and their families, including emergency shelter, food and clothing, primary health care, addiction and mental health services, employment supports, educational assistance, legal aid and transitional housing.

In 2007, VA reported that about 196,000 veterans are homeless on a given night and 400,000 veterans experience homelessness at some time during the year. The VA reports its homeless veteran programs serve 100,000 veterans annually, and NCHV member community-based organizations (CBOs) serve another 150,000.

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

FY 2009 VA BUDGET—HOMELESS VETERAN PROGRAMS

Congress has established a number of programs within VA to address homelessness among veterans. The primary goal for these programs is to return homeless veterans to self-sufficiency and stable independent living. The major homeless veterans programs administered by the VA include the Homeless Providers Grant and Per Diem (GPD) program, which includes transitional housing, supportive services centers, special needs grants, GPD program liaisons, and Stand Down support; the HUD-Veterans Affairs Supported Housing (HUD-VASH) program; the Multifamily Transitional Housing Loan Guarantee Program; and the Compensated Work Therapy Transitional Residence program. Homeless veterans also receive primary medical care, mental health and substance abuse services at VA medical centers and community-based outpatient clinics (CBOCs) through the Health Care for Homeless Veterans (HCHV) program.

The landmark Homeless Veterans Comprehensive Assistance Act of 2001 (Pub. L. 107–95) established new program authorities and reauthorized long-standing homeless programs within the VA. While the authorization law set explicit funding levels for many of the VA homeless programs and authorities, actual annual spending levels are set by the VA Secretary via allocation of funds from the VA medical services account, which are appropriated by Congress.

VA homeless veteran programs function not only as a safety net for homeless veterans unable or hesitant to access emergency shelter, transitional housing or supportive services organized for the general population, they also function as a safety valve when other VA programs fail to reach veterans at a high risk of homelessness, such as veterans with chronic mental illnesses, addictions and extreme economic hardships.

Our testimony will focus on these homeless veteran assistance initiatives, most of which owe their effectiveness and successes to the leadership of this committee. We have testified many times about the need for transitional housing and services for veterans in crisis, and celebrate the reduction in homelessness among these de-

serving men and women during the last 5 years. As we continue that legacy, we must also provide supports that will prevent homelessness among OEF/OIF veterans returning from war.

Homeless Provider Grant and Per Diem Program

The Homeless Provider Grant and Per Diem Program (GPD) is the Nation's largest VA program to help address the needs of homeless veterans and supports the development of transitional, community-based housing and the delivery of supportive services. The program's goals are to help homeless veterans achieve residential stability, increase their skill levels and income, and achieve greater self-determination. The GPD Program provides competitive grants to community-based, faith-based and public organizations to offer transitional housing and service centers for—homeless veterans. The GPD program is an essential component of the VA's continuum of care for homeless veterans, assuring the availability of social services, employment supports and direct treatment or referral to medical treatment. The program also funds GPD liaisons who provide program oversight, inspections and outcomes reporting essential to the success and efficiency of grant recipients.

In September 2007 the General Accountability Office (GAO) presented testimony before the Subcommittee on Health of this Committee regarding homeless veterans programs, and reported that an additional 11,100 transitional housing beds are needed to meet the demand presented by current VA estimates of the number of homeless veterans in need of assistance. This need does not yet include the increased requests for services expected from OEF/OIF veterans over the next 3 to 5 years.

The Consolidated Appropriations Act of 2008, which became Public Law 110–161 on December 26, 2007, provided for $130 million, the fully authorized level, to be expended for the GPD program. Based on GAO's findings and VA's projected needs for additional GPD beds, NCHV has concerns about the $138 million authorization for fiscal year 2009 and believes a $200 million authorization is needed. An increase in the funding level for the next several years would help ensure and expedite VA's program expansion targets. It would provide critical funding for service or drop-in centers—the primary portal that links veterans in need with the people who can help them. It would guarantee continued declines in veteran homelessness, and provide for scaling back the funding as warranted by the VA's annual Community Homelessness Assessment, Local Education and Networking Group (CHALENG) reports. The GPD program has evolved into a homelessness prevention network as much as a proven intervention care and treatment collaborative partner with the VA.

Special Needs Grants

The VA provides grants to VA health care facilities and existing GPD recipients to assist them in serving homeless veterans with special needs including women, women who have care of dependent children, chronically mentally ill, frail elderly and terminally ill veterans. Initiated in fiscal year 2004, VA has provided special needs funding to 29 organizations totaling $15.7 million. The VA Advisory Committee on Homeless Veterans 2007 report States the need and complexity of issues involving women veterans who become homeless are increasingly unexpected. Recognizing women veterans are one of the fastest growing homeless populations, the Committee recommended future notices of funding availability target women veteran programs including special needs grant offerings. Pub. L. 109–461 authorizes appropriations of $7 million for fiscal year 2007 through fiscal year 2011 for special needs grants. The increased risks of homelessness among each of these populations warrants funding for special needs grants above the currently authorized level. Additional funding for the Grant and Per Diem Program would address this need.

HUD-VASH

The joint HUD-VA Supported Housing Program (HUD-VASH) provides permanent housing and ongoing treatment services to harder-to-serve homeless veterans with chronic mental health, emotional and substance abuse issues. NCHV was pleased that Pub. L. 110–161 included $75 million to be used for 7,500 Section 8 vouchers for homeless and disabled programs. Under this program, VA must provide funding for supportive services to veterans receiving rental vouchers. The fiscal year 2009 VA budget must reflect a significant increase in funding these services.

We believe the $7.8 million in the fiscal year 2009 VA budget proposal was agreed upon before the dramatic increase in HUD-VASH vouchers became law. Based on historical data that shows each housing voucher requires approximately $5,700 in supportive services—such as case management, personal development and health services, transportation, etc.—we estimate approximately $45 million will be needed to adequately serve 7,500 or more clients in HUD-VASH housing units. Rigorous

evaluation of this program indicates this approach significantly reduces the incidence of homelessness among veterans challenged by chronic mental and emotional conditions, substance abuse disorders and other disabilities.

Multifamily Transitional Housing Loan Guarantee Program

This initiative authorizes VA to guarantee 15 loans with an aggregate value of $100 million for construction, renovation of existing property, and refinancing of existing loans to develop transitional housing projects for homeless veterans and their families. First authorized in 1998, only two projects have survived beyond the initial planning stages—in Chicago and San Diego—and only St. Leo's in Chicago has been developed.

While we believe this program seemed promising in its original design and intent, the real-life difficulties in long-term coalition building, planning and economic hardships developers have encountered to date strongly suggest a much more practical and streamlined program should be developed to address the critical supportive housing needs of homeless veterans and those at serious risk of homelessness due to chronic health problems and poverty.

A congressionally mandated analysis of 2000 U.S. Census data in fiscal year 2006 revealed approximately 1.5 million veterans are living below the Federal poverty level. The GAO and VA's own reports indicate an immediate need for more than 11,000 additional transitional housing beds for homeless veterans. And combat veterans from Iraq and Afghanistan—now in the fourth year of their repatriation—are requesting assistance in increasing numbers at VA and community-based service providers. The need for increased service capacity is immediate, and many community-based providers have successfully developed additional transitional and longer-term residential opportunities for their clients. We believe the resources earmarked for the Multifamily Transitional Housing Loan Guarantee Program might be better allocated to support projects that can be developed and brought on-line more swiftly.

Compensated Work Therapy/Transitional Residence (CWT/TR) Program

In VA's Compensated Work Therapy/Transitional Residence (CWT/TR) Program, disadvantaged, at-risk, and homeless veterans live in CWT/TR community-based supervised group homes while working for pay in VA's Compensated Work Therapy Program (also known as Veterans Industries). Veterans in the CWT/TR program work about 33 hours per week, with approximate earnings of $732 per month, and pay an average of $186 per month toward maintenance and up-keep of the residence. The average length of stay is about 174 days. VA contracts with private industry and the public sector for work done by these veterans, who learn new job skills, relearn successful work habits, and regain a sense of self-esteem and self-worth. We are pleased to see the additional funding provided for in the fiscal year 2009 proposed budget.

Mental Health Programs

Virtually every community-based organization that provides assistance to veterans in crisis depends on the VA for access to comprehensive health services, and without exception their clients receive mental health screenings, counseling and necessary treatment as a matter of course. These services are well documented, and case managers report this information to the VA as prescribed in their grant reports. Follow-up services—counseling, substance abuse treatments, outpatient therapies, medication histories and family support initiatives—are also monitored closely and reported in client case files.

Despite significant challenges and budgetary strains, the VA has quadrupled the capacity of community-based service providers to serve veterans in crisis since 2002, a noteworthy and commendable expansion that includes, at its very core, access to mental health services and suicide prevention. The development of the VA Mental Health Strategic Plan from 2003 through November 2004, and its implementation over the last 3 years with additional funding this committee fought for, has increased the number of clinical psychologists and other mental health professionals at VA medical centers, community-based outpatient clinics (CBOCs) and VA Readjustment Counseling Centers (Vet Centers). We believe the VA budget proposal would facilitate further implementation of the Mental Health Strategic Plan.

We strongly recommend, however, that more attention be directed to simplifying and expanding access to community mental health clinics for OEF/OIF veterans in communities not well served by VA facilities. Current regulations allow a veteran to apply for authorization to access services at non-VA facilities, but the process is often frustrating and problematic, particularly for a veteran in crisis. Protocols should be developed to allow the VA and community clinics to process a veteran's request for assistance directly and immediately without requiring the patient to first apply at a VA medical facility. In the interest of maximizing the immediate benefit

of mental health supports and minimizing the risk of harmful and even suicidal responses by a veteran to debilitating pressures—perceived or real—this initiative should be universal and well publicized.

Conclusion

The National Coalition for Homeless Veterans thanks this committee for its service to America's veterans in crisis. It has been a long and difficult campaign, but hundreds of thousands of lives have been restored and thousands of lives have been saved. We are honored to work alongside the Congress, the Administration, our Federal partners, and the service provider network that has transformed policy into hope and redemption for these deserving men and women. What we have learned in the last 20 years is the greatest promise we can offer the new generation of combat veterans coming home from Iraq and Afghanistan—we are prepared to honor your service, help heal your wounds, and ensure you enjoy the blessings of the freedom you have preserved.

PREPARED STATEMENT OF FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH (FOVA)

FY 2008 Appropriation—$480

FY 2009 President's Proposal—$442

FY 2009 FOVA Recommendation—$555

On behalf of the Friends of VA Medical Care and Health Research (FOVA)—the diverse coalition representing more than 80 national academic, medical, and scientific societies; voluntary health and patient advocacy groups; and veteran-focused organizations—thank you for your continued support of the Department of Veterans Affairs (VA) Medical and Prosthetic Research Program. We are deeply concerned about the President's proposed fiscal year 2009 budget for the VA research program. A time of war is not the time to cut research on the grievous injuries being suffered by veterans of the Afghanistan and Iraq wars.

FOVA Recommendations: For fiscal year 2009, FOVA recommends an appropriation of $555 million for VA Medical and Prosthetic Research and an additional $45 million for necessary research facilities upgrades appropriated via the VA Minor Construction account.

Prior Year Support: FOVA thanks the Committee for its strong support of VA research as evidenced by your fiscal year 2008 views and estimates with regard to the VA Medical and Prosthetic Research Program. The Committee's recommendation—$500 million—was an $89 million increase over the previous fiscal year and the President's fiscal year 2008 proposal. Your support for the program undoubtedly encouraged both chambers to adopt a significant increase in the program's final appropriation. FOVA encourages you to develop a views and estimates statement for fiscal year 2009 that reflects this same strong commitment to biomedical research for the benefit of veterans, and ultimately, all Americans.

VA Research Improves Veterans' Lives: The VA Medical and Prosthetic Research Program is one of the Nation's premier research endeavors, attracting high-caliber clinicians to deliver care and conduct research in VA health care facilities. The VA research program is patient-oriented and focused entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population. Recent successes to which VA has contributed include the implantable cardiac pacemaker, a new vaccine for shingles, and Stateof-the-art prosthetics, including a new bionic ankle.

President's Budget Request Falls Short: Considering the proven success of the VA research program, FOVA is disappointed with the President's proposal of $442 million for VA research in fiscal year 2009. The proposal fails to maintain funding at the level appropriated in fiscal year 2008. If enacted, the proposed $38 million (8 percent) cut will lead to significant programmatic reductions and will impede research advances in diseases and injuries that impact the veteran population. According to the President's proposal, VA will cut funding for research in central nervous system injury by 20 percent; acute and traumatic injury, military occupations and environmental exposure, and substance abuse by 18 percent; and mental illness by 15 percent. The cuts are counter to the Committee's report language calling for VA to "expand its research into the areas of neurotrauma, sensory loss, and Post Traumatic Stress Disorder with a focus on developing clinical practices using evidenced-based medicine." The President's budget request assumes the cut in the VA research account will be made up by large increases in Federal funding from other agencies, nonprofits, and private industry. We are skeptical these sources will be able to materialize such gains in VA.

Research Advances Require Sustained Investment: While FOVA appreciates the significant increase in funding approved last year, a one-time investment in research will not lead to the medical advances required to improve the lives of the Nation's veterans. VA research grants are awarded on a 3- to 5-year cycle; funding must be maintained over the grant cycle to sustain the investigator's research. Cuts in funding require VA to cut award levels for ongoing projects, thus diminishing productivity and output. In addition, funding fluctuation may limit the number of investigators willing to enter—and remain in—the VA system. The VA research program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators to the VA health care system, who in turn provide first-class health care to our Nation's veterans. FOVA encourages the Committee to consider the long-term needs of veterans and VA investigators when promoting future funding allocations for the program. The coalition encourages Congress to support planned growth for the VA research budget over the course of the next 3 years to continue the upward trajectory of the program in an orderly fashion.

Thank you for considering our views.

THE FOVA EXECUTIVE COMMITTEE

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PREPARED STATEMENT OF IRAQ AND AFGHANISTAN VETERANS OF AMERICA (IAVA)

Mr. Chairman and Members of the Senate Veterans' Affairs Committee, on behalf of Iraq and Afghanistan Veterans of America and our tens of thousands of members nationwide, I thank you for the opportunity to testify today regarding the VA budget request for 2009.

From April 2003–February 2004, I served as a First Lieutenant and Infantry Platoon Leader in Iraq. When I returned home, I quickly became concerned about the lack of real support for returning troops and veterans. In the early years of the wars, issues like Traumatic Brain Injury, Post Traumatic Stress Disorder, and homelessness received far too little attention.

But times have changed. Last year, this Congress showed tremendous commitment to our Nation's veterans, providing the VA with its single largest budget increase in 77 years. On behalf of the millions of veterans who rely on VA health care, including almost 300,000 troops newly home from Iraq and Afghanistan, we hope you will continue to show your support for veterans' health care. IAVA is one of the over 60 organizations who have endorsed the Independent Budget, and we endorse it again for fiscal year 2009.

As the war in Iraq continues into its fifth year, this generation of troops and veterans faces new and unique problems. Today, IAVA is releasing our annual Legislative Agenda. Our Legislative Agenda covers the entire warfighting cycle—before, during and after deployment—and outlines practical solutions to the most pressing problems facing Iraq and Afghanistan veterans. Our Legislative Agenda is available at IAVA's website, www.iava.org.

The cornerstone of our 2008 Legislation Agenda is a new GI Bill. After World War II, nearly eight million servicemembers took advantage of GI Bill education benefits. A veteran of WWII was entitled to free tuition, books and a living stipend that completely covered the cost of education.

Today we have the opportunity to renew our social contract with our servicemen and women, and help rebuild our military. IAVA supports reinstating a World War

II-style GI Bill that will cover the true cost of education and will fairly reward all combat veterans of Iraq and Afghanistan. We have endorsed S. 22.

Critics have said the GI Bill is too expensive. The fact is: a new GI Bill is a bargain. The current GI Bill cost the Veterans' Affairs Department $1.6 billion in 2004. Even if a World War II-style GI Bill were to double that cost, it would be about what we spend in a week in the War on Terror. And the GI Bill is more than a veterans' benefit. It is also an effective tool to stimulate the economy and to improve military readiness.

The GI Bill helped rebuild this country's economy after World War II. A 1988 Congressional study proved that every dollar spent on educational benefits under the original GI Bill added seven dollars to the national economy in terms of productivity, consumer spending and tax revenue.

Many of our Nation's leaders got their start thanks to the GI Bill, including Presidents Gerald Ford, George H.W. Bush, and Senators Bob Dole, George McGovern, and Pat Moynihan. The GI Bill also educated 14 Nobel Prize winners and two dozen Pulitzer Prize winners, including authors Joseph Heller, Norman Mailer, and Frank McCourt.

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

When Sgt. Bowers was activated for his second deployment to Iraq, he was forced to withdraw from his classes at George Washington University, racking up an extra semester's debt without receiving credit for his coursework. While he was deployed to Iraq, Bowers was wounded when a sniper's round penetrated his rifle scope and sent fragments into the left side of his face. He was awarded the Purple Heart and Navy Commendation medal with "V" device for Valor. But when Bowers returned home, he was not greeted as a hero by his university and credit lenders. His student loans had been sent to collection, and his credit rating was ruined. Struggling to keep up with payments, Bowers was eventually forced to leave school.

The GI Bill is also an important recruitment tool. For years, the military has been lowering recruitment standards and increasing bonuses. We now spend more than $4 billion annually on recruitment, but we're still struggling to meet recruiting goals. The GI Bill is the military's single most effective recruitment tool; the number 1 reason civilians join the military is to get money for college. A new GI Bill, one that put college within reach of a new generation of veterans, would be a tremendous boon to recruitment and would help rebuild our military after years of war.

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

For all of these reasons, IAVA is calling for a new GI Bill to be funded in this year's budget.

Thank you for your time.

Respectfully Submitted,

PAUL RIECKHOFF,
Executive Director.

IDAHO DIVISION OF VETERANS SERVICES,
Boise, ID, February 11, 2008.

Hon. LARRY E. CRAIG,
U.S. Senate, Washington, DC.

DEAR SENATOR CRAIG: In the 109th Congress, on June 6, 2006, you introduced Senate Bill 3421, which would amend title 38, United States Code to improve the following veterans' benefits:

> *To amend title 38, United States Code, to repeal certain limitations on attorney representation of claimants for benefits under laws administered by the Secretary of Veterans Affairs, to expand eligibility for the Survivors' and Dependents' Educational Assistance Program, to otherwise improve veterans' benefits, memorial affairs, and health care programs, to enhance information security programs of the Department of Veterans Affairs, and for other purposes.*

Under the provisions of section 1745 of Senate Bill 3421, the following benefits are stated:

'Sec. 1745. Nursing home care and medications for veterans with service-connected disabilities
'(a)(1) The Secretary shall pay each State home for nursing home care at the rate determined under paragraph (2), in any case in which such care is provided to any veteran as follows:
'(A) Any veteran in need of such care for a service-connected disability.
'(B) Any veteran who—
'(i) has a service-connected disability rated at 70 percent or more; and
'(ii) is in need of such care.
'(2) The rate determined under this paragraph with respect to a State home is the lesser of—
'(A) the applicable or prevailing rate payable in the geographic area in which the State home is located, as determined by the Secretary, for nursing home care furnished in a non-Department nursing home (as that term is defined in section 1720(e)(2) of this title); or
'(B) a rate not to exceed the daily cost of care, as determined by the Secretary, following a report to the Secretary by the director of the State home.
'(3) Payment by the Secretary under paragraph (1) to a State home for nursing home care provided to a veteran described in that paragraph constitutes payment in full to the State home for such care furnished to that veteran.'.
(2) PROVISION OF PRESCRIPTION MEDICINES—Such section, as so added, is further amended by adding at the end the following new subsection:
'(b) The Secretary shall furnish such drugs and medicines as may be ordered on prescription of a duly licensed physician as specific therapy in the treatment of illness or injury to any veteran as follows:
'(1) Any veteran who—
'(A) is not being provided nursing home care for which payment is payable under subsection (a); and
'(B) is in need of such drugs and medicines for a service-connected disability.
'(2) Any veteran who—
'(A) has a service-connected disability rated at 50 percent or more;
'(B) is not being provided nursing home care for which payment is payable under subsection (a); and
'(C) is in need of such drugs and medicines.'.
(3) CONFORMING AMENDMENTS—
(A) CRITERIA FOR PAYMENT—Section 1741(a)(1) is amended by striking 'The' and inserting 'Except as provided in section 1745 of this title, the'.
(B) ELIGIBILITY FOR NURSING HOME CARE—Section 1710(a)(4) is amended—
(i) by striking 'and' before 'the requirement in section 1710B of this title'; and
(ii) by inserting ', and the requirement in section 1745 of this title to provide nursing home care and prescription medicines to veterans with service-connected disabilities in State homes' after 'a program of extended care services'.
(4) CLERICAL AMENDMENT—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1744 the following new item:
'1745. Nursing home care and medications for veterans with service-connected disabilities.'.
(5) EFFECTIVE DATE—The amendments made by this subsection shall take effect 90 days after the date of the enactment of this Act.
(b) Identification of Veterans in State Homes—Such chapter is further amended—
(1) in section 1745, as added by subsection (a)(1) of this section, by adding at the end the following new subsection:
'(c) Any State home that requests payment or reimbursement for services provided to a veteran under this section shall provide to the Secretary such information as the Secretary considers necessary to identify each individual veteran eligible for payment under such section.'; and
(2) in section 1741, by adding at the end the following new subsection:
'(f) Any State home that requests payment or reimbursement for services provided to a veteran under this section shall provide to the Secretary such information as the Secretary considers necessary to identify each individual veteran eligible for payment under such section.'

On December 9, 2006, the President of the United States signed Public Law 109–461, which enacted your legislation. As of today, February 11, 2008, fifteen months after enactment, the Idaho State Veterans Homes can not received reimbursement from the Department of Veterans Affairs for these veterans because they have not

implemented the law. We have several veteran residents who face making the difficult decision to leave their Veterans Home and enter into a private facility where the Department of Veterans Affairs can reimburse private long-term care facilities and not State Veterans Homes. It is an injustice to our veterans that wish to remain residents of a State Veterans Home and cannot because this law has not been implemented.

We request your assistance in encouraging the Department of Veterans Affairs to put in place Public Law 109–461. We also request that reimbursements be retroactive to March 9, 2007, since the implementation of Public Law 109–461 was to be in effect 90 days after enactment.

I want to thank you for all you have done for the veterans of this country and especially Idaho. Without someone fighting for our rights in Washington, DC, we would not have the benefits we enjoy today.

Respectfully,

DAVID E. BRASUELL,
Administrator.

Boise, ID, February 8, 2008.

Senator LARRY E. CRAIG,
Senator MIKE CRAPO,
Representative BILL SALI,
Representative MIKE SIMPSON,
The Idaho Congressional Delegation

My father, Francis J. Hess Sr. is a veteran of WWII and an ex-POW. He is 90 years old and residing at the Idaho State Veterans Home in Boise. He has a 100 percent service-connected disability.

When discussing admission with the Idaho State Veterans Home over a month ago they assured me that they were in negotiations with the Department of Veterans Affairs to be one of the contractors in the Boise area that would provide nursing home care to veterans with a 70–100 percent service-connected disability and likely those negotiations would be complete by March 2008.

A bomb was dropped on my father, myself and my entire family today when we were informed by the Veterans Home that the Secretary of Veterans Affairs, Dr. Peake, has decided to halt negotiations until next year. This will cost my family and all the other families affected approximately $4300 per month. Our personal situation is even more precarious because our stepmother is suffering from cancer and has huge costs associated with that.

What was to be a blessing for our entire family has turned into a nightmare. How could I possibly move my 90-year-old father to another facility when he has been experiencing the best care available at the Idaho State Veterans Home? Why would Dr. Peake stop negotiations with the finest nursing home for veterans in the State of Idaho?

My entire family is praying that you will be able to prevail upon Dr. Peake to complete the negotiations now with the Idaho State Veterans Home.

Please help and thank you for all that you do for Idaho.

Respectively,

FRANCIS J. HESS JR.

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