S. HRG. 109–72

PROPOSED FISCAL YEAR 2006 BUDGET FOR DEPARTMENT OF VETERANS AFFAIRS PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

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C O N T E N T S

TUESDAY, FEBRUARY 15, 2005

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PROPOSED FISCAL YEAR 2006 BUDGET FOR DEPARTMENT OF VETERANS AFFAIRS PROGRAMS

TUESDAY, FEBRUARY 15, 2005

UNITED STATES SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:01 a.m., in room SR–418, Russell Senate Office Building, Hon. Larry Craig presiding.

Present: Senators Craig, Burr, Thune, Akaka, Rockefeller, Jeffords, Murray, Obama, and Salazar.

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

Chairman CRAIG. Well, good morning, everyone, and welcome to the Committee on Veterans' Affairs here in the U.S. Senate. Secretary Nicholson, welcome back. Your first experience here was a positive one. We will at least try to keep it level today; how is that?

It is a pleasure to welcome you and your staff and the veterans service organizations who are scheduled to testify this morning at this most important hearing. The subject of today's hearing is the proposed VA budget for fiscal year 2006. We will hear testimony from Secretary Nicholson and his senior VA officials who have accompanied him here today. Then, we will hear the views of five veterans service organizations on these budget proposals.

Before we turn to the important business, I will note that while this is the Committee's third hearing of this year, it is the first in which we have the opportunity to hear formal testimony from the veterans service organizations, and I want to welcome the representatives of the American Legion, the Veterans of Foreign Wars, the Disabled American Veterans, the Paralyzed Veterans of America, and AMVETS, who are here with us this morning. Ladies and gentlemen, thank you for being here. I do look forward to working with you as we advance the interests of our Nation's veterans.

I stated in this room a couple of weeks ago at Secretary Nicholson's confirmation hearing that I expected the fiscal environment this year to be considerably less friendly than it was during the flush years of the past four. Ladies and gentlemen, that prediction seems to have been borne out. Compared to prior years, this proposed budget is lean, particularly in the area of proposed medical care funding. But I do hasten to add that compared to other agen-

cies, which have to endure significant cuts in funding, the veterans seem at this time to be better off.

But clearly, the proposed funding increases for VA, particularly in the medical care area, are small. Equally clear, by themselves, they will not be sufficient to allow VA to continue to operate as it has. I think all will agree that the VA will need medical care funding that exceeds its requested appropriations increase if VA is to maintain current levels of service.

With one major exception, which I will discuss in a moment, VA does not propose cutbacks in services; indeed, it projects that it will treat more veterans in fiscal 2006 than it did in fiscal 2005. VA also projects that it will provide more and better medical services in 2006 than it did in 2005 under the proposed VA budget. For example, improve veterans access to mental health care and homeless treatment services; eliminate long-term care co-payments for former prisoners of war; provide greater assistance to defraying emergency care expenses borne by VA enrollees at non-VA emergency rooms and increase funding for non-institutional long-term care services.

So the question this year is this: how can the Congress fill the gap between what the VA requests in the form of appropriated funding and what the VA needs in order to provide the services that we want VA to provide? Here is what the Administration is suggesting: it suggests that it will improve efficiencies and streamline operations, thereby saving about $590 million.

It states that it will collect an additional $211 million in fees, reimbursements, under legal authorities that currently govern the VA. It states that it will collect an additional $424 million in fees if Congress authorizes it to require more cost-sharing by higher-income vets who are not service disabled. The fees VA proposes are, one, an enrollment fee of $250 per year to be paid by priority 7 and 8 veterans, and two, an increase in prescription drug co-pay to $15, to be paid by the same group of veterans.

Finally, VA proposes to save $606 million in the provisions of VA-provided or VA-financed institutional long-term care by narrowing the universe of veterans to whom such care would be provided. VA proposes that in the future, such care would only be provided to disabled veterans. It also proposes that Congress repeal the requirement that VA maintain nursing home care bed capacity at the 1998 levels.

These four proposals would, according to VA, yield savings and generate revenues exceeding $1.8 billion, an amount that VA says would bridge the gap between what it needs and what it asks for. Of course, the implementation of two of VA's proposals: increased management efficiencies and increased collections under current legal authorities require no Congressional action. We will expect in any and all cases that VA implement these changes.

The question that remains, then, is this: will Congress approve VA's cost-sharing proposals and its proposal to limit nursing home care to service-connected veterans? I, for one, will reserve judgment on that until I have heard all of the testimony. I do emphasize this, however: I have been told that in the past, such proposals have been declared dead on arrival, perhaps even before testimony was heard, and such proposals were finally analyzed.

I do not intend to take that approach with respect to these proposals or any other proposals. One of the advantages of new leadership in this Committee is that proposals to do different things at VA should receive a fresh view, and I intend to consider these proposals afresh. I intend, as well, to fairly consider alternatives to these proposals, including the alternative that VA be provided more appropriated funds than it has requested.

Unfortunately, I must warn all, as I did at Secretary Nicholson's confirmation hearing, that it may be unrealistic to anticipate this sort of funding increases that VA has enjoyed in recent years. If we cannot secure these increases, we may have to consider other alternatives and identify the alternatives that ensure that we properly care for the most worthy and the most needy of our veterans.

Again, I would like to welcome the witnesses. Before I do that, I have been joined by several of my colleagues, and let me turn first and foremost to Senator Danny Akaka, the Ranking Democrat on this important Committee, for his observations and comments he would wish to make.

Danny.

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

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

I really look forward to working with you on this Committee and also with the Secretary and the Department of Veterans Affairs. I want to extend my welcome and, where I come from, my aloha to the Secretary, and I must confess, Mr. Secretary, you look good, and I hope I can say that at every hearing we have with you, and I expect that to continue. Less than 1 month ago, you stood before this Committee at your confirmation hearing, and today, you are called upon to present and to defend the President's budget for VA. And I look forward to a good discussion with you and with the veterans groups represented here today.

This budget is presented as, and I quote, the best we can do in a tough financial climate, end quote. In my view, especially in a time of war, with so many competing demands, we can, and we should do much, much better. I have a number of concerns that I will discuss today and will work on it in the weeks ahead as we seek to shape the Department's budget for next year.

There is much in this budget that is, let me say, misleading. What we seem to have is agreement on a certain level of funding, but not a commitment to appropriate that amount. Let me say at the outset that our starting point on the health care side makes our work especially difficult. There can be little doubt that the proposed funding for medical care is below the amount needed to fund current services, let alone to improve mental health and long-term care, and it is certainly not enough to provide the best care for returning servicemembers.

Rather than providing sufficient funding, this budget calls upon veterans to shoulder the cost. We are presented with recycled proposals to double the drug co-payment and to charge a yearly enrollment fee for veterans who simply want to use VA care. Let me set the record straight about the types of veterans who would be shouldering these costs: these veterans are not affluent, as they have

been described. They are veterans living in States like Hawaii where the cost of living is one of America's highest. We are talking about veterans making as little as $26,000 a year.

The proposed cuts to long-term care are especially troubling. The Administration not only intends to freeze grants for the construction of State veterans homes, but to cut the daily funding for these homes. The State home program has been described by members of both parties as incredibly cost-effective. Still, we have an idea on the table that imperils the very existence of these homes.

The President's solution to making room for returning servicemembers is to literally force other veterans out of the system. This is short-sighted, as the proposed cuts will surely affect Iraq and Afghanistan veterans once the 2-year window of automatic VA care closes. Due to the punitive proposals in the budget and the fact that 2 years is simply not enough time for guaranteed VA care, I will be working to extend the time period for automatic VA care. Many health problems that can result from service do not surface until many years later, as we know it, including post-traumatic stress disorder and other mental illnesses.

With regard to the VBA budget, the additional 112 compensation staff are a 1-year only increase. VA has stated that it will look for solutions if work load rises higher than the 3 percent estimated. I am hopeful that VA can manage an increased work load from benefit delivery at discharge claims, possible legislation, or court decisions, but would urge caution because we have seen in the past that VA does not always absorb changes in law and new business processes without going into a nosedive.

I will continue to monitor VA's workload and rating output, because our veterans deserve nothing less than their claims rated accurately and in a less reasonable amount of time. Again, welcome to all of you here today, and I look forward to our work on behalf of the Nation's veterans in the weeks and months ahead, as our Committee continues in our efforts to get a much better fiscal year 2006 budget for veterans programs.

Thank you very much, Mr. Chairman.

Chairman CRAIG. Senator Akaka, thank you.

We have been joined by a variety of our colleagues. Could I ask this admonition of all of you, in sake of making sure that we get to those witnesses an adequate time? As the Chairman, I do believe that those who attend ought to have a right to make opening statements, and I am certainly going to agree to that. But if you could, shall we say, summarize them and place them in the record so that we can get at the testimony of all who have come today and, more importantly, get at the questions that follow, that would be greatly appreciated.

And if you can agree with me on that, let me move to a priority of those who came in, and we will handle that as they came in, and I will turn to Senator Rockefeller.

Senator.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman, and I will be very brief, and I also want to apologize not only to you, Mr. Chair-

man, but also to you, Secretary Nicholson. I have to go to a Commerce Committee hearing, which is doing transportation security, for which I, on my meager side of the aisle, am responsible, so you will forgive me if I submit my questions.

First of all, Mr. Chairman, again, even on our second hearing, for me, at least, I feel your fairness and your evenness and your good attitude in the way you chair the Committee. It makes all the difference in the world to all of us.

Also, Secretary Nicholson, I fully understand that while the budget was being prepared by others, you were not here; you were elsewhere, and that makes it very difficult. You know, I think, without my telling you that I have the highest regard for you, and we have had very, very good conversations. I guess your problem is that you are now responsible for this budget, even though you had nothing to do with the making of it, and that puts a burden on you, but it is a moral burden, and Mr. Chairman, I want to say that things can be changed.

I remember once when I was Chairman of this Committee, I prevailed upon Vice President Gore in a not particularly pleasant conversation to increase the amount of funding. You cannot do that with OMB, but you can if you can get to either the President or the Vice President. It is not just Secretary Nicholson, but it is all of us who have to fight for this increase.

I will just quickly say that the doubling of prescription drug copayments and the $250 deductible, I just predict to you will not reach halfway to first base. I mean, it just will not. It has been there before; it has not gotten there before. It is just an automatic rejection, I think, in both houses.

The budget does not even equal the cost of inflation and VA payroll, so these are important matters. The PTSD that Senator Akaka mentioned is huge. We do not just have the soldiers that we are already responsible for, but the ones who are coming back in enormous numbers. I would say with respect, Mr. Chairman, to State veterans nursing homes across the country, we are fortunate in Clarksburg that we have one that is underway, but there are a lot of States that do not, and I worry about that. I also worry about the commitment to research on what we used to call the Persian Gulf War Syndrome, which I guess is now called the Gulf War Veterans Illness.

I spent about 10 years, literally, on this Committee doing research on Gulf War Veterans Illness. We had a special investigative unit; came out with all kinds of things. Dr. Stephen Joseph, who is still at DoD, never replied to anything we had to say, and I think we are being proven correct, that pyridostigmine bromide was a problem; other things were a problem. I believe that defective babies of returning soldiers only emphasized how serious that problem was.

Last year, Secretary Principi pledged $60 million. $9 million has been cut. That means a lot, because general research is not just a matter of research into issues, but it is also a question of the nature and the quality of the doctors who are recruited. In turn, they attract others who come, and as you know, 50 percent of our physicians do some training at the VA hospital in the course of their careers.

There are a lot of areas, and I, like the Chairman, want to keep an open mind in terms of looking at alternative solutions, but at some point, you just cannot get around money, and that is where I think all of us here have a responsibility, and I want to work with you, Mr. Secretary, in terms of making the best possible outcome.

I thank you, Mr. Chairman. Can I submit my questions to you?

Chairman CRAIG. Without objection, your questions will be a part of the record, and we will submit the questions in writing to the Secretary.

[The questions follow:]

DEPARTMENT OF VETERANS AFFAIRS RESPONSES TO POST-HEARING QUESTIONS FROM CHAIRMAN LARRY E. CRAIG

Question 1. With respect to the Administration's proposal that VA increase prescription drug co-payments:

A. Are these proposals the same ones that VA has made in prior years? Since Congress has previously declined to approve such fee proposals, why has the Administration submitted them again?

Response: The proposals are similar to those previously presented. Eligibility reform legislation requires the Secretary to decide annually whether VA has adequate resources to provide timely, high quality care for all enrolled veterans. For several years, VA has proposed cost-sharing policies for Priority 7 and 8 enrollees as a means of balancing veteran demand for VA health care and available resources and ensuring that VA has the capacity to serve those veterans who need us most—veterans with service-connected medical conditions, special needs, and low incomes.

B. How does VA know that these new fees and co-payments will generate an additional $424 million in new revenues? Is it possible to be that precise?

Response: Milliman, Inc., a private-sector health care actuarial firm, produces the estimates of veteran demand for VA health care, including enrollment, utilization, and expenditures, that are the basis of the Veterans Health Administration (VHA) budget. Milliman also produced the estimate of the revenue expected from the enrollment fee and prescription drug co-payment increase. These estimates are based on actuarially sound assumptions regarding those enrollees who are expected to pay the enrollment fee and their estimated prescription drug utilization.

C. You propose to increase co-payments from $7 to $15 (for each 30-day supply of prescription medications). How did you arrive at the $15 number?

Response: The $15 co-payment for a 30-day supply of medication was considered to be a low level of cost-sharing for Priority 7 and 8 enrollees who wished to access prescription drugs through the VA health care system.

D. If the proposed increases in co-payments do become a reality, do you anticipate increasing the monthly and annual caps on out-of-pocket payments by veterans to reflect the new costs? If so, what will those new caps will be?

Response: The proposed increase in the prescription co-payment applies only to Priorities 7 and 8. The prescription drug co-payment caps apply to enrollees in Priorities 2–6, not enrollees in Priorities 7 and 8; therefore, the caps will not be affected.

Question 2. Current law (38 U.S.C. § 1722A(a)(2)) prohibits VA from requiring a veteran to pay an amount: in excess of the cost to the Secretary for medication provided to the veteran. The most recent information supplied to the committee showed that VA's average cost per 30-day of medication is just under $15 (approximately $14.85). Are you seeking to remove from statute the prohibition on charging veterans more than VA's cost for prescription medications? If so, are you at all concerned about the prospect of turning VA's prescription drug benefit into a profit-making endeavor? Why should Congress allow that?

Response: A legislative proposal accompanying the fiscal year 2006 budget submission would allow VA to increase the prescription drug co-payment of $15 per 30-day-supply of medication for priority 7 and 8 veterans. Consistent with Secretary Nicholson's February 16, 2005, testimony before the House Committee on Veterans' Affairs, the $15 co-payment was considered to be a reasonable cost share for veterans who have no compensable service-connected disabilities and do have the means to contribute to the cost of their care. VA does not anticipate making a profit on its prescription drug benefit. Only a small percentage of prescriptions would cost less than $15 (co-payment plus administrative cost). The cost of more expensive prescriptions would far outweigh those that are less than $15.

Question 3. Your drug co-payment proposal would create the following categories of VA co-payment payers: (1) Those whose incomes are below the pension level (who would pay no co-payments); (2) Those whose incomes are above the pension level, but below the priority 7 income "cut off" (who would continue to pay $7); and (3) Those in Priority 7 & 8 (who would now pay $15). Do you believe that VA has the ability to capture the correct information on which patients should pay which co-payments? Can you assure me that if you move forward in this area that indigent veterans won't start receiving drug co-payment bills for $15 each month for each medication he or she receives?

Response: Veterans are presently charged medication co-payments based on income and eligibility status. The proposal to incorporate a $15 co-payment for Veterans in Priority Groups 7 and 8 does not require VA to establish new income analysis procedures. VA already has income information available and uses it for medication copayment and medical care co-payment determination purposes as well as for enrollment priority assignment. VA performs these income assessments on a regular basis. Indigent veterans who provide requisite financial information to VA will not be inappropriately billed a $15 medication co-payment as a result of this legislation.

Question 4. Last year, Congress enacted the Medicare Modernization Act which, for the first time, provides Medicare beneficiaries with prescription drug coverage.

A. Has VA conducted any assessments of the impact this legislation will have on the number of veterans who rely on VA health care to provide prescription drug coverage? If so, what has this assessment shown?

Response: Milliman, Inc., the private-sector actuarial firm that develops projections of veteran demand for VA health care, has advised VA that the impact of the new Medicare drug benefit on VA enrollment, utilization, and expenditures is expected to be minimal. The biggest impact is expected to come from reductions in employer-based prescription drug coverage. However, the impact may not become significant until as late as 2016 since the most recent cutbacks have been for future retirees only; those eligible for retirement (over age 55) have been grandfathered into employer's current plan. Based on recent estimates of retirees who could lose benefits, enrollment in VA health care could increase by an estimated 35,000 (less than 1 percent) within the 10–15 year period following the start of the Medicare prescription drug benefit.

B. Does VA believe that there is a way VA can work in concert with Medicare on the provisions of prescription medications for Medicare-eligible veterans? If so, has VA leadership approached the leadership of the Centers for Medicare and Medicaid Services to discuss and proposals?

Response: VA currently provides prescription medications to enrolled veteran patients who are also eligible for Medicare. VA will continue to provide this prescription coverage to Medicare eligible veterans who chose VA as their health care provider, even after Medicare Part D is fully implemented.

VA believes that VA and the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) can work together so that beneficiaries who chose to use both VA and CMS prescription benefits do so in a safe and cost-effective manner.

To that end, VA Pharmacy Benefits Management staff and staff from the Centers for Medicare and Medicaid Services (CMS) have had preliminary discussions about potential VA/CMS patient safety and electronic prescribing initiatives.

Question 5. VA has also proposed that it be allowed to charge an annual "enrollment fee" of $250 to Priority 7 & 8 veterans.

A. What is the purpose of this proposed fee?

Response: VA has proposed cost-sharing policies for Priority 7 and 8 enrollees as a means of balancing veteran demand for VA health care and available resources and refocusing the VA health care system on those veterans who need us most. With the implementation of the enrollment fee, we expect that 71 percent of those using VA's health care system in 2006 will be veterans with service-connected medical conditions, special needs, and low incomes, up from 66 percent in 2004.

B. Is it not the case that enrolled veterans who do not "show up" for VA care cost VA nothing? If these enrollees do not cost VA anything, what is the problem that VA is trying to solve here?

Response: While some enrollees may not use any VA health care services in a given year, they have the potential to use VA health care services as long as they are enrolled. VA believes that the annual $250 enrollment fee is a modest level of cost sharing for those Priority, 7 and 8 enrollees who wish to access the VA health care system; and is in line with the premium of $230 paid by military retirees in TRICARE. Enrollees are expected to make an economic decision as to whether or

not to pay the enrollment fee, based in large part on whether or not they have other health care coverage options.

Question 6. VA's budget proposal seems to indicate that the proposed "enrollment fee" will cause nearly 'I million veterans to leave the rolls.

A. Is it true that approximately 900,000 (or 82 percent) of those who would "disenroll" are not users of the system today?

Response: It is estimated that from fiscal year 2005 to fiscal year 2006, the implementation of a $250 enrollment fee and increased pharmacy copay ($15) as of October 1, 2005 would result in a net reduction in P7/8 enrollment levels of 1.1 M, and a net reduction in the numbers of P7/8 patients of 203K. These FY05 to FY06 decreases are "net" decreases, as they include both projected new growth in P7 enrollments and in P7s' usage of health care as well as projected declines in P7/8 enrollments and P7/8 usage due to the implementation of the enrollment fee and increased pharmacy copay. Of the 1.1 M net reduction in the numbers of P7/8 enrollees between FY05 and FY06, it is estimated that about 900K could be categorized as "non-users" of the VA health care system. As this is a "net" end of fiscal year figure, it includes some veterans who are enrolled now and who will later decide to disenroll, as well as some who have not yet enrolled, but who will eventually enroll and also later decide to disenroll.

B. While I can understand why someone who doesn't use the system might not want to pay $250 for the privilege of just staying enrolled, why do you believe that nearly 200,000 users of the health care system would leave? Do you believe that most of these patients have private insurance? Or is this group predominately those without insurance who can't afford the new $250 fee?

Response: About 25 percent of all Priority 7 and 8 patients have private coverage, and about 69 percent of all Priority 7 and 8 patients have Medicare. When all sources of coverage are considered, about 85 percent of P7/8 patients have some type of health insurance coverage. Many P7/8 users of VA health care are largely low intensity users of VA health care services, such as pharmacy only, and since most of them have other health care options, which often include drug benefits, they would be inclined to disenroll rather than pay the $250 enrollment fee and the increased pharmacy copay.

Question 7. Your proposals to overhaul long-term care programs are ambitious. VA projects that if it narrows eligibility for long-term institutional care services to service-disabled veterans only, the number of long term care beds that VA will need will drop by almost 30 percent (from almost 14,000 to 9,795).

A. As I understand it, VA wants to deemphasize so called "geriatric care" and limit that type of service to service-connected and catastrophically disabled veterans. Why is that? Isn't there a need for geriatric care as well as "rehabilitative" care?

Response: VA will continue to emphasize the provision of a spectrum of institutional and non-institutional geriatric and extended care services to enrolled veterans. However, in a time of constrained national resources, VA proposes to restrict the provision of long-term maintenance nursing home care to our highest mission priority, service-connected disabled veterans and those with special needs not generally met in the community. VA's proposal is more generous than current law, which mandates nursing home care only for veterans who are 70 percent or more service-connected disabled.

VA is projecting a substantial increase in both workload and funding for the non-institutional programs it supports. The average daily census in these home and community-based care (HCBC) programs is projected to rise from 30,118 in fiscal year 2005 to 35,540 in fiscal year 2006 (an 18 percent increase). Funding is projected to increase from $339 million in fiscal year 2005 to over $400 million in fiscal year 2006 (also an 18 percent increase). The projected increases in HCBC programs will serve to offset some of the reductions in nursing home care. HCBC is preferred by most patients and their families and is more cost effective than inpatient care. VA believes the proposals on long-term care in this budget provide an appropriate balance between congressionally mandated nursing home services and the national trend toward increased use of non-institutional home and community-based services in preference to nursing home care.

B. Assuming there is a need for geriatric care, why doesn't VA want to meet the need? Who will meet it if VA does not?

Response: The projected need for long-term maintenance nursing home care is far beyond VA's capacity to meet alone. As noted above, VA must focus its efforts on its core mission in a time of constrained national resources. The remaining need will be met by other Federal and State programs (e.g. Medicare and Medicaid), personal insurance and private payments.

C. Please explain how you arrived at a projected bed level of 9,795? Will that number allow you to continue to provide so called "geriatric care" to the service connected and the catastrophically disabled who need those services?

How many of those beds would be used for "rehabilitative" nursing care as opposed to "geriatric" nursing care?

Response: VA's Long-Term Care Planning Model projects that an average daily census of 9,795 veterans in VA Nursing Home Care Units, combined with additional capacity in the community and State Veterans Home. programs also supported by VA, will be sufficient to provide: long-term maintenance care to all service-connected and special needs veterans who need long-term care, as well as short-term rehabilitative, hospice, and respite care for all priority groups of veterans who need short-term care. The average daily VA Nursing Home Care Unit census will include approximately 2,440 veterans receiving short-term care and 7,355 receiving long-term maintenance care.

Question 8. The State Home program, by most accounts, has been a successful partnership between the Federal and State governments for the care of aging veterans. Yet VA proposes to modify its past per diem payment policies—a change in policy that VA says will reduce the number of State home beds by more than 50 percent.

A. Why does VA want the States to reduce the number of State home beds? Even if VA does not want to provide institutional care to the non-service-connected, why does it want to discourage States from meeting that need?

Response: VA is proposing a change in per diem payment policy. VA is not proposing that the states reduce the number of State Home beds. The states are responsible for the operation and management of the State homes and the VA is prohibited by law from intervening in operation and management. However, in a time of constrained budgets, VA determined to focus its resources on our highest mission priority (service disabled veterans and veterans with specialized and short-term nursing home care needs). With this shift in mission, reductions were proposed for VA support of all three VA nursing home care programs.

VA recognizes the proposal on nursing home eligibility has challenged our relationship with State Homes. However, other portions of the State Veterans Home Program, the per diem for the domiciliary facilities, hospitals, and adult day healthcare, experience no reductions in the fiscal year 2006 President's Budget.

B. Under this proposal, VA would no longer pay per diems to support the care of poor veterans. Don't these veterans need help in meeting these expenses? If these patients are "priority" patients for purposes of eligibility for VA medical care, why does VA want to discourage the provision of this care by the States?

Response: VA would continue to pay per diems for the highest mission priority veterans and remains committed to providing long term care to these veterans. The cost of care in a State Veteran Home varies by State home. Provision of coverage and financial assistance varies by State. Some States cover all expenses that VA per diem does not cover, and some costs are met by other Federal and State programs (e.g., Medicare and Medicaid). All states remain at liberty to provide care for poor veterans to the extent State resources permit.

C. Does VA assume such closures will occur when payments for non-priority veterans (those without a service-connection) cease? Does VA believe that it has the legal authority to simply stop paying per diem payments to states for the care of veterans VA doesn't define as a priority?

Response: VA is seeking legislative authority to align VA per diem payments to State veterans homes with VA's revised long-term care eligibility policy. Enactment of this proposal would ensure fairness and consistency in how VA treats veterans needing long-term care across all venues, including VA nursing homes, community nursing homes, and State nursing homes. We are unable to comment on how individual States would respond to this change in policy.

D. It seems to me that VA encouraged the States to build long-term care capacity by offering them construction subsidies. Would a change in the "rules of the game" after these State homes have been built not break the bargain that the Federal Government has struck with the States?

Response: The VA State Home Construction Grant Program assists States in construction and renovation costs for nursing homes, domiciliary facilities and adult day healthcare. The program does, not require the State to participate in the State Veteran Home Per Diem Grant Program, or guarantee the ongoing subsidy of per diem payments. The law is separate for each of the programs.

E. Is VA proposing that current law, which requires that at least 75 percent of the beds in a State home be occupied by veterans, be changed to a lower "veteran occupancy" requirement so that the homes can remain open in spite of the fact that

veterans may not be the primary occupants? If this change is not on your radar screen, how do you propose the homes stay open with 66 percent less patients?

Response: State homes will continue to be occupied to the extent that individual states discharge their fiscal responsibility for the operation and management of the homes. The VA has not proposed that the current law requiring 75 percent of the beds in a State home be changed at present. The VA will work with the State Veterans Homes to consider alternative options, and may need to amend current laws.

Question 9. The description of your new policy on long-term care notes that VA will provide "the full spectrum of long-term care service to service-connected and catastrophically disabled veterans with special needs." As you know, current law requires VA to provide needed nursing home care to any veteran for a service-connected condition and those who are 70 percent: service-connected disabled or higher. How does your new policy differ from the mandate of current law? Am I correct that your new policy is more generous than your current mandate. But, not as generous as your current practice?

Response: You are correct. Under current practice, nursing home care is provided to all veterans for whom it is mandated by law if they need such care (Priority Group 1A), and to other priority groups as resources permit. Under the new policy, VA will continue to provide short-term rehabilitative, hospice, and respite nursing home care to all priority groups, but will restrict long-term maintenance care to Priority Groups 1, 2, and 3 and to those veterans with special needs that cannot be met in the community, such as spinal cord injury. Therefore, our new policy will continue to provide institutional long-term care beyond the mandate of current law.

Question 10. Part of your proposed increase in funding includes a new $100 million initiative to implement the VA Mental Health Task Force recommendations. However, the details of new services for mental health are lacking in your budget submission. Could you please elaborate on some of the actual things VA would do with another $100 million to provide . mental health services? For example, what specifically is needed to close the "variability and gaps in care" that you wrote about in your budget proposal?

Response: VHA has established priorities for additional funding of programs based on the recommendations of the Secretary's Mental Health Task Force as well as the initiatives contained in the Mental Health Strategic Plan. Areas identified for priority funding are expansion of PTSD services, OIF/OEF post-deployment mental health services, expansion of Substance Abuse programs, expansion of mental health services in CBOCs, creation of new MHICM teams and programs for the SMI (Seriously Mentally Ill) veteran, new Homeless Domiciliaries, and creation of case manager positions for the Grant and per Diem program. New Capital Asset Realignment for Enhanced Services (CARES) projections for mental health services were recently completed. This data is broken down by mental health program and is specific to the CARES markets. These data will soon be available to the VISNs who will then be able to identify where there may be gaps in services within their markets. The $100 million will be used to correct service gaps once the Networks come back with specific strategic plans on how these gaps need to be addressed. Priority for funding will be based on service need as identified by the Networks. The Under Secretary for Health has agreed to establish a team of Mental Health experts to continue to work with the actuarial data to develop a model that attempts to identify the gap.

Question 11. The 116th Calvary Brigade Combat Team of the Idaho Army National Guard are now stationed overseas in Iraq and fighting in Operation Iraqi Freedom. Like all National Guardsmen, when they return from active duty they will resume their duties of working under the command of the Governor of Idaho.

A. What will their eligibility be for VA services, including health care and benefits, be when they separate from active duty service?

Response: Army National Guard personnel activated by Federal declaration and who served on active duty in a theater of combat operations which includes Operation Iraqi Freedom are eligible for hospital care, medical services, and nursing home care. Public Law 105–368 gave VA authority (Title 38, USC, 1710(d)(D)) to provide a 2-year post-discharge period in which returning combat, veterans receive cost-free care for conditions potentially related to their combat service. Veterans who enroll with VA under this authority retain enrollment eligibility, regardless of any enrollment restriction that may be in effect after this 2-year post-discharge period.

For those veterans who do not enroll with VA during this 2-year post-discharge period, eligibility for enrollment and subsequent care would be based on other factors such as a compensable service connection rating, VA pension status, catastrophic disability determination or the veteran's financial circumstances.

In addition to health care benefits, they are also eligible for a full array of benefits offered through the Veterans Benefits Administration (VBA) to include:

- Disability Benefits
- Education & Training Benefits
- Vocational Rehabilitation and Employment Home Loans
- Life Insurance Burial Benefits Dependents' and Survivors' Benefits

B. Does the Department have any programs in place that will continue to follow these Guardsmen after their completion of their combat mission and they return home to a civilian life?

Response: Under 38 U.S.C. § 1710(e)(1)(D) and § 1710(e)(3)(C), OIF/OEF veterans may enroll in the VA health care system and, for a 2-year period following the date of their separation from active duty, receive VA health care without co-payment requirements for conditions that are or may be related to their combat service. After the end of the 2-year period, they may continue their enrollment, but may be subject to any applicable co-payment requirements. For OIF/OEF veterans who do not enroll with VA during the 2-year post-discharge period, eligibility for enrollment and subsequent health care is, of course, subject to such factors as a service connected disability rating, VA pension status, catastrophic disability determination, or financial circumstances.

OIF/OEF veterans have sought VA health care for a wide-variety of physical and psychological problems. The most common health problems have been musculoskeletal ailments (principally joint and back disorders); diseases of the digestive system (with teeth and gum problems predominating); and mental disorders (predominantly adjustment reactions). The medical issues we have seen to date are those we would expect to see in young, active, military populations, and no particular health problem stands out among these veterans at present. We will continue to monitor the health status of recent OIF and OEF veterans to ensure that VA aligns its health care programs to meet their needs.

Following is a brief description of VA initiatives that have been developed in response to the service needs of veterans from Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF). Many of these are brand new programs that were developed to meet these needs. All of them represent "lessons learned" from VA's experiences responding to the health care and other benefits needs of veterans returning from the 1991 Gulf War, and from the Vietnam War before that.

Immediate Health Care Needs for Combat Veterans: In response to immediate health concerns for OIF and OEF veterans, on March 26 and 27, 2003, VA developed a program called "Caring for the War Wounded," which was broadcast over the VA Knowledge Network satellite broadcast system. This program provided timely and relevant information about the anticipated health care needs of veterans of the current conflict in Iraq, included VA experts on treatments for traumatic injuries; chemical warfare agent health effects; infectious diseases; radiological health effects; and post-deployment readjustment health concerns, and was converted into a new Veterans Health Initiative (VHI) health care provider independent study guide, called "Caring for the War Wounded," which is available online at vaww.va.govNHI/ and on the Internet at *http://www.appcl.va.gov/vhi/*.

New Clinical Guidelines for Combat Veteran Health Care: In collaboration with DoD, VA developed two Clinical Practice Guidelines on combat veteran health issues, including one general guideline to post-deployment health, and a second dealing with unexplained pain and fatigue. The new clinical guidelines give our health care providers the best medical evidence for diagnoses and treatment. VA highly recommends these for the evaluation and care of *all* returning combat veterans, including veterans from OF and OEF. The value of the guidelines in providing care to returning veterans is described in a video "The Epic of Gilgamesh: Clinical Practice Guidelines for Post-Deployment Health Evaluation and Management," at *www.va.gov/Gilgamesh.*

New Specialized Combat Veteran Health Care Program: In 2001, VA established two new War Related Illness and Injury Study Centers (WRIISCs) at the Washington, DC, and East Orange, NJ, VAMCs. Today, the WRIISCs are providing specialized health care for combat veterans from all deployments who experience difficult-to-diagnose, but disabling illnesses. Concerns about unexplained illness are seen after all deployments including OIF/OEF, but VA is building on our understanding of these illnesses. More information is available online at *www.va.gov/environagents* under the heading "WRIISC Referral Eligibility Information."

Expanded Education on Combat Health Care for VA Providers: In addition to the programs already described, VA has developed several Veterans Health Initiative (VHI) Independent Study Guides relevant to veterans returning from Iraq and Afghanistan:

• "A Guide to Gulf War Veterans Health" was originally on health care for combat veterans from the 1991 Gulf War. The product, written for clinicians, veterans and their families, remains very relevant for OF and OEF combat veterans because many of the hazardous exposures are the same.
• "Endemic Infectious Diseases of Southwest Asia" provides information for health care providers about the infectious disease risks in Southwest Asia, particularly in Afghanistan and Iraq. The emphasis is on diseases not typically seen in North America.
• "Health Effects from Chemical, Biological and Radiological Weapons" was developed to improve recognition of health issues related to chemical, biological and radiological weapons and agents.
• "Military Sexual Trauma" was developed to improve recognitions and treatment of health problems related to military sexual trauma, including sexual assault and harassment.
• "Post-Traumatic Stress Disorder: Implications for Primary Care" is an introduction to PTSD diagnosis, treatment, referrals, support and education, as well as awareness and understanding of veterans who suffer from this illness.
• "Traumatic Amputation and Prosthetics" includes information about patients who experience traumatic amputation during military service, their rehabilitation, primary and long-term care, prosthetic, clinical and administrative issues.
• "Traumatic Brain Injury" presents an overview of TBI issues that primary care practitioners may encounter when providing care to veterans and active duty military personnel.

All are available in print, CD ROM, and on the web at *www.va.gov/VHI.*

Outreach to Combat Veterans: VA has many new products to offer combat veterans and their families.
• The Secretary of Veterans Affairs sends a letter to every newly separated OF and OEF veteran, based on records for these veterans provided to VA by DoD. The letter thanks the veteran for their service, welcomes them home, and provides basic information about health care and other benefits provided by VA.
• In collaboration with DoD, VA published and distributed one million copies of a new short brochure called "A Summary of VA Benefits for National Guard and Reservists Personnel." The new brochure does a tremendous job of summarizing health care and other benefits available to this special population of combat veterans upon their return to civilian life (also available online at *www.va.gov/EnvironAgents*).
• "Health Care and Assistance for U.S. Veterans of Operation Iraqi Freedom" is a new brochure on basic health issues for that deployment (also at *www.va.gov/EnvironAgents).*
• "OIF and OEF Review" is a new newsletter mailed to all separated OIF and OEF veterans and their families, on VA health care and assistance programs for these newest veterans (online at *www.va.gov/EnvironAgents*).
• "VA Health Care and Benefits Information for Veterans" is a new wallet card that succinctly summarizes all VA health and other benefits for veterans, along with contact information, in a single, wallet-sized card for easy reference (also at *www.va.gov/EnvironAgents*).

Special DU Program: OIF veterans concerned about possible exposure to depleted uranium can be evaluated using a special DU exposure protocol that VA began after the 1991 Gulf War. This program offers free DU urine screening tests by referral from VA primary care physicians to veterans who have concerns about their possible exposure to this agent.

COMBAT VETERAN HEALTH STATUS SURVEILLANCE:

Today we can monitor the overall health status of combat veterans very efficiently by using VA's electronic inpatient and outpatient medical records. This surveillance summarizes *every single visit* by a combat veteran including all medical diagnoses. VA has developed a new Clinical Reminder (part of VA's computerized reminder system) to assist VA primary care clinicians in providing timely and appropriate care to new combat veterans.

Question 12. As we discussed at your confirmation hearing, I believe VA transition efforts have traditionally been focused on the needs of returning soldiers who are leaving service—and not on the needs of the returning Reservists or National Guard members who are returning to reserve duty in the States after active duty in the war zone. In your written remarks you State that VA will make it a top priority to provide ongoing benefits and services to these individuals. What special steps is VA taking to provide outreach to members of the National Guard and Reserve when

they return home and transition back into civilian life? Does this proposed budget request separate funding for special outreach efforts to these returning troops?

VBA Response: Outreach to Reserve/National Guard members is part of the overall VBA outreach program. In peacetime this outreach is generally accomplished on an "on call" or "as requested" basis. With the activation and deployment of large numbers of Reserve/National Guard members following the September 11, 2001, attack on America, and the onset of OEF/OIF, VBA outreach to Reserve/National Guard members has been greatly expanded. National and local contacts have been made with Reserve/National Guard officials to schedule pre- and post-mobilization briefings for their members. Returning Reserve/National Guard members can also elect to attend the formal 3-day TAP workshops. The following chart shows the number of pre- and post-deployment briefings for Reserve/ National Guard members:

Reserve/National Guard Briefings

Fiscal Year	Briefings	No. Attendees
2003	821	46,675
2004	1,399	88,366
2005*	974	68,351,448

*Through March 2005

VA recently established a working group with the National Guard Bureau and representatives of the military reserve components to identify where improvements can be made in our working relationships to ensure that information and assistance are available to returning Reserve/ National Guard members and their families. Recommendations from the working group are being reviewed by VA top management officials and the National Guard leadership prior to implementation. It is anticipated that a memorandum of agreement will be signed by the end of April outlining our respective responsibilities to ensure that a robust outreach program is available on a continuous basis to returning Reserve/National Guard members and their families.

VA's planned 2006 outreach efforts to members of the National Guard and Reserve are part of our general outreach effort and are not separately funded.

VHA Response: VHA's transition efforts focus on the needs of all returning service members, including members of the Reserve and National Guard. The Vet Center program's capacity to provide outreach to veterans returning from the Global War on Terrorism (GWOT) in the theatres of combat operations in Afghanistan and Iraq has been augmented by VA. Specifically, the Vet Centers have hired and trained up to 50 new outreach workers from among the ranks of recently separated GWOT veterans at targeted Vet Centers. Augmented Vet Center outreach is primarily for the purpose of providing information that will facilitate a seamless transition and the early provision of VA services to new returning veterans and their family members upon their separation from the military. These positions are being located on or near active military out-processing stations, as well as National Guard and Reserve facilities. New veteran hires are augmenting Vet Center services by providing briefing services to transitioning servicemen and women regarding military-related readjustment needs, as well as the complete spectrum of VA services and benefits available to them and their family members. These Vet Center points of contact for OIF/OEF provide the link to other members of the VA team at VBA and VHA for additional services to meet the veteran/family needs. The new veteran hires are also organizing local community activities and "town hall meetings" to provide information and education about VA, DoD, and other community support services available to veterans and family members. During these community offerings new veterans are also able to view the video "We Are By Your Side" to increase their knowledge of other benefits that they might be eligible to receive.

Extensive VA outreach briefings have been conducted to the senior leadership in the Army National Guard and Army Reserve. Letters from the Secretary of Veterans Affairs, information toolkits and a copy of the video "We Are By Your Side" have been sent to the Chiefs of Staff for all services and the Reserve Chiefs. Treatment activities are provided by trained and licensed health care practitioners at VA healthcare facilities and by licensed and/or masters degree level counselors at Vet Centers. Outreach activities are performed through national intervention, by VA medical centers, community based outpatient clinics, and Vet Centers. The Secretary of Veterans Affairs has sent a letter to all accessible returning service members on the DoD roster (over 290,000) notifying them of their access to benefits and healthcare services and providing contact phone numbers for further information.

(Separated service members were not contacted if information from VA indicated that address information provided by DoD was incorrect.). Additionally, VA sent letters to all Adjutants General of the National Guard/Reserve to enlist their support in the distribution of printed and videotape information on VA eligibility and healthcare to their troops.

VBA outreach coordinators and Vet Center staff provide further information to service members at mobilizationsites as part of the Transitional Assistance Program (TAP) for National Guard/Reserve personnel who are separating from active duty to reserve or civilian status. VA Outreach coordinators will also be allowed blocks of time on the unit training schedule and during family programs to brief on VA Benefits/Services and home station.

VA's planned 2006 outreach efforts to members of the National Guard and Reserve are part of our general outreach effort and do not have separate funding. We are confident that our fiscal year 2005 budget and the President's fiscal year 2006 budget request contain sufficient funding to allow us to continue outreach efforts to OIF and OEF veterans, including returning members of the National Guard and Reserve.

Question 13. The President has requested a civil service pay increase of 2.3 percent and a military pay increase of 3.1 percent. In recent years Congress has provided civil service employees with a pay increase equal to the military pay increase. If Congress adheres to past practice and enacts a 3.1 percent increase for both service members and Federal civilian employees, by how much would VA discretionary appropriations need to increase?

Response: Should Congress enact a 3.1 percent pay raise as opposed to the 2.3 percent increase that was included in the President's fiscal year 2006 request, VA would be required to fund an additional $88.7 million in payroll costs.

	2.3 Percent Payraise (Budgeted)	3.1 Percent Payraise (Additional Amount for Military Parity)	Total Required
Medical Care	$247.2	$81.7	$328.9
VBA	14.0	4.8	18.8
NCA	1.6	0.5	2.1
Staff Offices	4.9	1.7	6.6
VA Total	$267.7	$88.7	$356.4

Question 14. The Administration's budget proposal estimates that fiscal year 2006 disability claims productivity will remain stagnant at 109 claims completed per assigned employee.

A. What accounts for the flat level of expected productivity? Shouldn't productivity increase if the Veterans Benefits Administration (VBA) expects additional Benefits Delivery at Discharge claims, claims which are supposedly easier to adjudicate than other types of claims?

Response: The projected productivity level of 109 disability claims per employee does not include all types of claims workloads. In addition to the disability claims, regional offices are also addressing the appeals inventory, trying to strike a successful balance between incoming claims and appellate workloads. The performance standards for our field station directors include both claims inventory targets and appellate reduction targets. This approach emphasizes the importance of both initial claims and appellate work and works toward reducing the inventory in both areas.

Claims received through the Benefits Delivery at Discharge (BDD) process are generally easier to develop than regular claims because the servicemember usually has all medical and military records available to submit with his/her claim. However, BDD claims are usually more complex both in terms of the number of issues claimed, as well as the complexity of the issues themselves. As a result, while development may be somewhat easier, the actual adjudicative process tends to be more complex.

B. What information technology investments will have the biggest impact on individual worker productivity in the future? Can future productivity gains be quantified for each of those investments?

Response: VBA has invested in numerous information technology solutions intent on increasing worker productivity. The following is a comprehensive list of IT solutions that directly impact productivity and offer potential gains for the future. However, we are unable to specifically quantify those gains.

COMPENSATION AND PENSION

Veterans Service Network (VETSNET)

VETSNET is the replacement system for the Benefits Delivery Network (BDN). The BDN system is technologically obsolete, making it extremely difficult to maintain and virtually impossible to expand to include new applications or enhancements that are vital to VBA's current and future operations.

The VETSNET suite of applications includes the following:

1. *Modern Award Processing-Development (MAP-D)*—supports claims establishment and development.
2. *Rating Board Automation (RBA) 2000*—supports the rating of disability claims.
3. *Award*—used to prepare benefit awards
4. *Financial Accounting System (FAS)*—supports generation of benefit payments.

VETSNET is user friendly and provides a standard payment and accounting system for veterans' benefits programs. It corrects various material weaknesses related to BDN, and provides end-to-end claims processing, including claims establishment and development, decision, award, payment, and accounting. It generates and displays detailed claims information for customer service and provides data for cycle time management. Additionally, VETSNET retains rating information for subsequent ratings, so that data will not have to be entered again at a later date. It also captures and retains award lines and supporting data for subsequent adjustments and automatically calculates retroactive awards and overpayments.

CAPRI

Compensation and Pension Records Interchange (CAPRI) is a current IT application used by VBA to search electronic health records maintained by the Veterans Health Administration (VHA). CAPRI is also used for requesting and returning compensation and pension (C&P) examinations between VBA and VHA. Future investment in the Federal Health Information Exchange (FHIE) and CAPRI will allow VBA users enhanced access to DoD electronic health records as additional categories of medical treatment are added to FHIE. Future investment in the Bi-Lateral Health Information Exchange will enable bi-directional, real-time data sharing between VA and DoD healthcare providers.

We can expect improvement in productivity measured by reduced claims processing time when the veterans' DoD service medical records are available electronically in CAPRI. Future enhancements are planned for the C&P examination request and return process to improve the quality of both the VBA C&P examination request and the VHA C&P report of medical examination. This will positively impact productivity by providing VBA employees better quality rating data earlier in the claims adjudication process.

PIES/DPRIS INTERFACE

Regional office (RO) personnel can electronically request imaged personnel records from the Army, Navy, and Marine Corps through the Personnel Information Exchange System (PIES)/Defense Personnel Records Imaging System (DPRIS) interface. Since the process is automated, users typically receive a response to their requests within 48 to 72 hours. During the first quarter of fiscal year 2005, ROs submitted more than 3,000 requests a month through the PIES/DPRIS interface. Programming changes are pending that will allow users to request personnel records from the Air Force through the PIES/DPRIS interface by November 2005.

VIRTUAL VA

Virtual VA is a web-based suite of nine different information solutions that provides electronic "e-Folders" to aid in both compensation and pension processing. Through the use of imaging, document management technologies and integration with the output capabilities of several other VA systems, users are able to perform a multitude of functions traditionally completed by accessing stand-alone applications and paper documentation. With future enhancements such as integration with payment and accounting systems, more streamlined claims processing and greater efficiency are possible. The impact Virtual VA has on claims efficiency will be measured through a study scheduled to begin in August 2005.

EDUCATION

The Education Expert System (TEES)

The information technology investment that will have the biggest impact on individual worker productivity in the future in the Education Program is TEES. TEES

will allow education benefits claims to be processed automatically without human intervention. TEES is envisioned to be a system that receives electronic input from claimants, training facilities, and other sources (e.g., DoD). Using a predefined set of business rules, TEES will process the information, issue certificates of eligibility and denial and award letters, authorize awards, and provide data for payment. TEES will collect, process, maintain, manage, and share all information pertaining to education claims.

Once TEES is fully implemented, we expect to gain improvements in customer service, reduce average days to process a claim, increase payment accuracy, and reduce labor costs involved with claims processing.

LOAN GUARANTY

Web-Based Loan Summary (WBLS)

This internet-based application offers a low/no-cost way for lenders to submit paperless applications for guaranty. It provides a 24-hour turnaround time for guaranty, and eliminates 15 sheets of paper and up to 54 manual coding actions per guaranty. WBLS was implemented in November 2004, and already handles approximately two-thirds of all guaranties issued. The Loan Guaranty program is considering making use of WBLS mandatory in all applications for guaranty, and we expect that after doing so, WBLS will handle 99.9 percent of guaranties. WBLS increases worker productivity by freeing up Loan Guaranty staff to perform other more important tasks than manual data coding, and processing of paper forms.

E-APPRAISALS

This application provides electronic ordering, submission, storage and manipulation of appraisals. It eliminates the need for hard-copy appraisals, and facilitates electronic communication between VA and appraisers. The Loan Guaranty program has realized timesaving in the appraisal review process, since employees can electronically access the required appraisal information from any location. This allows them to perform the necessary reviews in a more timely fashion. E-Appraisal also provides the capacity for national oversight and workload management. Through implementation and use of the E-Appraisal application, service to veterans and lenders continues to improve.

Automated Certificate of Eligibility (ACE)

The ACE system allows lenders to electronically request a determination of a veteran's eligibility for Loan Guaranty benefits. The system makes a determination, and generates an online Certificate of Eligibility (COE). In cases where data in the system is not sufficient to determine eligibility, the system refers the lender to a Loan Guaranty Eligibility Center. The ACE system handles approximately 25 percent of all eligibility determinations. This has freed up Loan Guaranty staff, especially at the Loan Guaranty Eligibility Centers to concentrate on more complex or difficult cases, and to provide better customer service to lenders and veterans requesting eligibility. The Loan Guaranty program intends to expand ACE usage through a Veterans Automated Certificate of Eligibility (or VACE) system, which will allow veterans themselves to log in and request a copy of their COE. VA expects an additional increase in productivity, and further improved customer service once the VACE system is developed and implemented.

LOAN GUARANTY WEB PORTAL

The Portal provides approved users with a single point of entry into Loan Guaranty systems and applications. Features include single-sign on / single password for users to access Loan Guaranty systems and information, and the ability to have personalized content 'pushed' to users, based on an established user profile. The Portal provides a one-stop-shop for veterans and for program stakeholders, as well as a faster, more effective means of communicating program information. Because Loan Guaranty has migrated its applications to the Portal, access to data and systems is timelier since we are no longer reliant on the antiquated technology and programming skill sets inherent to mainframe applications. Improved data access and manipulation capability provide the Loan Guaranty program with an improved planning and decisionmaking process, capabilities, which greatly enhance the productivity and effectiveness of the Service.

VA Loan Event Reporting Interface (VALERI)

VALERI is the loan data servicing system being built to support the newly redesigned business environment that resulted from the Loan Administration ReDesign (LARD) initiative. The LARD initiative standardized the Loan Guaranty program's

internal servicing procedures, and VALERI will be built,. incorporating these new business processes. Examples of how employees will use VALERI include accessing private-sector servicers' data, performing nationwide oversight and identifying servicer and Loan. Guaranty employee training needs. These functionalities will allow Loan Guaranty staff to work more efficiently and more productively.

VOCATIONAL REHABILITATION AND EMPLOYMENT (VR&E)

Corporate WINRS will migrate the VR&E Program to a paperless data-centric processing environment. In VR&E, the gathering, storage, and subsequent analysis of veterans' personal, medical, social, vocational, and training information are critical to the delivery of rehabilitation and employment services. Currently, this information is largely submitted and stored in paper form or hand-keyed into processing applications. The evolution toward electronic submission, storage, and access of that data will have a beneficial impact on worker, productivity, allowing VR&E professional staff more time to focus on counseling and planning activities with the veteran.

Question 15. The Administration's budget proposal projects an increased disability claims workload from separating service personnel from Operations Enduring Freedom and Iraqi Freedom.

A. How many of those separating personnel do you expect to come from National Guard or Reserve units? What resources does this budget devote to ensuring that demobilized National Guard and Reserve personnel know about their disability benefits and receive expedited claims decisions?

Response: In the period leading up to September 11, 2001, almost 37,000 active members of the National Guard and Reserve were receiving VA disability compensation. Based upon the current level of mobilization of National Guard and Reserve forces, we anticipate approximately 10,000 claims in fiscal year 2006 from veterans who will return to their previous National Guard or Reserve status. VA is committed to providing priority case-managed care and claims processing to all returning seriously injured veterans, including members of the activated reserve forces. VBA will also continue to provide outreach and information to returning individual reservists and units shortly after their return. In 2004 VA provided benefits briefings to more than 88,000 members of the National Guard and Reserve.

B. Its there a discrepancy in the amount of assistance VA provides to separating service members belonging to regular components of the Armed Forces and demobilized Guard/Reserve personnel?

Response: The assistance VA provides to seriously injured servicemembers is the same, regardless of the branch or component of the service to which they belong.

Active component service personnel who are not seriously injured can participate in Transition Assistance Program (TAP) briefings and the Benefits Delivery at Discharge (BDD) Program, usually during the two-to-six-month period immediately prior to their actual separation. Members of the reserve components are normally demobilized as a unit within days of their return from their overseas assignments. This prevents VA from conducting its normal TAP and BDD Program for returning Reserve and National Guard members. We therefore aggressively pursue pre- and post-deployment outreach to the Reserve and National Guard members to ensure they receive information and assistance on all VA benefit programs. In fiscal year 2004, VA conducted benefits briefings for more than 88,000 members of the reserve forces.

C. What are your thoughts about providing priority assistance to claimants who file claims within a year or two of discharge during the Global War on Terror?

Response: VA provides priority claims processing and case-management assistance for all seriously injured returning service members. We provide expedited claims processing for active component personnel through the Benefits Delivery at Discharge Program and conduct specialized outreach to returning National Guard and Reserve personnel. VA also prioritizes claims from veterans of all periods of service who are identified as terminally ill, in great financial difficulty, or homeless. We believe that most veterans who delay filing their claims until the second year or so following separation are less likely to be seriously disabled. As such, we believe that their claims should normally be processed as other claims received by VA.

Question 16. The strategic goal VA wishes to achieve for the average number of days to complete a disability claim has been lowered from 100 days to 125 days, primarily on account of built-in delays to processing created by the Veterans Claims Assistance Act. What time delays built into the system result in such lengthy and increasing average processing times? What are the opportunity costs of these built-in delays, i.e., does time and effort devoted to claimants taking advantage of their

rights under these built-in delays harm the quality and timeliness of service provided to other claimants?

Response: VA fully supports the Veterans Claims Assistance Act of 2000 (VCAA). We believe that a well-informed claimant can proactively participate in the claims process toward achieving the most favorable decision possible, consistent with the law. Nonetheless, the implementation of VCAA did introduce new "wait times" in the claims adjudication process that make attainment of an average processing time of 100 days in a non-BDD environment very difficult to attain. The initial VCAA notice calls for a 60-day wait time before VA can proceed if the claimant fails to respond or responds incompletely. When a claimant asks for our assistance in obtaining private medical evidence, VA must wait an additional 60 days for the provider to respond. In many instances private sources do not respond or respond by requesting payment of a fee for the needed information. VA has no authority to pay such fees. In circumstances where no reply is received or a fee is requested, VA must advise the claimant that we were unsuccessful and provide the claimant with an additional 30 days to provide the information. Finally, veterans may identify additional conditions that they believe should be service connected in the course of the adjudication of their claim. In such circumstances we consider these additional claimed conditions to be part of the original claim, but are required to provide a separate VCAA notice for them with the resulting 60-day wait tirne. VA does not consider the amount of time devoted to adjudicating a specific claim and insuring claimants are fully informed to be harmful to the quality or timeliness of service to other veterans.

Question 17. It is expected that a large portion of returning Iraq and Afghanistan veterans will have mental health problems, in some cases severe mental health problems like PTSD. Are VA claims adjudicators trained to quickly and accurately decide disability claims from these veterans?

Response: Yes, journey-level claims adjudicators are trained to quickly and accurately decide these types of disability claims. Additionally, VBA is developing a number of training tools for its recently hired employees to prepare them to adjudicate these important issues.

VBA has the following computer-assisted training initiatives on PTSD under development to be included in our Training and Performance Support System (TPSS):

- Introduction to PTSD for Rating Veterans Service Representatives (RVSRs)—Overview of PTSD issues, history, sensitivity awareness—TPSS module to be released September 2005
- Rating Cases with PTSD claims—TPSS module for RVSRs to be released February 2006
- Introduction to PTSD for Veterans Service Representatives (VSRs)—Overview of PTSD issues, history, sensitivity awareness with focus on VSR tasks—TPSS module to be released December 2005
- Electronic Performance Support System (EPSS) electronic job aid for VSRs on development issues for PTSD claims—To be released August 2005

Question 18. The backlog of disability claims on appeal has been steadily growing in the last few years. What is the cause of this growth? What resources are being devoted to reduce the number of appeals? Is the appeals problem more than a resource issue, i.e., are there structural problems that Congress needs to address?

Response: Cause of growth of appeals workload. The most important factors in the current appeal volume are the increasing volume of incoming claims and increased output of claims decisions. Over the last 3 years, VBA not only completed as many claims as were received, but also reduced the inventory of pending rating claims (which stood at over 432,000 in 2002 and was reduced to 253,000 claims by the end of fiscal year 2003). While the numbers of initial appeals have increased, the rate (percentage appealed) has not increased significantly, averaging around 10 percent.

Resources Devoted to Appeals Reduction

VA regional offices each have an appeals team, exclusively devoted to processing appeals from the notice-of-disagreement stage to certification to the Board of Veterans' Appeals. Generally, 5—10 percent of the Veterans Service Center staff members are dedicated to the appeals team.

In addition, in 1991 VA fully implemented a Decision Review Officer (DRO) program, affording a claimant the right to a de novo review of a denied claim by a DRO who was vested with the authority to review the appeal and render a new decision without deference to the prior decision under review. The intent of this program is to provide for earlier resolution of appeals, reduce the number of appeals certified to the BVA and increase veteran satisfaction with the process. The DRO process was designed to achieve these goals early in the process by assisting veterans in identifying and obtaining evidence that would support the benefit he/she seeks; clar-

ify the basis for the decision; and provide an independent review, ensuring all benefits supportable by the evidence of record are granted. The DRO program has met a number of these objectives.

To address the remanded appeals workload, VBA established the Appeals Management Center (AMC) in 2003. The AMC now serves as a centralized processing site for this appellate workload. The AMC has received approximately 18,000 remands per year from BVA, more than the number of remands initially anticipated. As a result, 46 additional employees were identified in fiscal year 2005 to support the AMC in addressing this workload. We will continue to devote this level of resources until the remand workload is reduced.

Structural Problems with the Appeals Process

Many studies have been conducted on the appeals process over the past 10 years with recommendations for structural reform of the process. Certain recommendations have been consistently made:

• The ability of the claimant to continually submit evidence or request a hearing at any time during the claims and appeals process makes it difficult to achieve a resolution of the claim.

Recommendation: close the record after full development of the case prior to certification of the claim to the Board of Veterans' Appeals.

• A claimant can ask for a hearing at anytime, and many times at the regional office level, the Decision Review Officer level, the Board of Veterans' Appeals level—even if there is no additional evidence for VA to consider.

Recommendation: limit the number of hearings provided for the same claim.

Question 19. What resources are being devoted this year to put into effect the collocation of the Boise VA Medical Center and Regional Office? What are projected for next year?

Response: In fiscal year 05, staff resources in VBA will accomplish the following:

• Secured a letter from the GSA initiating the transfer of the 2.13-acre parcel to VA. Obtain the signature of the Secretary of Veterans Affairs accepting transfer and control of the property.

• Complete a concept paper and Exhibit 300 business case application for construction of a new office building for the Boise Regional Office on the subject property. Obtain Departmental approval of the concept paper and Exhibit 300.

• Award a contract to an architect/engineer (A/E) firm to prepare a preliminary design and a request for proposals (RFP) for a Design-Build contract for the construction of the new office building. Funds from the Minor Construction program will be allocated to this contract.

• Begin the preliminary design for the new office building.

In fiscal year 06, staff resources in VBA will accomplish the following:

• Complete the preliminary design and the RFP for the Design-Build contract.

• Work with the VHA contracting officer to prepare the solicitation for the Design-Build contract.

• Advertise the project in the FedBizOps for a contract award in early fiscal year 07.

• Identify the necessary minor construction funds in the fiscal year 07 budget for the construction contract.

Question 20. What accounts for the doubling of "individual unemployability" cases in just 6 years? What standard is used to determine if an individual is "unemployable"? Is that a permanent designation or is it periodically reviewed? Are quality reviews conducted on these cases to ensure that correct decisions have been made?

Response: Increase in Individual Unemployability claims. VA has been reviewing the issue of individual unemployability (IU) and the increasing number of veterans granted this benefit. While we do not have complete answers for the significant rise in the number of claimants receiving IU benefits, we have identified a number of contributing factors.

• VA must consider findings of other Federal agencies such as the Social Security Administration. (See *Murincsak* v. *Derwinski,* 2 Vet. App. 363, (1992)). The provisions of the Veterans Claims Assistance Act of 2000 reinforce this requirement. Where such an agency finds a veteran entitled to disability benefits for the same conditions for which that veteran is service connected, that evidence is given great weight, often resulting in a grant of benefits.

• In claims for an increased rating, where the veteran's evaluation(s) meets the minimum criteria for a grant of IU benefits, and there is evidence of current unemployability due to service-connected disability, VA must consider entitlement to IU benefits even if the veteran has not claimed this benefit. (See *Norris* v. *West*, 12, Vet. App. 413 (1999); *Roberson* v. *Principi,* 251 F.3d 1378 (Fed. Cir. 2001))

• VA regulations prohibit the consideration of age in making IU determinations. (See *Hatiestad* v. *Brown*, 5 Vet. App. 524 (1993))

In addition, the general aging of the Vietnam veteran population and the relatively high number of veterans service connected for psychiatric conditions at the 70 percent level, may contribute to the number of veterans receiving IU benefits.

Standard for Determininq Unemployability

The veteran's disability evaluations must meet specific regulatory requirements.. one service-connected disability evaluated as 60 percent disabling, or two or more service-connected disabilities that combine to a 70 percent evaluation, with one of them rated at least 40 percent. In addition, there must be evidence that the veteran is unable to maintain substantially gainful employment solely because of his/her service-connected disabilities.

Proving an inability to maintain substantially gainful employment for IU benefits does not require the claimant to prove 100 percent unemployability. (*Roberson* v. *Principi*, 251 F. 3d 1378 (Fed. Cir. 2001)). VA will consider a total disability to exist when there is present any impairment of mind or body that is sufficient to render it impossible for the average person to follow a substantially gainful occupation due to his or her service-connected disability. VA does not consider marginal employment, with earnings below the poverty level, to be a substantially gainful occupation.

Periodic Review of IU Determinations and Quality Reviews

VA once required veterans receiving IU benefits to certify their employment status on an annual basis until age 60. Although that process was discontinued several years ago, we are reinstating it, pending OMB approval of the annual certification form. Additionally, all veterans receiving IU benefits are subject to wage verification through a Social Security Administration income verification match. While no separate quality review of IU cases is conducted, IU cases are part of the mix of cases that are reviewed in the national quality review program (referred to as STAR), conducted by VA's Compensation and Pension Service.

Question 21. VA offers the Benefits Delivery at Discharge program (BDD) at 139 sites in three countries. The program offers transitioning service members the ability to take compensation physicals prior to leaving active duty and, as result, they can have a compensation rating prior to discharge. The budget projects an increase of $13.3 million in fiscal year 2006 for the BDD program. To what is that attributed? How many providers of contract exams are there for BDD program participants?

Response: The estimated increase in the Compensation and Pension Contract Exam reimbursement for fiscal year 2006 can be attributed to two factors: an increase in the average cost per veteran and an increase in the number of contract examinations that QTC will perform.

The average cost per veteran is expected to increase due to a projected increase in the contract cost per exam, as well as a greater number of disabilities claimed per veteran. A veteran separating from service and examined under the BDD program will generally claim more disabilities than a veteran that has been separated from service for several years. As the number of disabilities increases, there is often more than one examination scheduled, and frequently specialty examinations are required. This causes the BDD examination process to be more complicated and expensive.

QTC is the only provider of contract exams and currently performs approximately one half of the BDD examinations. The number of contract exams will increase as more servicemembers separate through the BDD program. In addition, the number of contract exams requested to support non-BDD claims workload is also expected to increase.

Question 22. Has the quality of VHA-provided disability examinations been improving? How is examination quality measured? To what extent has VBA taken advantage of the expanded contract disability examination authority granted it under Public Law 108–183?

Response: The Compensation and Pension Examination Program (CPEP) Office has developed and implemented a multi-faceted quality improvement process that has resulted in dramatic results on a national scale. The CPEP Office worked with the STAR staff, the Clinical Advisory Board, and other experts in VBA, VHA, and the Board of Veterans' Appeals to carefully select representative indicators to measure the quality of C&P examination reports.

During fiscal year 2004, the national performance score (a CPEP index measure of examination report quality) for the 10 most frequently performed examination types improved substantially. The results are summarized below:

• National baseline exam report quality: 54 percent met at least 90 percent of CPEP indicators (1St quarter fiscal year 2003)
• October 2003 national performance score: 48 percent met at least 90 percent of indicators
• November 2004 national performance score: 71 percent met at least 90 percent of indicators

The quality of C&P examination reports was added as a VISN Director's performance measure in fiscal year 2004. The "met" level for the measure is 64 percent and the "exceptional" level is 75 percent.

VBA has not expanded the use of contract disability examinations as provided under Public Law 108–183.

Question 23. The Administration's budget proposal budget states that due to cost constraints computer upgrades and/or replacement of peripheral applications will be deferred in fiscal year 2006. What affect will deferring computer upgrades and replacements have on efficiency? What level of funding is necessary to ensure VA's workforce has the best equipment to fulfill its mission?

Response: For the past 2 years, VBA has had to realign funds to its payroll accounts in order to maintain an adequate number of FTE to support the President's initiative to reduce the claims inventory and improve the timeliness of claims processing. This has had a significant adverse impact on our operational accounts. During this time we have been unable to complete our planned 25 percent annual replacement/upgrade of computers and peripheral equipment. The one-time transfer of $75 million from Medical Care to VBA in 2005 allows us to obligate $7 million for computer replacements this year. As we noted in our Compensation Budget submission, the FY2006 information technology investments, while lower than FY2005, are in fact returning to normal levels. Our FY2006 budget submission performance objectives are in line with maintaining our FY2005 levels of performance.

Question 24. One of the performance measures used by the VA's Compensation Service is "Overall Satisfaction." The strategic target is 90 percent, but the actual rate has remained in the mid–50 range. Given that some veterans are denied compensation, is 90 percent a realistic goal and, if not, what is?

Response: The most recent customer satisfaction survey results released in March 2004 show that the overall customer satisfaction rate increased from 55.7 percent in 2000 to 59.4 percent in 2003.

The strategic goal of 90 percent was initially developed as part of the 2003–2008 VA Strategic Plan in accordance with the Government Performance and Results Act (GPRA) and Executive Order 12862, Setting Customer Service Standards, to provide the highest quality of service possible "equal to the best in business." At the time we set the goal, we elected to only survey a sample of those who had applied to VA for benefits during the previous year rather than to also sample the entire population of over 3 million beneficiaries receiving VA compensation and pension benefits during that year. We believe that the 90 percent strategic goal would be a more realistic strategic goal if we sampled from the entire population of current VA beneficiaries as well as recent applicants for benefits.

We have deferred making any changes in the survey process or our strategic goal for customer satisfaction until the agency-sponsored periodic program evaluation is completed for the compensation program and the Disability Benefits Commission has completed its work. We anticipate that the information provided through this evaluation will assist us in determining what changes are appropriate.

Question 25. I note a significant increase in the number of education claims projected through the remainder of the decade. Will staffing need to be increased to address the increased workload? Or will further improvements in productivity continue to allow the workforce to do "more with less"?

Response: Provided that technological improvements are funded at an adequate level, workforce productivity can continue to increase to match the workload.

Question 26. What affect will the new educational assistance benefits for Reserves, enacted as part of the Fiscal Year 2005 National Defense Authorization Act, have on the budget for education administration? Will additional dollars be required to implement a new pay system for this program?

Response: The new educational assistance benefits for activated reservists, enacted as part of the fiscal year 2005 National Defense Authorization Act, will increase the aggregate number of beneficiaries for all VA educational assistance programs. Many of the beneficiaries under the new program would have received benefits under either the existing Montgomery GI Bill—Selected Reserve or Montgomery GI Bill-Active Duty programs. Since the monthly benefit for the new program is higher than monthly benefits under the current Selected Reserve program, the total dollars paid in educational assistance benefits will also increase. Based on Department of Defense estimates, the number of students receiving benefits under the new

program will average more than 50,000 each year over the next 5 years. Based on these same estimates, we anticipate paying $100 million more in benefits each year over the next 5 years. We are reviewing the need for modification of our existing processes with the Department of Defense.

Question 27. The Administration's budget proposal supports a continued reduction in FTE for housing administration, a reduction that began during the 1990s. The FTE reduction has occurred without any deterioration in services to veterans; rather, service has vastly improved. To what level can FTE levels be reduced for housing administration without affecting the quality of service provided to veterans? If default rates on loans guaranteed by VA were to increase, would staffing also need to increase to provide foreclosure-avoidance services on those loans?

Response: The level of FTE requested in the President's fiscal year 2006 budget is sufficient to provide home loan benefits, including Specially Adapted Housing Grants and Native American Direct Loans. It also provides for the appropriate level of resources to assist veterans who are delinquent on their guaranteed loans. The home loan program is a relatively small percentage of VBA's total employment. Under credit reform, the administrative costs of the program are appropriated each year; therefore, if default rates were to increase over time, VBA would adjust its future year requests as needed.

Question 28. One of the issues cited in the Administration's budget proposal with respect to Vocational Rehabilitation and Employment (VR&E) as a barrier to employment for some disabled veterans is employer attitudes toward veterans and a lack of understanding of the value of military service. This barrier would not appear to be unique to disabled veterans; rather, it would appear to apply to all veterans. What is VA doing, if anything, to help remove this barrier? Are the services provided by Department of Labor's DVOPS being duplicated by VA? What can be done to improve employers' perceptions of veterans and is that a role that VA should fill?

Response: VA's Vocational Rehabilitation and Employment Program (VR&E) has a number of strategies to assist veterans in overcoming negative employer attitudes:

- A new video, "Working Partners," was developed and released to VA field stations. VR&E Counselors and Employment Specialists use the video to educate private sector and public sector employers to focus on abilities, not disabilities. The video illustrates the value of a veteran's transferable skills, training, and prior military experience to a new employer.
- Employment Specialists and Vocational Rehabilitation Counselors at VA's Central Office and field stations meet with potential employers to educate them about veterans, their abilities, and overcoming pre-existing stereotypes.
- Employment Specialists and Vocational Rehabilitation Counselors participate in community Disability Awareness Seminars, Career Fairs, and other employer-related events in order to explain the VR&E Program and the value of employing veterans.
- The new Five-Track Employment Model, recommended by VA's Vocational Rehabilitation and Employment Task Force, focuses on building effective partnerships with Department of Labor (DOL), One-Stop Career Centers, national employers, local employers, union apprenticeship programs, training facilities, and faith-based and community agencies. VR&E recently developed memorandums of understanding with Home Depot, Helmets to Hard Hats, and the YMCA.

DOL is a vital employment services partner for VR&E. VR&E does not intend to duplicate services where DVOPs or LVERs are available and accessible to veterans participating in a VR&E program. However, one aspect of the new Five-Track Employment Model is the establishment of Job Labs. Job Labs enhance our ability to fully execute a plan of effective vocational services in those areas where DVOPs or LVERs are not co-located or available to assist during the initial vocational evaluation phase of the rehabilitation process. The tools associated with the new Five-Track Employment Model allow VR&E staff to provide more robust resources to assist veterans in career-exploration activities, including research of the current; local labor market. Easy access to this type of information assists the veteran and the VR&E counselor in developing successful rehabilitation plans with solid, well-researched employment goals. This type of ready access to employment information is also critical to veterans whose life circumstances change to the point that their rehabilitation strategy needs to be significantly modified and new employment goals need to be established.

DVOPs and LVERs co-located with VR&E regional offices can be more efficiently and effectively integrated into the delivery of employment services if they are able to access the same full range of Job Lab resources and on-line technologies available to VA staff. Under the Five-Track Employment Model, DOL is a vital employment services partner with VR&E.

Question 29. One aspect of helping service members recover from disabling injuries is to help them find and maintain suitable employment. But the healing process can take time. To what extent does VA's VR&E component work with other VA components to ensure that service-connected veterans are also receiving other services, like counseling, they may need?

Response: To deliver effective case management services to veterans with disabilities, VR&E works with several other VA components. VR&E works closely with the Veterans Benefits Administration's (VBA) Compensation and Pension, Loan Guaranty, and Education programs to ensure that veterans are compensated for their service-connected disabilities; referred to Loan Guaranty's Specially Adapted Housing Program, when appropriate; aware of educational and work-study opportunities; and advised of and assisted in applying for any other VA benefits to which they may be entitled.

In addition, the Veterans Health Administration (VHA) is one of VR&E's primary partners, providing comprehensive services to assist service-connected disabled veterans obtain necessary medical services, prosthetics, prescriptions, and specialized counseling services. Annually, VR&E field staff submit about 15,000 requests to VHA facilities for Chapter 31 recipients needing a variety of clinical and support services.

VR&E also refers veterans for outpatient counseling services to the Veterans Readjustment Counseling Program (VET Centers). VR&E counselors, as appropriate, schedule regular office hours at VET Centers, staff mutual cases, and accept referrals from VET Center staff.

VR&E, VHA, and VET Center Staff cooperate in joint activities that result in improvements in meeting disabled veterans' treatment needs. Recently, field guidance was jointly developed for the provision of timely access to any VA health care services for participants in the VR&E Program.

Question 30. The Administration's budget proposal states that VA will establish "Job Resources Labs" in each VA regional office. Each lab would provide veterans and VR&E staff a resource for preparing for and conducting a job search. Would this effort duplicate the Department of Labor's "one-stop" centers, which, by law, are required to give veterans preference in services provided?

Response: The Job Labs and the online employment technologies are specific resources necessary to support the Five-Track Employment Model—the cornerstone of the new employment-driven service delivery system recommended by the VA Vocational Rehabilitation and Employment Task Force in their 2004 report to the Secretary of Veterans Affairs. The Job Labs and online employment technologies are part of a Five-Track Employment Model pilot test at four regional offices (Montgomery, Alabama, St. Louis, Missouri, Detroit, Michigan, and Seattle, Washington). Conducting the pilot allows VR&E to fully integrate, measure, modify, and deliver a tested product for national deployment.

The Five-Track Employment Model is designed to expedite services to disabled veterans in the most efficient and effective manner possible. VR&E's recently released orientation video, the Job Labs, new online technologies, and the addition of the employment coordinator position are all components of a new service delivery system that emphasizes returning disabled veterans to suitable employment.

The Five-Track Employment Model and the new Job Labs significantly enhance VR&E's ability to execute a plan of services in those areas where DVOPs or LVERs are not co-located or available to assist during the initial vocational evaluation, or in researching local labor market information and developing a rehabilitation or employment plan. Additionally, those DVOPs and LVERs co-located with VR&E staff can be more efficiently and effectively integrated into the delivery of employment services if they are able to access the same full range of Job Lab resources and online technologies available to VA staff.

Under the Five-Track Employment Model, the Department of Labor is a vital employment services partner. Resources will not be duplicated, but instead will be enhanced and available to both VA and DOL as they work together to help veterans become employed.

Question 31. VA's National Cemetery Administration (NCA) has received outstanding customer satisfaction ratings. What is NCA doing to ensure that customers continue to receive the highest quality service they have come to expect?

Response: NCA has a number of initiatives in place that are focused on maintaining our cemeteries as the national shrines they are intended to be and continuing to provide the high level of dignity, respect and compassion that veterans and their families deserve. NCR's Operational Standards and Measures furnish cemetery directors and their staffs a road map to measure the progress of all national cemeteries in meeting the standards of appearance commensurate with their status as national shrines. The standards define the attributes of service that veterans expect

at the committal service, at the burial, and in the care and appearance of headstones and markers, the grounds, and the facilities. NCR's Organizational Assessment and Improvement Program is based on the Baldrige Criteria for organizational excellence and our Operational Standards. The program combines cemetery self assessment with regular independent site visits to validate performance and progress toward achieving superior results.

A key strategy NCA has employed for improving the quality of service is to obtain feedback from veterans and their families on the quality of service provided at the national cemeteries. NCR's annual Survey of Satisfaction with National Cemeteries and the Administration's participation in the American Customer Satisfaction Index ensure that cemetery managers have regular access to customer perspectives and expectations. Feedback of this nature enables NCA to assess, review, modify and improve customer service.

NCA is also using information technology to enhance service to veterans. NCA continues to expand the number of kiosk information centers at national cemeteries to assist visitors in finding the exact gravesite locations of individuals buried there. In 2004, NCA launched a Web-based (Internet) Nationwide Gravesite Locator system. This innovation will make it easier for anyone with Internet access to search for the gravesite locations of deceased family members and friends, and to conduct genealogical research. The nationwide gravesite locator contains more than three million records of veterans and dependents buried in VA's national cemeteries.

Another critical success factor is maintaining a high-performing workforce. Toward this end, in 2004, NCA established the NCA Training Center to focus on the unique training needs of cemetery staff. As 11 new national cemeteries become operational, the Training Center will ensure consistency in operations and well-trained staff for key positions.

NCA has also developed new performance metrics that will be used to improve the appearance of its national cemeteries. Baseline data were collected in 2004 for three new performance measures designed to assess the condition of individual gravesites, including the cleanliness and proper alignment of headstones and markers. With this baseline data, NCA has identified the gap between current performance and the strategic goal for each measure.

Question 32. In 2002, NCA concluded that its National Shrine Commitment would require nearly $280 million in needed repairs. Given the tighter budgetary request this year, what is NCA doing to address these deficiencies? Assuming NCA receives the level of funding requested in the Administration's budget proposal, how much in remaining repairs of the original $280 million will remain outstanding?

Response: The Veterans Millennium Health Care and Benefits Act Report to Congress on the condition of VA's national cemeteries identified the need for 928 repair projects at an estimated cost of $280 million. Through fiscal year 2004, NCA has completed an estimated $77 million of the repairs identified in the report, including work on 89 projects. NCA has also initiated work on additional gravesite renovation projects, which are currently in process. With the resources included in this budget, approximately $160 million in repairs will remain outstanding.

In planning to complete the large number of repair projects identified in the report, repair projects are evaluated and prioritized on an annual basis to take into account the current condition of cemetery assets. This assessment is conducted within the Department's budget and planning processes. The funding requested in the 2006 budget will allow VA to continue to make steady progress in improving the appearance of its national cemeteries. A multi-year effort will be required, and VA is committed to ensuring that a dignified and respectful setting appropriate for each national cemetery is achieved.

NCA has also established an Organizational Assessment and Improvement Program to ensure consistent assessment of performance against established standards and to direct resources to those areas most in need of improvement. Each national cemetery is evaluated through site visits on a cyclical basis. In addition, NCA will continue to identify and evaluate new innovations and process improvements to make the most effective use of existing resources in meeting cemetery maintenance needs.

Question 33. In fiscal year 2004, NCA had 1,588 employees to carry out 94,000 interments (which roughly equates to 1 FTE per 60 interments). NCA estimates annual interments to reach approximately 115,000 in 2010. If NCA were to be staffed at the above-referenced FTE per internment ratio, it would need 1900 FTE, nearly 330 more than it has in fiscal year 2004. Does VA see a need to increase NCA FTE levels to meet future burial needs? If not, then what steps are occurring to ensure NCA's quality of service does not suffer as interments increase?

Response: As veteran deaths increase and new national cemeteries are opened, annual interments in national cemeteries will continue to increase. The number of in-

terments is estimated to increase from 95,900 in 2005 to 102,700 in 2006, an increase of 7 percent. Each year, NCA evaluates the annual resource requirements to address growing workloads in order to maintain service levels. The President's budget request provides an additional $891,000 and 13 FTE to meet the estimated increase in interment workloads in 2006.

Approximately 40 percent of fiscal year 2004 obligations in the NCA Operations and Maintenance account are attributed to support of burial (interment) operations. The remaining 60 percent is linked to cemetery maintenance activities and the administration of the headstone and marker, Presidential Memorial Certificate, and State Cemetery Grant programs. Establishing a ratio for total FTE per interment does not take into account these other missions.

NCA continually evaluates improvements in its operational processes. Some of these improvements have allowed NCA to increase its efficiency to make the most efficient use of its resources. For example, NCA is expanding the use of pre-placed lawn crypts at its national cemeteries. These crypts are installed at the time of construction and help to reduce long-term maintenance needs and the time involved in conducting individual interments. Pre-placed crypts are essentially pre-excavated graves, and only require removal of approximately 18 inches of soil in order to perform the interment. In this way, the interment process is shortened and simplified.

Question 34. The budget request for the Office of the Secretary touts an increased success rate for the average processing time for adjudication, or otherwise appropriate disposition, of Office of Employment Discrimination Complaint Adjudication (OEDCA) claims from 90 days in fiscal year 2002 to 65 days in fiscal year 2004. It also notes that VA anticipates that the trend will continue into fiscal year 2005, with reductions to 60 days and to 55 days in fiscal year 2006. Has this speed efficiency come at the expense of the accuracy of these decisions?

Response: OEDCA's efficiency in complaint adjudications and other dispositions has not come at the expense of accuracy. Since commencement of operations, OEDCA has enjoyed, and continues to enjoy outstanding success at the appellate level before the Equal Employment Opportunity Commission. The vast majority of OEDCA decisions reviewed on appeal by the Commission involve appeals by employees or applicants for employment who are challenging a finding of no discrimination. Since 1998, OEDCA's overall affirmance rate on the merits (i.e., decisions affirmed in whole) on appeal has been high—85.9 percent to date. The reversal rate on the merits (i.e., dispositions reversed in whole or in part) has been low—only 3.6 percent. The remaining 10.5 percent involve miscellaneous dispositions unrelated to the merits of the complainant's appeal (e.g., dismissal of the appeal on procedural grounds, withdrawal/abandonment of the appeal, improper denial of a hearing by an EEOC judge, etc.). These affirmance/reversal rates attest to the quality and accuracy of OEDCA's decisions. OEDCA's increased speed and efficiency have resulted from a combination of streamlining its case processing procedures and contracting out certain types of cases that can be handled more efficiently by a contractor than by in-house attorneys.

Question 35. In fiscal year 2003, over $3 billion, more than 31 percent of VA's total acquisition dollars, were spent on goods and services from small business vendors. Notwithstanding, the Administration's budget proposal states that there is a disturbing trend showing a decline in small business program accomplishments during the past several years. Does this proposed budget provide enough for the outreach efforts to inform the VA acquisitions professionals and service-disabled veteran-owned small businesses of contracting opportunities?

Response: The Office of Small and Disadvantaged Business Utilization believes the fiscal year 2006 budget is sufficient for the necessary outreach efforts to inform VA acquisition professionals and service-disabled veteran-owned small businesses of VA contracting opportunities.

Question 36. VA's Board of Veterans Appeals (BVA) is the component of the agency responsible for making a final decision on behalf of the Secretary for thousands of veterans' benefit claims that are presented for appellate review. After the advent of judicial review in the early 1990's, BVA's backlog of pending cases rose due, apparently, to slowed decisionmaking productivity. More recently, BVA has reversed the trend and productivity has increased to pre-decline levels. Yet the added problem of a 75 percent remand rate has caused additional backlog concerns. What resources, if any, does this proposed budget anticipate will specifically address the remand problem?

Response: The Board's remand rate for fiscal year 2004 was 56.8 percent. For fiscal year 2005 to date (as of March 14, 2005) the annual remand rate stands at 44.43 percent, but it is trending lower due to remand reduction initiatives. The remand rate stands at 39.26 percent for the period February 1, 2005, through March 14, 2005, and the trend continues to improve.

The Department has initiated measures to reduce avoidable remands. The Board conducted training for all attorneys and judges in ways to decrease avoidable remands. Under the direction of the Deputy Secretary, the Board and VBA together developed a tracking system to identify the causes of remands. When identified, the most persistent reasons for remands are addressed through training, or we may revise procedures. The Board will address the remand issue within existing resources.

Question 37. It is my understanding that resources expended by BVA per case adjudicated for fiscal year 2004 was $1,302. For fiscal year 2005, the cost is estimated to be $1,546, and for fiscal year 2006 the cost is projected to be $1,647. VA bases these estimates on the inverse relationship between the appeals decided per Veterans Law Judge and the dollar resources devoted to personal services. However, it is unclear how you count those personal service dollar resources. Are you combining and aggregating all FTE salaries at the Board to arrive at the figures? If so, are the anticipated increases due to cost-of-living increases for those employees or to actual incurred costs in processing claims?

Response: The cost per case is determined by dividing the estimated number of decisions into the Board's total budget allocation. The actual cost per case for fiscal year 2004 was lower due to the remand conversion decisions and an increased number of decisions produced by overtime work. It is not anticipated that this will be the case in fiscal year 2005 or fiscal year 2006.

The increases for fiscal years 2005 and 2006 reflect the projected cost of living increases for employees as well as reduced numbers of decisions processed. Final decisions take more time to produce than remand decisions.

The Board issued several thousand remand decisions in cases that had previously been involved in Board evidence development during fiscal year 2004. The Board development process was invalidated by *Disabled American Veterans* v. *Secretary of Veterans Affairs*, 327 F.3d 1339 (Fed. Cir. 2003), so the Board chose to remand all cases involved in development. Those cases were processed quickly by converting previously drafted development memoranda to remands; therefore, the cost per case was lower in fiscal year 2004.

Question 38. Currently, BVA has transcription services performed by a unit in Wilkes-Barre, PA. This unit handles 59 percent of BVA's claims cases. It is suggested in the budget request that any overflow backlog of transcription requirements would be met by contractors. Would contracting out transcription services sacrificing accuracy?

Response: Board internal quality reviews of transcripts produced by the transcription contractors found that the use of contractors does not sacrifice accuracy. The Board did discontinue two transcription contractors because their quality was inadequate. The Board continues to monitor contractors to ensure that they produce quality, accurate transcriptions.

Question 39. As I understand it, BVA conducted 7,259 hearings in fiscal year 2004, and it expects an increase of 14 percent in hearings in fiscal year 2005 and another 9 percent in fiscal year 2006. How do you arrive at these numbers?

Response: The projected 2005 and 2006 increases are based upon increased requests for hearings by appellants. The workload estimate is based upon the number of appeals pending with hearing requests, the resources available to the Board to conduct those hearings, and the historical percentage of claimants who appear for the scheduled hearings.

Question 40. While the Office of General Counsel (OGC) has done a stellar job of settling tort claims administratively (89 percent), have there been any internal studies of the common aspects of the cases that required judicial action? Is there something further OGC can do to increase its performance level?

Response: Although there have been no formal internal studies of the common.aspects of cases that are litigated rather than resolved administratively, OGC attorneys who handle administrative tort claims alleging medical malpractice cite the following reasons: (1) OGC finds that there is no liability for the claim, which the claimant may choose to dispute in court; (2) OGC finds there is exposure to liability on the claim, but the claimant and VA are unable to agree on the damages payable based on that exposure; and (3) OGC is unable to complete its investigation within the 6-month administrative claim period under the Federal Tort Claims Act, and the claimant decides to file suit rather than await VA's decision. The first and second reasons show that some litigation is necessary to assure the integrity of the administrative process. OGC should not settle claims with no liability or for more than their value. Of course, claimants may disagree with OGC's decision and litigation ensues. The third reason best lends itself to improvement, and OGC is working with the Veterans Health Administration to improve response times on claims by obtaining medical records more quickly so that a claims investigation may begin,

and in obtaining more timely medical expert reviews that are the key to determining liability and the extent of damages.

Question 41. The OGC has asked for an increase in its overall budget of some $3.2 million. Most of these increased funds (approx. $2.7 million) would be devoted to anticipated payroll requirements brought about by the expected COLA, and the balance would be expended for non-payroll items. The Administration's budget proposal states that OGC has borrowed over the years from the non-payroll account to support payroll requirements. Has OGC done an internal audit of its personnel requirements to ascertain why this seems to be a chronic problem? If so, what was the result of that audit? If not, does the OGC plan to do such an audit in the future?

Response: The Office of General Counsel (OGC) audits its personnel requirements continuously to ensure that the number of attorneys and support personnel in the headquarters and field locations are sufficient to deliver quality, timely legal services to the Department. We have determined through this continuous audit process that 670 full-time employees will allow us an adequate number of human resources to accomplish our mission. We have not had the budget authority during the past several years to meet that requirement.

In each of the last 3 years, the pay raises exceeded projections by 1.5 percent in FY 2003, 2.1 percent in fiscal year 2004 and 2 percent in fiscal year 2005. As OGC's payroll constitutes 95 percent of its budget authority, the unanticipated pay increases significantly affect the number, of employees that the budget will support. Specifically, with our average payroll cost per employee of approximately $98,000, (with benefits) for each 1 percent of unanticipated increase in payroll costs, we are unable to support eight employees. Accordingly, we have fallen short of our employment projections by 9 employees in fiscal year 2003, 20 employees in fiscal year 2004, and. 8 employees in fiscal year 2005. Moreover, differences between payroll projections and actual pay raises compound from year-to-year, as higher than budgeted pay raises must be absorbed during the following fiscal year. For example, we did not know what the final enacted fiscal year 2003 pay raise would be when we prepared the fiscal year 2004 budget.

As a result of these factors, we instituted a hiring freeze in fiscal year 2003, because we exhausted non-payroll funding to pay for unfunded payroll expenses. At the end of fiscal year 2003, OGC offered buyouts to eligible employees, because our budget projection for fiscal year 2004 could not support the FTE we had on board in fiscal year 2003.

The difference between budgeted and actual pay raises for three consecutive years has had a significant impact on OGC's ability to fund budgeted FTE. Because 95 percent of OGC's requirements are payroll, they are unable to absorb these costs in non-payroll funding. However the additional funds included in this budget will help OGC address its pay and non-pay requirements.

Question 42. The Administration's budget proposal states that OGC has hired paralegals using the funding transferred from non-payroll to travel and personal services, and it states this hiring has increased the capacity of attorneys to provide legal services. How has the OGC measured this increased productivity? What results were obtained?

Response: During fiscal year 2005, the Office of General Counsel (OGC) fully implemented the use of a case and time management system (GCLAWs) that allows for comprehensive monitoring of workload and the time that our employees spend to address that workload. We are just beginning to develop the data from GCLAWs that will enable us to provide a comprehensive analysis of the increased capacity provided by paralegal specialists. We have developed a policy that promotes the hiring of paralegals, and that will ensure that our subordinate managers employ paralegals to extend the capacity of our attorneys in providing legal services.

Our existing paralegal staff has demonstrated that they are able to make our attorneys more productive. Our paralegals interview witnesses, provide legal research, draft dispositive motions that limit or avoid time consuming and expensive hearings, and prepare documents and materials for depositions and hearings. This allows our attorneys to concentrate their efforts on preparing significant cases for hearing or trial and finalizing work started by the paralegals. The attorneys have the capacity to complete more cases—more effectively—with the assistance of qualified paralegals.

We look forward to the opportunity to update the answer to this question as we develop analytical tools from GCLAWs to measure the impact described in the previous paragraph. We estimate that measurable data will be available by early in fiscal year 2006 to demonstrate the increased productivity allowed by our paralegal staff.

Question 43. The Administration's budget proposal projects the opening of an Office of Inspector General (OIG) office at the Bay Pines VA Medical Center Office.

Why is this necessary? What will this office's mission be? How long does VA anticipate that it will operate? What measures did OIG take to redeploy existing resources to meet its staffing needs in Bay Pines?

Response: In order for the OIG's independent, objective oversight to keep pace with VA's expanding services and delivery locations, OIG is opening a regional office at the Bay Pines VA Medical Center. Staffed with auditors, health care inspectors, and criminal investigators, the OIG's Bay Pines office will provide the full range of audit, inspection, and investigative services across all VA programs and operations in the Southeast on a permanent basis. For the reasons cited below, and in consideration of the temporary deployments the OIG made during the Bay Pines and CoreFLS review last year, key stakeholders and VA found existing oversight resources inadequate.

In 1996, the Congress enacted legislation expanding eligibility for the complete continuum of VA care, including outpatient care and prescription drugs, to all 25 million veterans. From 2000 through 2003, Bay Pines VA Medical Center, Veterans Integrated Service Network (VISN) 8, had experienced a 69 percent increase in unique patients. VA operations in Florida today involve a VISN headquarters, 6 medical centers, 10 outpatient clinics, 30 community based outpatient clinics, 11 veterans centers, 4 national cemeteries, and VBA's largest regional office. With the implementation of VA's Capital Asset Realignment for Enhanced Services plan, Florida as well as Puerto Rico will increase service to one of the largest veteran populations in the United States. With the expansion of VA services and the increase in number of veterans served comes; the opportunity for additional instances of waste, criminal activity, mismanagement, and abuse.

As a result of these changes, the workload of OIG has dramatically increased. The Office of Investigations' current caseload approximates 20 cases per FTE with a backlog of unassigned criminal and administrative cases. The Office of Audit has numerous audits and reviews identified to address significant areas of vulnerability that have the potential for millions of dollars in savings and recoveries, but continually has to suspend or postpone higher priority national audits to address an ever-increasing reactive workload. During the past several years alone 75 identified national reviews were either never started or were suspended. The Office of Healthcare Inspections, with 36 operational FTE, had been operating on a ratio of I health care inspector for every 40 VA health care facilities and one Inspector to review every 1.3 million patient encounters. In addition, the Office of Healthcare Inspections has been able to investigate less than 10 percent of the health care service and malpractice complaints received. In excess of 90 percent of the health care complaints received had to be referred to the Veterans Health Administration for internal review in order to receive timely review of a complaint.

Question 44. What accounting methodologies did VA use to arrive at the return-on-investment of $49 to $1 (dollar impact of $3.24 billion/cost of OIG operations at $66.4 million)?

Response: The Inspector General Act of 1978, as amended, mandates a rigorous system of accountability through semiannual reporting to both Congress and the VA Secretary. Throughout the year, the OIG records results in the form of published reports and investigative actions. In the period in question, the OIG reported a better use of funds in the amount. of $2.8 billion; fines, penalties, restitutions, and civil judgments totaling $258 million; Fugitive Felon Program results in the form of overpayments and cost avoidance amounting to $117 million; dollar recoveries of $24 million; and questioned costs in VA programs of almost $17 million. The largest element of monetary impact comes from funds put to better use, which is defined by statute in the Inspector General Act, at Section 5(f)(4). These amounts come from actual dollar recoveries or as the result of agreed upon monetary impact. After aggregating the monetary impact of OIG operations, they establish a ratio between impact and general operating expenses for the period in order to calculate the return-on-investment measure.

Question 45. The OIG has conducted an audit of part-time physicians to reassess time and attendance practices. Does it plan any future such audits of other professional health care workers such as specialized nurses in similar settings?

Response: The OIG has conducted audits of part-time physicians to assess time and attendance practices as one aspect of the OIG's program to ensure that VHA patients receive appropriate medical care from privileged providers in the proper setting. The OIG considers the time VA physicians allocate to patient care activities, when compared to other duties, critical to the successful and efficient delivery of health care. The OIG also conducted a related review on nurse staffing, where they made recommendations to improve the management of nursing resources, promote high quality patient care, facilitate nursing recruitment and retention efforts, and enhance nurses' job satisfaction. The OIG will continue to focus on time and attend-

ance issues, as a pulse point in its Combined Assessment Program reviews, as part of an overall effort to ensure that VHA employs the hospital staff that is appropriate to the medical needs of the hospital population.

Question 46. The Office of Information and Technology (OIT) has requested an additional 76 FTE for fiscal year 2006 to prepare for staff losses due to projected retirements. The estimated FTE level for fiscal year 2006 is 532, up from 287 in fiscal year 2004. How much of this increase is necessary to provide direct support and how much is for gearing up for retirements? Once the retirements occur, what is the ideal staffing level for OIT and when does VA expect to be there?

Response: All FTE are for new responsibilities (for example):

- Enterprise Project Management
- IT Exchange Consolidation
- 508 Compliance
- Seamless Transition
- VA Web Page Consolidation and Hosting
- Enterprise Cyber Security Infrastructure ProgramNirtual Private Network (ECSIPNPN)
- Security Configuration and Management Program (SCAMP)
- Continuity of Operations (COOP)
- Enterprise Architecture
- Data Architecture Development
- Data Registry and Repository
- Registration Eligibility Contact Management
- Critical Infrastructure Protection
- Project Management Certification

These all include continuing efficiencies or new requirements.

The increase in FTE does not include the need for replacing upcoming retirements—that in itself is a one-to-one replacement. OI&T is acutely aware that the potential workforce must consist of a younger, diverse employee and include hires with new competencies and skills needed to accomplish future requirements. OI&T expects to be at end strength of 532 by the end of fiscal year 2006.

Examples of hiring programs being used by OI&T:

- Vet IT—Hiring disabled veterans who have returned from Iraq and Afghanistan. Presently we have hired five disabled veterans that have recently been discharged from the military and three pending direct hire immediately upon discharge. VA Central Office has several disabled military soldiers that have volunteered to work at the VA while being treated at WRAMC—this allows them to receive valuable on-the-job training in a real time work environment so they may be better prepared for a different career upon being discharged from the military.
- VA IT Intern Program—over 20 college graduates have been hired to begin their career in an IT environment with the Office of Information and Technology.
- College recruitment for special skills—The Office of Information and Technology has started to recruit from special programs in local colleges. An example is our efforts to recruit from the George Washington University Masters in Cyber Security Program. Programs like this are preparing graduates with state-of-the-art education in Cyber Security and bring valuable learning experiences to VA.
- Project Management certification—VA is making a concerted effort to increase the number of certified Project Managers to run all major projects. At this point, we have a certified Project Manager for each Project 300 submitted to OMB.

Department of Veterans Affairs Responses to Post-Hearing Questions From Senator Richard Burr

Question 1: According to the NIH, more than 18 million people in the U.S. have diabetes and the disease has substantial costs on Medicare and veterans health programs. Veterans diagnosed with diabetes on average cost the Department of Veterans Affairs considerably more than those without diabetes. In fact, the American Diabetes Association (ADA) says diabetes is the main cause of kidney failure and new onset blindness in adults and a major cause of heart disease, limb amputation and stroke, and costs the Nation about $100 billion each year.

At the same time we've begun to understand diabetes' deadly and costly complications, research has firmly established the importance of tight control of blood glucose levels to successfully manage diabetes and prevent its complications.

The VA is currently considering a proposal to standardize blood glucose testing equipment made available to veterans suffering with diabetes. Since there is often a clear patient preference for a particular type of testing equipment, concerns have been raised about the impact on patient care and VA health system costs of moving

to a single award contract. Standardization of certain products purchased by VA has shown savings in some areas, but diabetes may be different. Should access to varying types of diabetes testing equipment be limited in the VA at the same time health experts and other Administration initiatives are working to advance diabetes self monitoring?

Please detail the efforts of the Department of Veterans Affairs to standardize diabetes testing equipment and explain what the expected effect of such standardization will be.

Response: While VHA plans to continue to explore some form of standardization in this area, as the initiative moves forward it will be different from the initial concept, especially in one very important way. The initial concept contemplated an award for a single Self Monitoring of Blood Glucose (SMBG) device, which would be utilized, exclusively across VA, except when medical need dictated the use of an alternate device. The current evaluation and planning is focused on allowing each VA patient to continue to use their existing device, while identifying a single device that would be used for newly diagnosed diabetic patients. This "new" device could be one of the three commonly used by VHA, or it could potentially be a device not currently used by large numbers of VA patients. This approach will result in no fewer devices and potentially one additional device, and patients will not be required to stop using their existing devices.

At this time, VHA has not completed its interdisciplinary SMBG review. However, VHA believes that by modifying its approach to standardization as described below, when an initiative is pursued it will be in compliance with the intent of the House Report 108–674 statement that multiple vendors provide the best opportunity for competition.

VA agrees that veterans with diabetes must receive the best care possible, including the use of reliable, state-of-the-art SMBG equipment with which they are comfortable. Therefore, if the interdisciplinary review team's decision is to pursue a national contract for a SMBG device, VHA will identify only those patients who; 1) are newly diagnosed, or 2) request conversion from their present device as candidates for the contracted device.

No veteran will be forced to change equipment; however, introducing new equipment as an option may allow VA to achieve significant savings on equipment and supplies provided to veterans. By allowing veterans to continue to use their existing devices, if that is their preference, VA will indeed be using multiple vendors to supply SMBG equipment and induce competition as included in the House Report language. In fact, the Veterans Integrated Service Networks (VISNs) are already successfully employing separate standardized SMBG contracts at the VISN or local level.

A. Quality of care: While the National Diabetes Fact Sheet (Centers for Disease Control and Prevention) notes that 8.7percent of the U.S. population over 20 years of age had diabetes in 2002, over 19 percent of the veteran population has diabetes—making the veteran population a very high-risk population. Accordingly, VHA is committed to giving the best possible health care and to embrace the latest technology and test equipment in a cost-effective manner, to appropriately manage this population to prevent higher rates of morbidity and mortality. VA believes it is possible to improve SMBG standardization as well as maintain and/or improve the quality of care for our diabetic patients.

The role that SMBG can potentially play in the treatment of patients with diabetes remains a topic of debate. While studies exist which support SMBG can provide clinical benefit in some patients with type I diabetes, the evidence for similar benefit in type 2 diabetes patients, which is the predominate type of diabetes in VA, is much less convincing.

Before VA began consideration of further SMBG standardization, a clinical determination of its feasibility was performed by reviewing published studies about the beneficial outcomes resulting from glucose monitoring and discussing the issues with key clinical staff. While some studies have shown modest benefits with intensive control for type 2 diabetic patients who are not using insulin, there is no randomized trial linking frequent home blood glucose monitoring with improved clinical outcomes. Presently, studies on SMBG have only evaluated the laboratory test HbA1 c as a surrogate endpoint. Whether or not SMBG plays a role for patients with type 2 diabetes achieving or even maintaining glycemic control remains an issue of legitimate debate.

The vast majority of SMBG studies to date have been unable to show that frequent monitoring of blood glucose results in improved HbA1 c values, while only a few have shown only modest benefit. In fact, a VA study showed that reducing the number of strips dispensed did not result in deterioration of glycemic control. Patients who demonstrate good glycemic control while on a stable oral regimen may

require few or no strips. In most cases, periodic HbA1c is sufficient to ascertain the level of glycemic control. Another recent study showed that SMBG did not result in improved HbA1 c values in patients with good or adequate glycemic control; however, SMBG (6–10 strips/month) did benefit those with very poor glycemic control at baseline. VA recognizes that when metabolic control of otherwise stable patients worsens or changes due to illness, exercise, diet or as adjustments are made to their medication regimen, SMBG requirements may increase.

Impact of switching testing equipment: Each of VA's 21 Veterans Integrated Service Networks (VISNs) has been standardized to a single outpatient blood glucose monitoring device for many years. Three VISNs standardized to the Lifescan system, six VISNs to the Abbott system, and twelve VISNs to the Roche system (both of the previous VISNs which now comprise VISN 23 use the Roche system). Most, if not all of these past standardization efforts required some degree of conversion from one device to another. VA is unaware of any significant quality, safety, or patient satisfaction issues that may have been caused by these past standardization efforts.

Since SMBG standard ization'has been successfully demonstrated at both the local and VISN levels, it is not expected that changing the scope of standardization effort from the VISN level to the national level would introduce any quality of care concerns.

B. Direct and indirect costs: VA has estimated a range of capitated conversion costs should we move forward with some form of SMBG standardization. The costs range from $5 per person to $25 per person and are dependent upon the conversion method used. Based on the level of discount expected, the $5 conversion would be recouped with the first 2-month supply of strips issued and is based on a group education model. Similarly, the $25 conversion cost would be recouped with the first 10-month supply of strips issued and is based on one-on-one education model.

It is not possible to determine the overall cost to the entire VA health care system until such time as an award is made. For example, if an award is made to one or more vendors who currently have a large market share in VA, there will be less cost than if the vendor has a smaller VA market share.

In order to minimize the direct and indirect conversion costs of SMBG standardization, VA can develop contract options which: 1) require the manufacturer to provide free equipment upgrades, at VA's discretion; 2) mandate stable pricing over the entire length of the contract (up to 8 years); and 3) not require mandatory national conversion to a single device, but allow individual VISNs to implement the contract at their own pace.

While precise estimates cannot be projected until an award is made, VA estimates that the savings can potentially far out weigh transition costs. This estimation is based on current cost data and past contracting experience. VA's purchase of SMBG strips has increased 70 percent in 5 years—from 91 million strips in fiscal year 1999 to 156 million strips for fiscal year 2004. From fiscal year 1999 through fiscal year 2004, VA's average cost per strip and total number purchased, with total costs was:

Year	Price/Unit	Volume	Cost
FY 1999	$0.46	91 million	$41.9 million
FY 2000	0.41	106 million	43.5 million
FY 2001	0.37	123 million	45.5 million
FY 2002	0.35	136 million	47.6 million
FY 2003	0.34	144 million	49.0 million
FY 2004	0.34	156 million	53.0 million

Based on past standardization contracting experience, it is estimated that VA could realize a cost savings of approximately $11 million to $18 million per year for a total of $88 million to $144 million over the life of an 8-year contract. By carefully crafting a contract solicitation, VA can minimize conversion costs so that the majority of the cost reductions accrue directly to VA.

Should the work group recommend further SMBG standardization in VA and should VA move toward that goal, the SMBG work group, Pharmacy Benefits Management office, and VISN clinicians will develop measures and monitor implementation efforts overtime.

C. Public input: VA has a well-established and independently validated process of using an objective, evidence-based approach for all of its pharmacy standardization efforts and is applying these techniques to its review of SMBG devices. In September 2003, VA formed a multidisciplinary medical professional advisory com-

mittee to conduct the literature and product reviews. This advisory committee is comprised of physicians, nurses, diabetic educators, medical technologists, pharmacists, and contracting staff whose charge is to conduct an evidencebased SMBG standardization feasibility assessment.

VA will allow existing patients to continue using their present devices and only require use of a new device for: 1) newly diagnosed patients; 2) patients who need replacement devices; and 3) patients who desire a switch to the contracted device. As is the case for any pharmaceutical or medical device, patients who have a demonstrated clinical need for a particular SMBG device will be able to obtain that device, even if it is non-contract, through VA's non-formulary request process.

While VA is relying exclusively on the advisory group for recommendations and guidance, VA has also received a large amount of input from other stakeholders and incorporated all information received into the deliberative process. VA continues to welcome stakeholders to forward relevant information to the SMBG work group.

Question 2: Public Law 106–419, which was enacted on November 1, 2000, directed the Department of Veterans Affairs to conduct an independent follow-up study of the National Vietnam Veterans Readjustment Study (NVVRS) cohort that was first assessed in the mid–1980's and report on the findings by October 1, 2004. This follow-up, known as the National Vietnam. Veterans Longitudinal Study (NVVLS), will produce important information about the long-term health consequences of combat exposure at a time when a new cohort of combatexposed troops could benefit from the information. The deadline passed months ago, and no report of findings has been submitted. Can you explain why not? What is Department of Veterans Affairs' plan for complying with the Public Law 106–419 mandate, and when will the report of these important study findings be delivered to Congress?

Response: In December 2003, the Office of the Inspector General (OIG) was asked to conduct an audit to assess the effectiveness of the procurement and project management processes used for the National Vietnam Veterans Longitudinal Study. That same month, VA officials met with staffs of the House and Senate Committees on Veterans' Affairs to advise them of the delay in completing the study. The OIG has recently released a draft report on the issue and plans to issue a final report soon. VA is carefully reviewing the information in this draft report and is considering management options based on the findings.

DEPARTMENT OF VETERANS AFFAIRS RESPONSES TO POST-HEARING QUESTIONS FROM SENATOR JOHN D. ROCKEFELLER IV

Question 1: Co-payments and fees as budget gimmicks: Why does this Administration persist in submitting a budget that suggests doubling prescription drug co-payments and imposing a $250 enrollment fee on some of our middle income veterans when such provisions have been consistently rejected?

Response: Eligibility Reform opened VA health care to all veterans and established an enrollment system based on priority levels as a tool to manage demand for VA health care within available resources. By law, the VA Secretary must decide annually whether VA has adequate resources to provide timely, high quality care for all enrolled veterans. Each year, VA reviews actuarial projections of the expected demand for VA health care in light of the expected budgetary resources and develops policies accordingly. The cost-sharing policies proposed in the fiscal year 2006 Budget follow from this mandated use of enrollment priority levels to manage demand for care within available resources and is in line with the premium of $230 paid by military retirees in TRICARE. VA strongly believes that these policies represent the best opportunity for VA to secure the necessary resources to serve our core population—veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs.

Question 2: General Budget: How can you justify submitting a budget that only increases VA health care by $522 million—not even enough to cover inflation and VA employee payroll?

Response: The 2006 estimate of $22.377 billion represents a 3.5 percent or $761 million increase over the 2005 estimate in Medical Services budget authority. Given the current fiscal environment, it is more important than ever that VA concentrate its resources, policies and strategies on those veterans identified by Congress as highest priority. These resources will allow VA to treat more than 5.2 million patients. Those in Priorities 1 to 6 will comprise 78 percent of the total number of veteran patients in 2006. This will represent the third consecutive year during which our core constituency will increase as a percentage of all veterans treated.

• About 9 of every 10 medical care dollars in 2006 will be devoted to meeting the health care needs of our highest priority veterans.

• The budget ensures continuation of the Presidential priority where VA is working closely with the Department of Defense to ensure that service members returning from Iraq and Afghanistan and their families are provided timely, high-quality services.

• The 2006 budget request calls for a total investment of $2.2 billion in enhanced mental services, which is $100 million above the 2005 funding level. This budget proposal ensures a full continuum of care for veterans with mental health issues, to include comprehensive treatment for those veterans with post-traumatic stress disorder (PTSD).

• The 2006 budget calls for $1.2 billion for prosthetics and sensory aids, a $100 million increase over 2005.

• Funding for non-institutional care would increase by more than 18 percent over 2005, with a total investment of $400 million in the President's proposed budget.

• Funding allows for VA to address inflation by $540 million and payroll item increases by $859 million.

Follow-up Questions: How is VA planning to serve the more than 192,000 returning veterans, including our National Guard and Reservists, from fighting in Iraq and Afghanistan? How have these new veterans affected the workload in VAMC to date? And in our Vet Centers?

Response: VA will serve the Reservists and National Guard members using its expansive healthcare system and will capitalize on the capacity and success of its Vet Centers. It is important to note that not all veterans will present to VA for care or services. Our latest data indicate that as of December 2004, 244,054 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans had separated from active duty. Approximately 20 percent of these veterans (48,733) have sought health care from VA. A very small number (930) have had at least one episode of hospitalization. Reservists and National Guard members make up the majority of those who have sought VA health care (27,766, or 57 percent). Separated active duty troops have accounted for 43 percent (20,967). All in all, OIF/OEF veterans have accounted for only slightly more than 1 percent of our total veteran patients (4.7 million in fiscal year 2004); however, many of them will, of course, have suffered much greater acute trauma.

Since the inception of the Vet Center program in 1979, the Vet Centers have served over 2 million veterans. Annually, the Vet Centers see, on the average, approximately 130,000 veterans and provide over 1,000,000 visits to veterans and family members. In fiscal year 2003, the Vet Centers saw 1,931 OEF/OIF veterans, and in fiscal year 2004, they saw 9,597 OEF/OIF veterans. We are estimating that in fiscal year 2005, we will see 11,184 returnees from Afghanistan and Iraq in the Vet Centers. OEF/OIF veterans and their family members had 2,450 visits to Vet Centers in fiscal year 2003 and 18,819 visits in fiscal year 2004. At current rates of utilization, we are projecting 29,000 visits for OEF/OIF veterans for fiscal year 2005. The Vet Centers are complemented by the medical care capacity of medical centers and community based outpatient clinics (CBOCs), which support a full spectrum of clinical care.

Meeting the comprehensive health care needs of returning OIF and OEF veterans who choose to come to VA is one of the Department's highest priorities. We are confident that our current budget and the Presidents' fiscal year 2006 budget request contain sufficient funding to allow us to continue to provide for all the health care needs of these veterans.

Question 3: PTSD: Medical experts warn that one in six veterans or more returning from Iraq and Afghanistan will face serious issues on Post-Traumatic Stress Disorder (PTSD). How is VA in general preparing for this huge issue?

Response: We believe that our capacity to care for veterans with PTSD is sufficient.

As of December 2004, 4,783 patients at VAMCs were coded with a diagnosis of suspected PTSD. In addition, 2,082 veterans received services for PTSD through our Vet Centers. Allowing for those who have received services at both VAMCs and Vet Centers, a total of 6,386 individual OIF/OEF veterans had been seen with potential PTSD at VA facilities following their return from Iraq or Afghanistan. To put this number in the context of our capacity, in fiscal year 2004, we saw approximately 279,000 patients at VA health care facilities for PTSD alone and 63,000 in Vet Centers. Thus, OIF and OEF veterans account for only about 2 percent of VA's PTSD patients.

To address the PTSD needs of these veterans, and, indeed, of all veterans with PTSD, we have in place some of the most comprehensive programs and initiatives in the country.

• VA developed a computerized clinical reminder for its clinicians. This reminder opens for all OIF/OEF veterans and reminds clinicians to screen the patient for symptoms of PTSD, substance use disorder, or depression.
• VA will invest funding in new programs for PTSD, OIF/OEF veterans, and for substance use disorder treatment programs as it implements the mental health provisions of PL 108–170.
• VA will invest additional funds in fiscal year 2005 in establishing PTSD Clinical Teams in those medical centers and large CBOCs that currently do not have those programs. Other funds will be invested in fiscal year 2006 to continue expansion of PTSD services and OIF/OEF mental health services.
• The Vet Center program is a special VHA program designed to provide readjustment counseling to veterans exposed to the uniquely stressful rigors of military service in a combat theater of operation. VA's Vet Center program consists of 206 community based Vet Centers located across the country, outside of the larger medical facilities, in easily accessible, consumer-oriented facilities with staff that are highly responsive to the needs of local veterans. Vet Centers have had over 35,000 encounters with more than 15,000 veterans returning from Afghanistan and Iraq.
• VA Readjustment Counseling Service (RCS) is in the process of adding 50 Global War on Terror (GWOT) veterans as peer counselors to assist troops in the transition from military to civilian life. These peer counselors provide a natural connection to separating service members to outreach on issues of readjustment and PTSD.
• Letters have been sent by the Secretary to over 230,000 returning OIF and OEF troops informing them of the availability of VA to meet their healthcare and readjustment needs, including the 2-year eligibility for care provided under Directive 2002–049.
• Through the Seamless Transition Task Force, and now the Seamless Transition Office, VA has established skilled points of contact in each VAMC and has instituted outreach to demobilization centers by Vet Center and VBA staff. VHA placed Social Work case managers in major DoD hospital facilities such as Walter Reed Army Medical Center, Madigan Army Medical Center, and National Naval Medical Centers, Bethesda to facilitate the transition of OIF/OEF Veterans to VA.
• 144 Specialized PTSD programs exist in all VA's 21 Networks, including outpatient, inpatient and residential care programs.
• VA, in conjunction with DoD,. established a Clinical Practice Guideline (CPG) for the treatment of PTSD. To our knowledge this is the first CPG for PTSD that was ever created.
• In 2004 a new Mental Illness Research, Education and Clinical Center (MIRECC) was established at VAMC Durham to focus on issues of post-deployment health for returning OIF/OEF Veterans. It will collaborate with the National Center for Post-Traumatic Stress Disorder (NCPTSD) and the nine other MIRECCs as well as with DoD and VA Office of Research and Development and Employee Education Service.
• VHA also established a new MIRECC, Denver, CO to focus on suicide and its prevention—a growing concern in the OIF/OEF population.
• VA maintains the National Center for PTSD, which promotes research, and education on PTSD within VA and in collaboration with DoD. The NCPTSD web site, *www.ncptsd.org*, describes the NCPTSD Divisions and their accomplishments. and provides valuable Fact Sheets for clinicians, veterans, their families and the general public.
• NCPTSD Divisions include the Executive Division (White River Junction) which houses the Published International Literature on Traumatic Stress (PILOTS) data base of all English language publications on PTSD and some in foreign languages as, well.
• The Behavioral Sciences Division (Boston) has carried out many collaborative studies on PTSD psychotherapy and created assessment tools for PTSD. Boston is also home for the Women Veterans Health Division of the NCPTSD, created in 1992 to address the issues of the increasing numbers of women veterans in our Armed Forces.
• The Biological Sciences Division (West Haven) focuses on basic science of PTSD, identifying the physiological and neuroanatomical changes associated with PTSD and biological process to PTSD care.
• The Clinical Laboratory and Education Division (Palo Alto) provides practical training for advanced students of PTSD care from across the Nation. This division, in collaboration with VA Employee Education Service, also created the award-winning series of videotapes on the unique PTSD issues of ethnic/cultural groups of veterans including Native Americans, African Americans, Hispanic Americans and Asian/Pacific Islander Americans. Videos for each group address mental health clinicians, other health care providers and veterans and their families.

• The NCPTSD created the Iraq Clinician War Guide in 2003 to assist VA clinicians in meeting the needs of veterans returning from Iraq and Afghanistan. It was modeled after a similar publication created at the time of the Persian Gulf War. In 2004 the Iraq War Guide was released in revised form with new chapters contributed by U.S. Army clinicians dealing with troops being treated for combat related limb amputations at Walter Reed Army Medical center. Issues of families of wounded veterans are also addressed.
• VHA collaborated with DoD in the Treating War Wounded satellite broadcast in April 2003. This program focused traditional combat injuries as well as chemical, bacteriological and radiological injuries and mental health issues. It has since been transformed into a Veteran Health Initiative hard copy, CD and web-based training tool.

Follow-up Question: GAO issued a report in September 2004 highlighting the problems of sharing data between DoD and VA which makes it harder for VA to plan to serve veterans with PTSD. Are you aware of this report and these issues? If so, what are you doing to remedy the problem? If not, will you follow up and let me know how VA will coordinate with DoD on this data and coordination?

Response: GAO reviewed DoD's efforts to identify service members who have served in Iraq and Afghanistan and are at risk for PTSD, and VA's efforts to ensure that PTSD services are available for all veterans. GAO concluded that VA lacks the information it needs to determine whether it can meet an increase in demand for VA PTSD services. GAO recommended that VA determine the total number of veterans receiving PTSD services and provide facility-specific information to VA medical facilities and Vet Centers.

VA concurred with this recommendation and in October 2004, consolidated the necessary data into a national report and distributed the report to all VISNs, medical centers, and Vet Centers to assist them in estimating potential PTSD workload expansion. VA updates and distributes this report on a quarterly basis.

VA also identifies related demographic data requirements that assist in determining expanded workload demands. Fundamental to all of these efforts is DoD's timely provision of demographic, health and exposure information to VA. DoD has supplied demographic data for returning veterans. VA has analyzed and trended these data quarterly, and they are then provided to the network offices for follow-up outreach efforts.

VA continues to work with DoD's provision of basic post-deployment health data which assists VA in providing health care to individual veterans. Those data assist us in better understanding and planning for the health problems for all OIF/OEF veterans. Although' DoD officials have provided VA with some useful demographics on separated veterans, we continue to strengthen our cooperative ties with DoD mental health officials. We are hopeful that information sharing will be expedited and are especially encouraged by recent deliberations of the VA/DoD Health Executive Council to highlight mental health issues as a primary focus.

Follow-up Question: What is being done to support and enhance Vet Centers to fulfill the needs of returning veterans? What special outreach is being done for National Guard and Reserve units?

Response: The Vet Center program's capacity to provide outreach to veterans returning from the Global War on Terrorism (GWOT) in the theatres of combat operations in Afghanistan and Iraq has been augmented by VA. Specifically, the Vet Centers have hired and trained up to 50 new outreach workers from among the ranks of recently separated GWOT veterans at targeted Vet Centers. Augmented Vet Center outreach is primarily for the purpose of providing information that will facilitate a seamless transition and the early provision of VA services to new returning veterans and their family members upon their separation from the military. These positions are being located on or near active military out-processing stations, as well as National Guard and Reserve facilities. New veteran hires are augmenting Vet Center services by providing briefing services to transitioning servicemen and women regarding militaryrelated readjustment needs, as well as the complete spectrum of VA services and benefits available to them and their family members. These Vet Center points of contact for OIF/OEF provide the link to other members of the VA team at VBA and VHA for additional services to meet the veteran/family needs. The new veteran hires are also organizing local community activities and "town hall meetings" to provide information and education about VA, DoD, and other community support services available to veterans and family members. During these community offerings new veterans are also able to view the video, "We Are By Your Side," to increase their knowledge of other benefits that they might be eligible to receive.

Extensive VA outreach briefings have been conducted for the senior leadership in the Army National Guard and Army Reserve. Letters from the Secretary of Vet-

erans Affairs, information toolkits and a copy of the video," We Are By Your Side," have been sent to the Chiefs of Staff for all services and the Reserve Chiefs. VA has also sent letters to separating service members, which welcomes them as new veterans and instructs them on the enrollment process for VA care as well as applying for disability benefits. VBA outreach coordinators and Vet Center staff provide further information to service members at mobilization sites as part of the Transitional Assistance Program (TAP) for National Guard/Reserve personnel who are separating from active duty to reserve or civilian status. VA Outreach coordinators will also be allowed blocks of time on the unit training schedule and during family programs to brief on VA Benefits/Services and home station.

Recently, VA authorized establishment of its newest Vet Center in Nashville, Tennessee. This initiative represents a collaborative effort between VA's Readjustment Counseling Service and the Veterans Integrated Service Network 9 for the purpose of augmenting VA's mental health and related services to local veterans.

Follow-up Question: Since it can take time for PTSD to manifest, is action needed to lengthen the eligibility of National Guard and Reservists so that when they need care, they can get it? Can assure me that they will be covered when they need the care?

Response: Under 38 U.S.C. § 1710(e)(1)(D) and § 1710(e)(3)(C), veterans who have served in combat may enroll in the VA health care system and, for a 2-year period following the date of their separation from active duty, receive VA health care without co-payment requirements for conditions that are or may be related to their combat service. If they do enroll in the VA health care system, they may continue their enrollment following the initial 2-year period, but may be subject to any applicable copayment requirements.

For combat veterans who do not enroll with VA during the 2-year post-discharge period, eligibility for enrollment and subsequent health care is subject to such factors as a service connected disability rating, VA pension status, catastrophic disability determination, or financial circumstances. If PTSD appears in a non-enrolled combat veteran following the end of his or her 2-year period of eligibility, and is subsequently determined to be service-connected, that veteran would then become eligible for enrollment in Priority Group 1, 2, or 3, and thus they would be able to receive needed care.

Question 4: Gulf War Veterans' Illnesses (GWVI): Last year, former Secretary Principi pledged $60 million in continuing research over several years for Gulf War Veterans' Illnesses. This is an issue that has concerned me for over a decade. This VA budget cuts $9 million from research. What does this tell this Committee and veterans about the VA's long-term commitment to research on Gulf War Veterans Illnesses (GWVI)? And how will it affect recruitment of physicians?

Response: Funding for Gulf War Veterans' Illnesses: VA remains committed to continuing research into the causes of and potential treatments for GWVI and agrees that it essential to find answers to what is causing GWVI and to identify appropriate treatments.

At a press conference on November 12, 2004, former Secretary Principi announced that VA would commit up to $15 million in additional Federal funding in fiscal year 2005 to support continued research into the causes of and potential treatments for GWVl. He noted that this represents VA's single largest set-aside of research funding for a specific area of investigation and almost 20 percent of all new research grant awards for fiscal year 2005. Although VA presently has no earmarks beyond fiscal year 2005, the Department is committed to fund scientifically, meritorious research approved through VA's merit review process in future years.

As of February 2005, VA has approved 28 new projects for funding totaling $4.9 million. A specific program announcement to solicit proposals for research directed to understanding illnesses affecting Gulf War veterans was recently issued. To assure that the results of this research are credible to the scientific community, it is crucial that all of these studies undergo the same intensive peer review and be held to the same standards of scientific rigor as all projects sponsored by VA research. To manage this review process, VA is creating a new merit review panel and has received over 60 nominations for the peer review panel needed to evaluate solicitations received in response to the GWVI program announcement. In addition, recruitment for a portfolio manager for deployment health is underway. The deployment health portfolio will include research about GWVI.

VA will also establish a center dedicated to the investigation of potentially effective treatments for GWVI. The center will utilize observational and epidemiologic methods to identify promising therapies and will conduct pilot studies that may serve as preludes for more definitive clinical trials. A meeting of the planning committee for the GWVI Treatment Center is being scheduled for spring 2005.

Recruitment of Physicians: While VA's appropriated budget is relatively small compared to agencies such as the National Institutes of Health (NIH) and the National Science Foundation (NSF), VA research makes a significant contribution to the advancement of medical science. By devoting nearly 70 percent of the research budget to supporting over 2,200 investigator-initiated research projects, VA maintains a climate of scientific inquiry and rigor that continues to attract physicians of the highest caliber.

Within the broad range of research from the very basic as well as applied research, VA highly values research that specifically addresses medical issues that are most relevant to the veteran population. In many such areas, VA is widely regarded as an international leader, including research related to rehabilitation and health services delivery. VA also emphasizes research that capitalizes on its unique strengths, such as the integrated delivery system and the electronic medical record. The VA Cooperative Studies Program, for example, is internationally recognized for conducting the highest quality, multi-center studies that address clinically important topics that are difficult, if not impossible, to perform in other settings.

Question 5: Rehabilitation for Returning Veterans: Medicine and care in the combat zones has improved in extraordinary ways so that many of our soldiers come home, but some of those who make it have severe wounds, including loss of limbs or mobility. What new efforts are underway to provide rehabilitation for such veterans, including future employment opportunities? How is VA reaching out to nonprofits and private sector groups who have experience in training and employment?

Response: Senate report 108–353 directed VA to establish a new prosthetics and integrative health care initiative. Additionally, Public Law 108–422 (section 302) required VA to establish centers for research, education and clinical activities on complex multi-trauma associated with combat injuries. Both provisions focus on furnishing care to combat injured patients who have sustained amputations and other severe and lasting injuries.

VA is committed to providing veterans of the Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) conflict with the best of both modern medicine and integrated holistic rehabilitative care and treatment. It is VA's goal to provide a seamless transition from the excellent care and rehabilitation provided by military treatment facilities, such as Walter Reed Army Medical Center (WRAMC), to VA facilities with high level expertise and training to meet ongoing specialty care needs. The Secretary of Veterans Affairs has designated four VA medical centers, based on their current level of expertise, as Polytrauma Centers. The Centers are located at Richmond, Virginia, Tampa, Florida, Minneapolis, Minnesota, and Palo Alto, California. These comprehensive medical centers will have a full spectrum of specialty and subspecialty services. The Centers will provide medical care and rehabilitation to service members sustaining multiple conditions such as amputation, traumatic brain injury, visual and auditory impairment, post-traumatic stress as well as other mental health conditions, complex orthopedic injuries, wounds, and spinal cord injury.

Additionally, through the Veterans Benefits Administration's Vocational Rehabilitation and Employment Service (VR&E), VA continues to implement new strategies and partnerships to meet the changing rehabilitation and employment needs of all our disabled veterans, including those with severe wounds such as loss of limbs and loss of mobility. Veterans with the most severe wounds are integrating into all of our programs. The following are some of the more significant actions recently taken.

- VR&E has developed a pocket-sized guidebook (Quickbook), which provides detailed information about VR&E benefits. This Quickbook can be left at the bedside of injured service members who can then reference it as a resource for future benefits when they are ready.
- VR&E employees or vendors provide timely contact with wounded service members and veterans, including those with loss of limbs and mobility, at military treatment facilities and. VA Medical Centers. During this contact the injured service member or veteran is provided basic information about VR&E benefits, the above referenced Quickbook, and contact information for the Regional Office that will be able to process their claims for VR&E benefits. Depending on the length of stay in the treatment facility, some of these injured men and women participate in an assessment of interests, aptitudes, and abilities and are provided employment information for their local area as well as provided guidance on how to access employment community resources.
- In October 2004, VR&E Service initiated a pilot test of a new Five-Track Employment Process that provides five specialized program and service delivery options for veterans with disabilities. The Five-Track Employment Process uses triage techniques for timely assessment of veterans' needs to quickly direct them into specialized services and the appropriate track for obtaining suitable employment.

• VR&E works cooperatively with private sector, public, and non-profit employment resources to increase employment opportunities for all disabled veterans, including those with severe wounds, amputations, or loss of mobility. VR&E field station personnel continue to utilize organizations such as Jewish Vocational Services, Goodwill Industries, and Salvation Army to provide rehabilitative services, including vocational assessments and work adjustment training. Specifically these organizations provide an opportunity, in a non-competitive environment, to test out and relearn employment skills. For example, a person with a recent amputation and new prosthetic device can practice employment skills using this equipment in this environment before re-entering the competitive marketplace.

VR&E is currently developing a satellite broadcast training for VR&E field counselors on Blast Injuries to better equip them in providing services to veterans who have experienced such injuries, which often cause amputations, loss of mobility, or other similarly disabling conditions.

VR&E recently established these new partnerships to improve the delivery of VR&E employment services to veterans with severe wounds, including amputations or loss of mobility:

• The Military Severely Injured Joint Support Operations Center in Arlington, Virginia provides severely injured service members with a central source for advocacy, medical care, education, retraining, rehabilitation, discharge, family support and employment. VR&E works with the Joint Support Operations Center to quickly identify veterans in need of our services and coordinate all necessary rehabilitation and employment services with VR&E's partner agencies (DOD, VHA, DOL), and private sector partners.

• VR&E has initiated a pilot project with Armed Services YMCAs to provide new opportunities for training and placing disabled veterans in administrative and non-profit facility management.

• VR&E has a memorandum, of understanding with Helmets to Hardhats. This organization's program will assist returning service members and VR&E participants in identifying opportunities for on-the-job training, apprenticeships, and direct placement in the construction and building trades industry.

• Home Depot launched Operation Career Front in partnership with VR&E, Department of Labor (DOL), and the Department of Defense (DOD) to provide direct employment opportunities for disabled veterans and their family members. VR&E Employment Specialists are meeting with local Home Depot Human Resources staff to identify career options and refer job-ready veterans.

Question 6: Acute Inpatient Psychiatric Unit at Clarksburg VA Medical Center: I understand there are ongoing discussions about the possible closing of the Acute Inpatient Psychiatric Unit at the Clarksburg VA Medical Center, and I am deeply concerned and highly opposed to this. I have been in touch with the network director and Under Secretary for Health to urge them to maintain and strengthen this unit. Given the high demand for this specialized care with current veterans and the guaranteed need for future veterans, what steps are being taken to ensure this vital, program remains at the Clarksburg VA Medical Center?

Response: A concept Behavioral Health Care Model was submitted by the Clarksburg VA Medical Center to the Network Director, VISN 4, on February 7, 2005. Follow-up discussions were conducted between Network and VA Medical Center staff. The model was well received and accepted with the primary focus on the provision of behavioral health services through a continuum of care while enhancing quality, access and cost effectiveness. Clarksburg VA Medical Center is currently developing an implementation plan which details the transition from the existing model of care to the proposed model, which has been designed in support of the President's New Freedom Commission on Mental Health Goals. A small inpatient care unit would continue to provide acute psychiatric care for patients, but to complement this level of care, Clarksburg proposes the implementation of subacute beds, a partial hospital program and other new components of mental health care not currently available at Clarksburg.

Question 7: West Virginia Nursing Home: I was relieved to learn that ongoing construction for the West Virginia State Veterans Nursing Home will not be affected by the 1-year pause in State nursing home construction. But I remain deeply concerned about potential cuts in per diem funding. State Veterans Nursing Homes are ongoing partnerships with our states. West Virginia was eager to work with VA on this facility, but now the support is changing. How much will my State and other states lose by such cuts? For the record, I think this is an unfair cost shift to states, and will be hard for states to absorb these new costs if the HHS Secretary is successful in cutting Federal funding and Federal matching rates for Medicaid.

Response: In a time of constrained budgets, VA determined to focus its resources on our highest mission priority. With this shift in mission, reductions are proposed for all three VA nursing home care programs.

VA recognizes the proposal on nursing home eligibility has challenged our relationship with State Homes. However, other portions of the State Veterans Home Program, the per diem for the domiciliary facilities, hospitals, and adult day healthcare, experience no reductions in the fiscal year 2006 President's Budget.

VA will continue to fully support nursing home care for veterans in the following categories:

- Long-term care Nursing Home Care (NHC) for service disabled veterans and those with specialized care needs
- Short-term NHC for all priorities, including post-hospital care (rehabilitation for stroke patients, broken hip, etc.)
- Hospice and Respite Care
- Non-institutional Long-Term Care (LTC) alternatives such as Skilled Home Care, Adult-Day Health Care, and Homemaker/Home Health Aide.

VA has prepared a preliminary estimate of the effects of the fiscal year 2006 budget proposal on State Veteran Homes. The estimate is found on the attached spreadsheet.

DEPARTMENT OF VETERANS AFFAIRS RESPONSES TO POST-HEARING QUESTIONS FROM SENATOR JAMES M. JEFFORDS

Question 1: (Nursing Beds): Mr. Secretary, I am quite concerned by the budget proposals that would reduce the number of nursing home beds nationwide. I certainly share the VA's commitment to meeting the needs of more veterans with home-based health care, but this should not come at the expense of nursing home beds. As America ages, so does our veteran population. The GAO estimates that the VA still has a long way to go to meet adequate nursing care capacity.

Response: VA will continue to fully support nursing home care for veterans in the following categories:

- Long-term care Nursing Home Care (NHC) for service disabled veterans and those with specialized care needs
- Short-term NHC for all priorities, including post-hospital care (rehabilitation for stroke patients, broken hip, etc.)
- Hospice and Respite Care
- Non-institutional Long-Term Care (LTC) alternatives such as Skilled Home Care, Adult-Day Health Care, and Homemaker/Home Health Aide

To insure fairness and consistency, the VA proposes similar eligibility criteria across all institution long-term care venues: VA Nursing Home Care Units, Contract Community Nursing Homes and State Veteran Homes. The Department would continue to expand access to non-institutional long-term care with an emphasis on community-based and in-home care. This approach allows veterans to receive needed services in the comfort of their own homes and is much more closely aligned with community standards.

VA is projecting a substantial increase in both workload and funding for the non-institutional programs it supports. The average daily census in these home and community-based care (HCBC) programs is projected to rise from 30,118 in fiscal year 2005 to 35,540 in fiscal year 2006 (an 18 percent increase). Funding is projected to increase from $339 million in fiscal year 2005 to over $400 million in fiscal year 2006 (also an 18 percent increase). The projected increases in HCBC programs will serve to offset some of the reductions in nursing home care. HCBC is preferred by most patients and their families and is more cost effective than inpatient care. VA believes the proposals on long-term care in this budget provide an appropriate balance between congressionally mandated nursing home services and the national trend toward increased use of non-institutional home and community-based services in preference to nursing home care. .

Question 2: (Payments to State Homes): I am concerned that the VA's new budget proposes to break with tradition and drop per diem reimbursement to State homes for veterans who are not service connected. Since most State nursing homes take veterans who need care without regard to their degree of service connection, this would leave the states without reimbursement for a significant share of State home nursing patients. As the Nation ages, the last thing the VA should be doing is cutting back on care for the elderly. As the states struggle with increasing health care burdens, the VA should not cut back on existing reimbursements to states. I would appreciate your thoughts on this proposal.

Response: State Veterans Homes are owned, operated, and financed by the States. VA provides limited financial assistance to the States in the form of per diem grants for nursing home, hospital, domiciliary, and adult day healthcare. Only the nursing home per diem is affected by the fiscal year 2006 budget proposal. The cost of care in State Veterans Homes varies from State to State, as does the amount of assistance provided to the Homes by the State. Currently, costs not covered by the VA per diem payments are covered from various sources, including the veterans themselves and State and Federal programs such as Medicare and Medicaid. VA's proposal could increase the share of costs borne by the State, depending upon the State's own policies for coverage of the costs of State Home care. In addition, VA long-term care has shifted from inpatient to outpatient, similar to the private sector. This is more convenient to patients and their families and is more cost-effective.

Question 3: (Boiler at Vermont State Home): It is my understanding that the VA has proposed a moratorium on grant funds to the States for renovating State nursing homes. The states are required to put up 40 percent of these costs, and the VA is now proposing to drop its share of funding for a significant number of projects in the pipeline. If these renovations are to happen, this will mean an increased burden on the States. One of these projects is a boiler plant replacement at the Vermont Veterans Home in Bennington. I can only assume that this is a critically important project for this home! There are hundreds of other projects on this list that will also not be funded in fiscal year 2006. Do you have a plan to redress this shortfall?

Response: Under the grant program, VA is responsible for 65 percent of all project construction costs. The project did not rank high enough to receive funds in fiscal year 2005. The State has revised the scope and phases of the project, and as a result it has been redesignated to the life safety category. This improves the chances of getting funding in the future. If the moratorium for fiscal year 2006 is approved, the project, along with all others will compete for fiscal year 2007 funds. The ranked projects will be committed to by VA as funds are authorized and appropriated. If any State completes a project with State funds, they may still be eligible for 65 percent reimbursement.

VET CENTERS

Mr. Secretary, I am very impressed with the work of the Vet Centers. I see these centers as vital links between the returning Iraq veteran, particularly the guard member or reservist who may need services, and the VA. Many veterans are reluctant to reach out, confused about what services are available to him or his family, or just plain overwhelmed by the volume of demands that await a returning service member. Vet centers can help. Vet centers are also playing a critical role in counseling the families of war casualties and helping there understand what resources are available to them. While the demand on vet centers has already increased exponentially, the budget seems to reflect only a small increase in personnel, far below the amount needed to meet the projected demand.

How do you propose to meet this need?

Response: Since the inception of the Vet Center program in 1979, the Vet Centers have served over 2 million veterans. Annually, the Vet Centers see, on the average, approximately 130,000 veterans and provide over 1,000,000 visits to veterans and family members.

In fiscal year 2003, the Vet Centers saw 1,931 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans and 9,597 OEF/OIF veterans in fiscal year 2004. We are estimating that in fiscal year 2005; Vet Centers will see 11,184 returnees from Afghanistan and Iraq. The Vet Centers provided 2,450 visits to OEF/OIF veterans and their family members in fiscal year 2003 and 18,819 visits in fiscal year 2004. At current rates of utilization, we are projecting 29,000 visits for OEF/OIF veterans for fiscal year 2005.

The Vet Center program's capacity to provide outreach to veterans returning from combat operations in OEF and OIF has been augmented at targeted Vet Centers by hiring and training a cadre of 50 new outreach workers from among the ranks of recently separated OEF and OIF veterans. VA has also authorized establishment of a new Vet Center in Nashville, Tennessee. This initiative represents a collaborative effort between VA's Readjustment Counseling Service and the Veterans Integrated Service Network 9 for the purpose of augmenting VA's mental health and related services to local veterans.

Although we have seen a significant increase in OEF and OIF veterans since fiscal year 2003, we, nonetheless, believe that we have the resources to allow the Vet Centers to continue aggressive outreach to OEF/OIF veterans and to successfully

meet the service needs of all veterans and their family members who choose to avail themselves of Vet Center services.

RESEARCH FUNDING

Mr. Secretary, The VA has long been known for its high quality research program. Not only is cutting edge research being performed at the VA, but participation in VA research is one of the biggest incentives for high quality medical professionals to join the VA system. It is my understanding that the budget before us proposes a cut in VA direct research funding by $9 million. This cut would impair the ability of the VA to lead the Nation in research such as post-traumatic stress disorder, spinal cord injury, and cancer. I am proud to have the National Center for PTSD headquartered in Vermont. The VA has painstakingly assembled a state-of-the-art research program, and any decision to cut funding for this program would be a national loss. I, for one, do not believe that the choice must be made between treating Iraq combat veterans or funding a top-notch research program. The VA can, and should, do both. I would appreciate your comment on this funding dilemma.

Response: VA Research continues to make significant contributions to the healthcare of veterans, and the program enjoys the full support of the Department. We fully agree that participation in VA research is a significant incentive for high quality medical professionals to join the VA system.

VA research makes a significant contribution to the advancement of medical science. By devoting nearly 70 percent of the research budget to supporting over 2,200 investigator-initiated research projects, VA maintains a climate of scientific inquiry and rigor that continues to attract the highest caliber physicians. The other 30 percent . supports nearly 500 research projects involving career development awards, multi-site programs, rehabilitation centers, centers of excellence, health services research centers, service directed research, and special research initiatives. In addition, VA researchers receive funding from non-VA appropriations such as the National Institutes of Health, pharmaceutical firms, and the Department of Defense to conduct multi-site trials such as the recent study that confirmed a new vaccine can prevent or reduce the effects of shingles, to collaborate on joint projects involving OIF/OEF veterans, and many other aspects of VA research. The total funding received from these sources is estimated at $820 million in 2005, and expected to increase by nearly $50 million in fiscal year 2006.

At present, 80 percent of the Office of Research and Development (ORD) budget is devoted to recurring and multi-year commitments—mainly research centers and studies. We are also carefully looking at ways to ensure that adequate funding is directed to research about innovative approaches to limb loss, prosthetics and tissue replacement, as well as mental health research (e.g., issues involving PTSD) for our newest veterans returning from Afghanistan, Iraq and other combat deployments. To meet newly identified veteran-centric needs, ORD is transitioning to shorter durations of awards and conducting competitive reviews of all centers to assure that a higher percentage of funding is available annually above the only 20 percent of the annual appropriation that is now available for new projects. The goal is to achieve a workable balance among the competing needs for research.

Within the broad range of research from the very basic as well as applied research, VA highly values research that specifically addresses medical issues that are most relevant to the veteran population. In many such areas, VA is widely regarded as an international leader, including research related to rehabilitation, mental health and post-traumatic stress disorder, and health services delivery. VA also emphasizes research that capitalizes on its unique strengths, such as the integrated delivery system and the electronic medical record. The VA Cooperative Studies Program, for example, is internationally recognized for conducting the highest quality, multi-center studies that address clinically important topics that are difficult, if not impossible, to perform in other settings.

DEPARTMENT OF VETERANS AFFAIRS RESPONSES TO POST-HEARING QUESTIONS FROM SENATOR KEN SALAZAR

Question 1: Priority 7 and 8 veterans. The budget request would continue the ban on new priority 8 enrollments that has turned away 192,000 veterans since 2003. This year's budget would force an additional 1.1 million Priority 7 and 8 vets who are in the system now to drop out. You said that many of these veterans have other health care options including Medicare and private insurance. I wanted to break that down a little more, because I think it's important that we know how our budget decisions will affect real people.

A. The VA has surveyed enrolled Priority 7 and 8 veterans to determine what other healthcare they have, is that not correct?

B. What percent have private health care insurance?

C. As you know, the VA is allowed to get reimbursement from private insurers. Why are we forcing out the very veterans who can contribute to their costs of care?

D. What percent do not have any other options?

E. So based on what you've said, how many veterans who currently have VA health care would have no health insurance by next year under your proposed budget?

Response: A. Yes. The VHA Survey of Enrolled Veterans' Health and Reliance Upon VA is a recurring effort to survey enrolled veterans in all priority groups, including Priority 7 and 8 veterans. The survey, last conducted in 2003, includes inquiries on the non-VA health care use of VHA enrolled veterans.

B. Among Priority 7 and 8 enrolled veterans, 33 percent have some private health coverage.

C. We realize that many veterans will choose not to pay the proposed enrollment fee and elect not to remain enrolled in the VA health care system. Each veteran must make this decision after a close examination of his or her individual economic and health care circumstances. We expect that a significant portion of the enrollees who are not expected to pay the enrollment fee are non-users or low users of VA health care services.

D. Based on the 2003 enrollee survey, approximately 12 percent of Priority 7 and 8 enrollees have no health insurance at all, either public or private.

E. We believe that there will be minimal, if any, impact on current Priority 7 and 8 enrollees. Priority 7 and 8 enrollees who have no other health care options are expected to pay the enrollment fee in order to remain in VA's health care system.

On the other hand, many Priority 7 and 8 enrollees who have other health care coverage (and who are generally non-users or low users of the VA health care system) are not expected to pay the enrollment fee and, thus, will no longer be enrolled.

Question 2: Nursing Homes. The VA wants to cut the number of veterans in nursing home care.

A. State-run nursing homes are one of the most cost-effective ways for the VA to care for elderly veterans. How will these cuts affect State facilities? Aren't we damaging one of the most successful partnerships in the VA's long history?

Response: VA has prepared a preliminary estimate of the effects of the fiscal year 2006 budget proposal on State Veteran Homes. The estimate is found on the attached spreadsheet. The number of average daily census (ADC) in State Veterans Nursing Homes on whose behalf VA pays a per diem payment would decrease from 18,500 to 7,217 from 2005 to 2006 with a total funding reduction across VA of $293.5 million. To ensure fairness and consistency, the VA proposes similar eligibility criteria across all institution long-term care venues: VA Nursing Home Care Units, Contract Community Nursing Homes, and State Veteran Homes.

Over the same period, however, VA is projecting a substantial increase in both workload and funding for the non-institutional programs it supports. The ADC in these home and community-based care (HCBC) programs is projected to rise from 30,118 in fiscal year 2005 to 35,540 in fiscal year 2006 (an 18 percent increase). Funding is projected to increase from $339 million in fiscal year 2005 to over $400 million in fiscal year 2006 (also an 18 percent increase). The projected increases in HCBC programs will serve to offset some of the reductions in nursing home care. HCBC is preferred by most patients and their families and is more cost effective than inpatient care. VA believes the proposals on long-term care in this budget provide an appropriate balance between congressionally mandated nursing home services and the national trend toward increased use of non-institutional home and community-based services in preference to nursing home care.

VA will continue to fully support nursing home care for veterans in the following categories:

- Long-term care Nursing Home Care (NHC) for service disabled veterans and those with specialized care needs
- Short-term NHC for all priorities, including post-hospital care (rehabilitation for stroke patients, broken hip, etc.)
- Hospice and Respite Care
- Non-institutional Long-Term Care (LTC) alternatives such as Skilled Home Care, Adult-Day Health Care, and Homemaker/Home Health Aide

B. The VA has never come close to complying with the 1999 Mill Bill regarding minimum VA nursing home capacity or access to a spectrum of long-term care options. In your statements you discussed the alternatives to nursing home care, but we both know that the VA has a long way to go . to providing elderly patients with

the full spectrum of care. How many in nursing homes will be turned out? And where will they go?

Response: Under this budget proposal, VA remains committed to providing long-term care to veterans in our highest mission priority groups. 'VA will also continue to provide short-term nursing home care, hospice and respite care to all veteran priority groups. No veteran currently receiving services in VA nursing homes will be discharged ("turned out") as long as the veteran continues to require nursing home care.

Question 3: DoD to VA Transition. I want to commend the VA for working on the Benefits Delivery at Discharge program and for trying to create a seamless transition from Department of Defense duty to VA care. But my understanding is that there is still a great deal to be done. In particular guard and reserve troops returning from Iraq may be unaware of the benefits that they are entitled to. I've read reports of VA officials and VSO representatives not being allowed on military bases to counsel soon-to-bedischarged troops. Can you give a brief update on the challenges of making sure that all troops and guard and reserve troops in particular can get the VA benefits they deserve?

Response: We are not aware that any VA personnel assigned to conduct briefings on military bases are having difficulty with base access. The Department of Defense (DoD) informs us that there are currently no known base access problems for veteran service organization representatives and that issues that existed in the past have been resolved. In point of fact., we are doing a tremendous amount of outreach for members of the Reserves and National Guard.

From fiscal year 2003 through fiscal year 2005 to date, Veterans Benefits Administration (VBA) military services coordinators conducted the following transition briefings and related personal interviews in the United States. These briefings include pre and post-deployment briefings for Reserve and National Guard members.

Overall Briefings

Fiscal Year	Briefings	No. Attendees	No. Interviews
2003	5,368	197,082	97,352
2004	7,210	261,391	115,576
2005*	2,263	79,105	34,106

*Through Jan. 2005

In addition to military services briefings in the United States, VBA representatives conduct briefings overseas under arrangement with DoD. The following data reflects our overseas activities since 2003.

Overseas Briefings

Fiscal Year	Briefings	No. Attendees	No. Interviews
2003	472	12,943	12,947
2004	624	15,183	6,544
2005*	36	1,278	464

*Through Jan. 2005—Please note, VBA does not conduct overseas briefings during the first quarter of the fiscal year because DoD does not provide funding for conducting these briefings until around January. Consequently, overseas transition briefings and interviews are a 9-month activity, running from January through September.

Outreach to Reserve/National Guard members is part of the overall VBA outreach program. However, in peacetime this outreach is generally accomplished on an "on call" or "as requested" basis. With the activation and deployment of large numbers of Reserve/National Guard members following September 11, 2001, and the onset of military actions in Afghanistan and Iraq, VBA has greatly expanded its outreach to this group. We have made national and local contacts to Reserve/National Guard officials to schedule pre- and post-mobilization briefings for their members. Returning Reserve/ National Guard members can also elect to attend the formal 3-day Transition Assistance Program workshops. The following data is included in the above data for overall military services briefings.

Reserve/National Guard Briefings

Fiscal Year	Briefings	No. Attendees
2003	821	46,675
2004	1,399	88,366
2005*	531	32,448

*Through Jan. 2005.

VA recently established a working group with the National Guard Bureau and representatives of the military reserve components to identify where improvements can be made in our working relationships to ensure that information and assistance are available to returning Reserve/National Guard members and their families. VA senior management officials and National Guard leadership are currently reviewing recommendations from the working group prior to implementation.

On the Veterans Health Administration (VHA) side, all members of VHA's Vet Center teams provide the first step and introduction of VA services/benefits for National Guard and Reserve service members and families. Once interviewed and specific health or disability needs are identified, the veteran is referred to the local VA Medical Center (VAMC) or VA regional office (VARO) for further assistance. This reduces the challenges that may be encountered in navigating the complex VA system. At each VAMC and VARO, a Point of Contact Case Manager/Coordinator will be the veteran's guide and assist the veteran in further information about obtaining services/benefits. There is a true partnership among the Vet Centers, VAMCs, Community Based Outpatient Clinics, and VAROs to ensure that the veteran and family receive the needed services and benefits. While they are at the Vet Center, the veteran may have the opportunity to view the video, "We are By Your Side," and receive additional tools and brochures to learn about other VA and DoD benefits that they may be eligible to receive. Vet Center staff will counsel them and then refer them to others on the VA team for additional assistance.

In order to reach the large number of returning National Guard/Reserve veterans, extensive outreach and information briefings have been presented to the senior leadership in the Army National Guard and Army Reserve. Town Hall meetings have been conducted in communities for family members to learn about VA Benefits/Services to include vocational rehabilitation and employment. The video "We are By Your Side" is being viewed by returning service members and mobilization and unit briefings. The brochure, "Summary of VA Benefits for National Guard and Reserve Personnel," is available for distribution at the mobilization station and home unit for each returning National Guard/Reserve member, as well as a wallet card with valuable information about VA benefits and services.

Chairman CRAIG. Now, let me turn to Senator Murray, I believe, who came in second.

Please proceed, Patty.

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

Senator MURRAY. Thank you, Mr. Chairman, and Mr. Secretary, thank you so much for being here today. I know that you are new to this job, and this budget was formulated prior to your taking on the position, so I am very interested to hear your responses to the questions today. I will submit my entire statement for the record.

But I will just say that I am deeply concerned about the impact of this budget proposal on the VA system. We have been down the road before of increasing costs to veterans. We know that we cannot do that today. It is an average increase of about $1,000 per veteran, the proposals that are on the table today, with a $250 enrollment fee and paying for their medication.

And as Senator Akaka so rightly put it, many of these people simply cannot afford to do it, but I think the other point we need to remember is that these veterans have already paid the price. We should not be asking them to do it a second time. So this proposal has been dead on arrival before. I know Senator Craig said that he

was open to this again. We want to hear the testimony. But for me, this is just a non-starter, and I believe our veterans deserve better than that.

I am also very concerned about the proposal that is in this budget dealing with the state-run nursing home beds. The VA has always had a strong partnership with States. Dumping this on the lap of States today is not just going to cause a hardship. It is going to mean veterans who will not have State nursing homes today. In my State of Washington, 300 families are going to find out, if this proposal were to pass as is, that they now have to care for a family member that this country promised something to, and I think that is a deeply flawed approach.

A number of other things that I will go through in my questioning, but let me just point out: Washington State has 4,000 National Guard members who are going to be coming home shortly. We already have long waiting lines. People are being turned away. VISN 20 has already had a hiring freeze. VISN 20 covers Washington, Oregon, Idaho, Alaska and Montana. There is a hiring freeze in place. I am looking in the eyes of these veterans today and people who work in the Veterans Administration in my area who are just panicked about the number of people coming home, the impacts of that, the hiring freeze that is in place, and this budget does nothing to deal with that.

So I think it is a deeply flawed approach and one that this country has an obligation, especially in a time of war, to be telling our veterans that we will keep the promises that we made to them.

Thank you, Mr. Chairman.

Chairman CRAIG. Thank you much, Senator Murray.

Now, let me turn to Senator Thune.

STATEMENT OF HON. JOHN THUNE,
U.S. SENATOR FROM SOUTH DAKOTA

Senator THUNE. Thank you, Mr. Chairman, Senator Akaka, and Secretary Nicholson, thank you for being here, and I also appreciate the testimony that we are going to receive later from the veterans service organizations.

This is an incredibly important discussion to have. The VA is now the Nation's largest integrated health care system and will treat over 5 million patients this year. Since 2001, the VA has enrolled an additional 2.5 million veterans in health care, increased outpatient visits from 44 million to 54 million, increased the number of prescriptions filled from 98 million to 116 million, and to date, has treated more than 32,000 veterans who served in either Afghanistan or Iraq. So this is an organization that is doing a tremendous amount of work, and I, too, share many of the concerns that have been voiced already about having the resources that are necessary to serve that population.

I am anxious to work with you and with our colleagues here on this Committee and in the Senate to make sure that the needs that our veteran community has are being addressed, realizing that much of that is a resource-driven debate and also realizing that the fiscal constraints that are imposed upon us force us to look at these things in new ways, but also welcome the opportunity to work with you toward steps that we can take that would bring greater effi-

ciency and further streamline the agency, the Department, and make sure that many of the innovations that are already taking place at the VA, areas of telehealth and some of the things that you have already done with electronic medical records and things that I think need to be modeled in other aspects of health care in this country, that we continue to develop that and figure out ways, if we can, to make our resources go further and to find those efficiencies that can again make sure that we are dealing in an appropriate way with the responsibility and the obligation that we have to America's veterans, but using the most modern technology and everything else we can to accomplish that goal.

So I appreciate your work, welcome you to the Department, and look forward, as I said earlier, to working with you and with the Members of this Committee and the Senate to make sure that we are doing the job that we need to do to take care of our veterans and also understanding, as was mentioned earlier, that this is the starting point, not the ending point, and we have got a lot of heavy lifting ahead of us in this budget to figure out what our priorities are going to be and how we address the important needs that face us in this country, none of which is more important than the way that we deal with America's veterans.

So I, Mr. Chairman, will also have to not be here for all of this, but would like to submit a statement for the record, if that is OK.

Chairman CRAIG. Without objection, your full statement will become a part of the record and be submitted to the Secretary.

Senator THUNE. Thank you, Mr. Chairman.

Thank you, John.

PREPARED STATEMENT OF HONORABLE JOHN THUNE,
U.S. SENATOR FROM SOUTH DAKOTA

Good Morning Chairman Craig and Ranking Member Akaka:

Last week President George W. Bush released his proposed fiscal year 2006 budget for the Department of Veteran's Affairs. The President's proposed budget is a record breaking $70.8 billion which will primarily fund veteran's health care and benefits. The President's budget is responsibly focused on the veterans who count on the VA the most: those with service connected injuries or illnesses and the indigent.

The VA is Nation's largest integrated health care system. In 2006 the VA will treat more than 5.2 million patients, eighty percent of which are expected to be high priority. Since 2001, President Bush's budget requests have allowed the VA to enroll 2.5 million more veterans in health care services, increased outpatient visits from 44 million to 54 million, and increased the number of prescriptions filled from 98 million to 116 million. All this has been done without the President or Congress overspending. However, what is even more impressive is fact that the VA is now considered a leader in the medical community with advances in laptop medicine, interactive healthcare websites, and the software program "VistA" that cuts down on unnecessary paperwork and streamlines efficiency. These developments have also increased health care to rural communities that have cut down on the amount of time and travel for veterans in my home state; however rural care still remains a long term goal to be fully reached. This year the VA was awarded the National Committee for Quality Assurance seal approval, a gold standard in the medical community. The VA ranked first in all seventeen performance measures and in every single category the VA outperformed the highest-rated non-VHA hospitals. All in all, I believe we are delivering on our promise.

The fiscal year 2006 budget will also support important VA initiatives like the seamless transition of servicemembers between the Department of Defense and Department of Veteran's Affairs to ensure that those returning from Iraq and Afghanistan are provided the best possible care. To date, more than 32,000 veterans who served in Afghanistan and Iraq have been provided VA care. The budget will also provide $750 million for the Capital Asset Realignment for Enhanced Services pro-

gram that is realigning the VA infrastructure in order to enhance access to health care services for our veterans.

This is a bi-partisan Committee and I know that we can provide legislation that best serves America's veterans. As we enter the budget process, I remind my colleagues that the President's budget represents the beginning and not the end of our opportunity to fulfill our mandate. I look forward to working with the Committee on this critical issue. Thank you Mr. Chairman, I yield back my time.

Chairman CRAIG. Now, let me turn to Senator Obama. Senator, welcome.

STATEMENT OF HON. BARAK OBAMA,
U.S. SENATOR FROM ILLINOIS

Senator OBAMA. Thank you very much, Mr. Chairman, Secretary Nicholson, members of the VA; I appreciate this opportunity.

I will be very brief in the interests of time. Many of my concerns have already been voiced by Senators Rockefeller, Akaka, Murray, and I share Senator Thune's concerns about trying to be as efficient as possible at a time where we have fiscal constraints. It strikes me that not all of these constraints are inevitable. Some of them are artificially imposed as a consequence of choices made not by your Department, but by the Administration generally.

I just want to reiterate a couple of things: under this proposal, for example, on the nursing home issue, Illinois, my understanding is, would stand to lose $16 million in receipts as a consequence of this shift. Just to give you one example, in the town of Quincy, in Illinois, the largest of four homes serving veterans in Illinois, it serves 500 to 550 residents. They expect that they would lose $5 million to $6 million in receipts if the proposed change in per diem proposed in the budget actually occurred.

This would shut down nursing homes that are serving veterans in Illinois. It does not strike me that that is a tenable position to take, particularly because the States simply cannot pick up the slack. Illinois has a $2 billion budget deficit that they have got to close this year. And so, the assumption that somehow, we can shift these costs onto the State in any meaningful way is simply not realistic. What is realistic is that these veterans will be out on the streets, or their families are going to have to bear the burdens if we are not providing these services.

So again, to reiterate what has already been stated before, I recognize, Mr. Secretary, that you did not craft this budget initially. This is the second time where I am asking tough questions, and you just got here, and so, you know, I hope you recognize the respect I have for you and the efforts that you and your staff are going to be making, but this just does not seem to reflect the kinds of priorities that I would think we would be trying to propose at a time of war, and I am deeply distressed by it.

I have got a conflicting meeting as well, but I am going to try to stay at least for awhile so that I can hear some of the testimony. Thank you very much, Mr. Chairman.

Chairman CRAIG. Senator, thank you very much.

Senator Jeffords, Jim? Is your mike on, Jim?

STATEMENT OF HON. JAMES M. JEFFORDS,
U.S. SENATOR FROM VERMONT

Senator JEFFORDS. I join you in congratulating the Secretary on his confirmation, and I look forward to working with you. In getting the job done for America's veterans, we have a lot to do, and I would refer also to the remarks made by Senators Rockefeller, Akaka and Obama.

This budget is tough. It has been constructed against a backdrop of an overall Federal budget that claims to reduce the huge Federal deficit by cutting domestic spending programs in the name of deficit reduction. It does not reduce the expensive tax cuts given to the richest segment of American society. In this context, it is very difficult to construct a veterans budget that does justice to the men and women who have served this country.

I know it is your desire to honor our commitment to our veterans, giving them the best health care and the quickest processing of benefit claims the system can provide with the least possible cost to them, but I do not see how this budget does that. This budget relies on increased collection of funds from the veteran in order to maintain current services. This does not seem right.

I am interested to hear your testimony and pursue these matters in my further efforts as we go forward today.

Chairman CRAIG. Jim, thank you very much.

Senator Salazar, Ken.

STATEMENT OF HON. KEN SALAZAR,
U.S. SENATOR FROM COLORADO

Senator SALAZAR. Thank you, Senator and Mr. Chairman Craig and Senator Akaka and Members of the Committee.

Secretary Nicholson, let me just say that as one of our favorite sons from Colorado, I am delighted that you have been now confirmed, and it was not even controversial.

[Laughter.]

Senator SALAZAR. So congratulations to you, and I very much look forward to working with you in the 4 years ahead.

Let me also say that I know these are very tough times for our Nation as we look at the sea of red ink that is piling up in our country. But I think as we look at that red ink, it is important for us to be fiscally responsible. And I look at the comments from Senator Jeffords, which I very much agree with: if we are going to have to get our fiscal house in order, we need to make sure that we are looking at the entire house, that we cannot deconstruct those parts of our house which are so important for the men and women who have served our country.

For me, I see this first hand and foremost in the number of homeless veterans that we see in my own State and in our own City and County of Denver. There are thousands of veterans who sometimes do not even have a place to live. And so, when I look at the budget that was proposed by the Administration, a budget that was created before you became Secretary of Veterans Affairs, I very much agree with the characterization that has been given to that budget by organizations that have been fighting and standing up for veterans for decades after decades in our country.

The VFW in their analysis of this budget, where they characterize it as a budget that fails to live up to our Nation's obligations to veterans is an accurate characterization. The American Legion called the budget a smokescreen to raise revenue at the expense of veterans.

I have a much longer statement that I will just submit for the record that will go over some of the more specific points that I have in the interests of time, but I do want to say that there are measures that are set forth in this budget, including the co-payments for drugs and the $250 co-payment for veterans services, the cuts in nursing homes and others that I am going to oppose, because I think that those particular proposals in the budget do a dishonor to the commitment that we have to our Nation's veterans. And I think at a time when we see the men and women in our country who are sacrificing life and limb and family to serve in Iraq and Afghanistan and around the world, it is an even more important time for us to step up to what should be for all of us as a Nation one of our highest priorities.

So I look forward to your testimony and look forward to working with you as we navigate this very difficult fiscal time in our history.

Chairman CRAIG. Ken, thank you very much.

Now, let me turn to you, Mr. Secretary, and welcome you once again before the Committee. You have brought along with you key Department heads, and I tell the Committee, last week, I took the time to go down to the headquarters office to visit with the Secretary and all of these fine people and walk through their offices. I would recommend you all do that to get to know better what they do and their responsibilities as we tackle this budget for our veterans.

I must also say that I was given a variety of handouts and this weekend had time on an airplane, and I read some of them. One of those handouts most striking to me was an interesting independent observation of the quality of health care delivered by the Veterans Administration today. It was an absolutely glowing report by a critic, who had prior to that written in pretty loud ways about health care delivered by veterans, today rating it among the top in the Nation.

The innovations that have occurred that many of you have been a part of are truly a compliment to veterans health care, but most importantly to veterans themselves, to be standing now at the top along with some of our finest private hospitals in the country delivering quality care through innovation and creativity is without question a testimony not only to the Veterans Administration, but to this Committee and to the Congress for providing the resources to do so.

And I read that and obviously had to reflect on our task at hand and what we will be doing in the near future to not only sustain the qualities that we have been able to get to in providing health care, but also with the expanded needs of veterans coming in from Iraq and Afghanistan to make sure that they are well-served.

So, Mr. Secretary, if you wish to, I would ask you to introduce those who have accompanied you, and please proceed at will.

STATEMENT OF HON. JAMES NICHOLSON, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Secretary NICHOLSON. Thank you, Mr. Chairman and Members of the Committee. Good morning, and I want to at the outset thank you again for your consideration during my confirmation process.

Today marks the second full week that I have been on this job, and I can report to you that I think it is a fantastic job. It is a great opportunity to serve my country, my fellow veterans, my President, his Administration. During this 2 weeks, while I have spent a great deal of time on budget matters, as you would expect, I have also been able to get out and visit a medical center and a regional office for benefits, and I am very pleased by what I see in the dedication and the competency and the motivation of the people who are working for the Veterans Administration, and I have also had a chance to talk to many of the patients who seem so well taken care of and so grateful for what they are receiving.

I am joined here today by a group of experts, a tremendous collection of people who are working for the Veterans Administration, and it is a pleasure for me to be able to join them and work with them, and I want to introduce them to you. On my far left is Mr. Tim McClain, who is the General Counsel of the Veterans Administration. And my immediate left is Dr. Jonathan Perlin, who is the Acting Under Secretary for Health Benefits. To my far right is Mr. Dick Wannemaker, who is the Acting Under Secretary for Memorial Affairs. Next, coming this way, is Admiral Dan Cooper, who is the Under Secretary for Benefits, and my immediate right is Rita Reed, who is the Deputy Assistant Secretary for Budget Affairs.

I would ask, Mr. Chairman, that my written statement be submitted for the record and that I be allowed to offer some highlights of the President's proposal before I take your questions.

Chairman CRAIG. Without objection. Please proceed.

Secretary NICHOLSON. President Bush is requesting a total of $70.8 billion for the Department of Veterans Affairs in fiscal year 2006: $37.4 billion for entitlement programs and $33.4 billion for discretionary programs. This total represents a 2.2 percent increase over the fiscal 2005 enacted level. The discretionary funding level would represent an increase of $880 million, or 2.7 percent over the enacted level for 2005. The proposed mandatory spending level represents a $639 million or 1.7 percent increase over the 2005 level.

When compared to the fiscal 2001 enacted budget, this budget represents a total increase of more than 47 percent in medical care funding, with a 44 percent increase in discretionary funding alone. It results also in a 49 percent increase in appropriations for veterans benefits.

The President's 2006 proposal will allow us to meet the health care needs of all newly separated veterans of the conflicts in Iraq and Afghanistan; to maintain the high standards of health care quality for which VA is now nationally recognized, while treating over 5.2 million patients, about 1 million more than were treated in 2001. It will allow us to follow through on a historic realignment of our health care infrastructure, reduce the backlog of disability compensation and pension claims, and continue the largest expansion of the national cemetery system since the Civil War.

In the health care area, in recent years, the Department's successes in delivering top notch health care have been stunning. VA now exceeds the performance of private sector and Medicare providers for all key health care quality indicators for which comparable data are available. A recent Rand Corporation study also showed that patients in VA's health care system are significantly more likely to receive recommended care than are private care patients.

This is all the more impressive when you consider the explosive growth in VA health care usage. VA expects to treat about 1 million more patients in 2006 than it did in 2001. The President's budget will ensure that there is no slippage in our high level of performance even at these elevated levels of demand. Ninety-four percent of the primary care appointments are scheduled within 30 days of the patient's desired date, and 93 percent of the specialty care appointments are scheduled within that same timeframe.

The President's 2006 budget asks that you enact two important provisions affecting only priority 7 and 8 veterans: an annual enrollment fee of $250 and an increase in pharmacy co-payments from $7 to $15 for a 30-day supply of drugs. The proposed enrollment fee is similar to the fee legally required of military retirees enrolled in the Tri-Care system, and some would argue even more justified. As you know, most Tri-Care enrollees have served on active duty for at least 20 years and are former enlisted, in most cases, with modest retirement incomes.

The proposed enrollment fee would affect those veterans who may have served as few as 2 years and who have no service connected disability. In addition, some of these veterans, those in priority group 8, have incomes above the HUD geographic means test. This budget proposal also ensures the following highest priority veterans receive the long-term care they need: that would be those injured or disabled while on active duty, including veterans who served in Operations Enduring and Iraqi Freedom, those catastrophically disabled, patients requiring short-term care subsequent to a hospital stay and those needing hospice or respite care.

These eligibility criteria would be applied to VA-sponsored long-term care services, including VA, community and State nursing homes. This would save approximately $496 million that would be redirected toward our high priority veterans. The Department would continue to expand access to non-institutional long-term care with an emphasis on community-based and in-home care. In many cases, this approach allows veterans to receive these services in the comfort and familiar settings of their homes, surrounded by their families.

In order to be more prepared to care for our veterans returning from OIF and OEF, VA's 2006 medical care request includes $1.2 billion, which is $100 million over the fiscal year 2005 enacted level, to support the increasing work load associated with the purchase and repair of prosthetics and sensory aids to improve veterans will of life and includes $2.2 billion, or $100 million over the 2005 level, to standardize and further improve access to mental health services across the system.

We are also proposing a number of program enhancements, to include covering out-of-pocket costs for emergency care that insured

veterans receive in non-VA facilities; exempt former POWs from co-payments for VA extended care services; and exempt veterans from co-payments for hospice care delivered in hospitals or at home. We have projected increased health care management efficiencies of 2 percent in 2006, which will yield about $600 million in savings.

The $750 million requested for CARES in the fiscal 2006 is $172 million more than the 2005 enacted level and brings the total 3-year investment in this historic transformation of our health care system to $2.15 billion. At its core, CARES means greater access to higher quality care for more veterans closer to where they live. Its impact is already felt in Chicago, where the proceeds from an enhanced use lease of VA's Lake Side facility are being reinvested at VA's West Side facility. This will lead to a new modern bed tower for Chicago's veterans.

Finally, the $786 million proposed in support of VA's medical and prosthetic research program would fund about 2,700 high priority research projects to expand knowledge in areas critical to veterans health care needs. The combination of VA appropriations and funding from other sources would bring our 2006 research budget to nearly $1.7 billion.

Veterans benefits: the President's request includes $37.4 billion for the entitlement costs mainly associated with all benefits. Our request also includes $1.26 billion for the management of the Department's benefits program, which is 6.6 percent over the 2005 level.

VA has made significant improvements to the claims decision-making process, but clearly, more must be done. VA takes seriously its obligation that every veteran's claim must be treated fairly and equitably, and we must be consistent. Our inspector general has been directed to conduct a review of our disability claims adjudication process. The results will identify areas of inconsistency and will help us formulate steps to remove to the maximum degree possible inconsistencies which obviously exist today in a difficult process.

In addition to this independent systemwide review, the Veterans Disability Benefits Committee has been established to carry out a study of the statutory benefits that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service. This commission is expected to examine and make recommendations concerning the appropriateness of these statutory benefits, the appropriateness of the level of the benefits and the appropriate standard or standards for determining whether a disability or death of a veteran should be compensated.

The President's request would also permit us to continue the benefits delivery at discharge or BDD program. This program enables active duty servicemembers to file disability compensation claims with VA staff at military bases, complete their physical exams and have their claims evaluated before or closely following their military separations.

Burial benefits: the President's 2006 budget includes $290 million in discretionary funding for VA's burial program, which includes operating and maintenance expenses for the National Cemetery Administration, capital programs, the administration of mandatory burial benefits and the State cemetery grants program. This

total is nearly $17 million, or 6.4 percent, over the 2005 enacted level. It includes $90 million for cemetery construction projects.

Consistent with the provisions of the National Cemetery Expansion Act of 2003, we are requesting $41 million in major construction funding for land acquisition for six new national cemeteries and $32 million for the State Cemeteries Grants Program. We believe that every veteran should have the option to be buried in a veterans cemetery within 75 miles of their home. More than 80 percent will have that option under this budget proposal.

Mr. Chairman, despite the many competing demands for Federal funding, the President continues to make veterans benefits and services a top priority of his Administration. And Mr. Chairman and Members of the Committee, our veterans deserve no less. We are now prepared to take your questions.

[The prepared statement of Secretary Nicholson follows:]

PREPARED STATEMENT OF HON. JAMES NICHOLSON, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, good morning. I am deeply honored that the President has given me the opportunity to serve as Secretary of Veterans Affairs. My service in the United States Army was the defining experience of my life and instilled me with a strong sense of duty, honor, and country. I look forward to working with you and the thousands of dedicated employees who are carrying out the compelling mission of the Department of Veterans Affairs (VA) by ensuring the delivery of timely, high-quality benefits and services earned by our servicemen and women who have sacrificed so much in defense of freedom.

I am pleased to be here today to present the President's 2006 budget proposal for VA. The request totals $70.8 billion-$37.4 billion for entitlement programs and $33.4 billion for discretionary programs. Our budget request for discretionary funds represents an increase of $880 million, or 2.7 percent, over the enacted level for 2005.

With the resources requested for VA in the 2006 budget, we aim to buildupon many of the Department's achievements that have dramatically improved benefits and services to veterans and their families since the President came to office. The most noteworthy accomplishments are that VA:

- Provided health care to about 1 million more patients
- Improved the quality of patient care that sets the national standard of excellence for the health care industry
- Dramatically lowered the backlog of rating claims for disability compensation and pension from a high of 432,000 to 321,000 (for all claims the backlog peaked at over 600,000)
- Reduced the average length of time to process compensation and pension claims from a high of 230 days to approximately 160 days
- Continued the largest expansion of the national cemetery system since the Civil War to honor veterans with a final resting place and lasting memorial that commemorates their service to our country.

With strong support from the President, VA has made excellent progress in sharpening its focus on more effectively meeting the needs of those veterans who count on us the most-veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs. I fully support this strategy and am committed to ensuring that our health care resources continue to be concentrated on care for veterans most in need of the Department's services. As an integral part of this focused strategy, we will make it a top priority to provide ongoing benefits and services to the servicemen and women who served in Operations Enduring and Iraqi Freedom. VA's goal is to ensure that every seriously injured or ill serviceman or woman returning from combat receives priority treatment and consideration. We will continue to work closely with the Department of Defense (DoD) to develop ways by which to move records more efficiently between the two agencies, share critical medical information electronically, protect the health of troops stationed in areas where environmental hazards pose threats, process benefit claims as one shared system, and in every way possible, ease their transition from active duty to civilian life.

MEDICAL CARE

The President's 2006 request includes total budgetary resources of $30.7 billion (including $750 million for construction and $2.6 billion in collections) for the medical care program, an increase of 2.5 percent over the enacted level for 2005, and more than 47 percent above the 2001 level. The $750 million in construction will be devoted to the Capital Asset Realignment for Enhanced Services (CARES) program, bringing the total Department investment to $2.15 billion over 3 years.

Given the current fiscal environment, it is more important than ever that VA concentrate its resources, policies, and strategies on those veterans identified by Congress as high priority. The President's 2006 budget request includes policies and strategies used successfully during the last few years to focus VA health care resources on veterans with service-connected disabilities, those with lower incomes, and veterans needing our specialized services. In particular, this budget assumes continued suspension of enrollment of new Priority 8 veterans, as this has proven to be the most effective vehicle through which to focus our health care resources on our highest priority patients.

But maintaining the current enrollment policy will not in itself ensure us sufficient resources for the care of those who need us the most. The President's 2006 budget asks that you enact two important legislative proposals-an annual enrollment fee of $250 and an increase in pharmacy co-payments from $7 to $15 for a 30-day supply of drugs, both pertaining to only Priority 7 and 8 veterans. This fee and the increase in co-payments pertain to only veterans who have no compensable service-connected disabilities and do have the means to contribute to the cost of their care. This budget asks these veterans to shoulder a small share of the cost so that we may adequately care for our high-priority veterans.

The proposed enrollment fee is very similar to the fee the law requires retired servicemembers to pay in order to participate in TRICARE, and is arguably even more justified. As you know, TRICARE enrollees generally must have served on active duty for at least 20 years, and many of them are former enlisted personnel with modest retirement incomes. Many of the veterans who would be asked to pay our proposed fee would have served only 2 to 4 years. In addition, all Priority 7 and 8 veterans affected by this proposal would have incomes above $25,842 if they are single and above $30,013 if married.

I recognize that Congress has not supported either of these proposals during the past 2 years. However, these two legislative proposals are consistent with the priority health care structure Congress enacted several years ago and will help us meet the needs of our highest priority veterans. In addition, past utilization of VA's health care services has demonstrated that veterans with higher incomes (Priority 7 and 8 veterans) rely less on VA for delivering their health care and usually have other health care options, including third party insurance coverage and Medicare. An annual enrollment fee of $250 and an increase in co-payments for pharmacy benefits from $7 to $15 would give higher income, non-disabled Priority 7 and 8 veterans the option of sharing a small portion of the cost of their care or utilizing other health care options. Our high-priority patients typically do not have other health care options, so we must act decisively to protect their interests by making sure that sufficient resources are available to handle their health care needs.

With medical care resources of $30.7 billion, we project that we will treat more than 5.2 million patients. Those in Priorities 1 to 6 will comprise 78 percent of the total number of veteran patients in 2006. This will represent the third consecutive year during which our high-priority veterans will increase as a percentage of all veterans treated. In addition, about 9 of every 10 medical care dollars in 2006 will be devoted to meeting the health care needs of those veterans who count on us the most.

Even with an increasing patient workload among our highest priority veterans, we will continue our steadfast commitment to providing high-quality and accessible health care that sets the national standard of excellence for the health care industry. Our two primary measures of health care quality-clinical practice guidelines index and prevention index-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 with improved health outcomes for patients and more efficient care. 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 hold steady at the current high performance level of 77 percent. As an indicator aimed at primary prevention and early detection recommendations dealing with immunizations and screenings, the prevention index is projected to remain at its existing high rate of performance of 88 percent. VA continues to exceed the performance of private sector and Medicare providers for all

15 key health care quality indicators for which comparable data are available. These indicators include cancer screening for early detection, and immunization for influenza and pneumonia. In addition, they cover disease management measures such as compliance with accepted clinical guidelines in managing diabetes, heart disease, hypertensive disease, and mental health.

The Department has greatly improved access to our health care services during the last few years by opening additional outpatient clinics, applying information technology strategies to streamline administrative, business, and care delivery processes, and implementing pay policies and human resource management practices to facilitate hiring and retain sufficient health care workers to meet capacity demands across the full continuum of care. These initiatives have helped VA raise the percent of primary care appointments scheduled within 30 days of the patient's desired date to 94 percent and the percent of specialty care appointments scheduled within 30 days of the patient's desired date to 93 percent. By continuing these types of strategies, improving clinical efficiencies, and effectively utilizing the resources requested in our 2006 budget, VA will maintain these high performance levels.

The Department's record of success in health care delivery is substantiated by the results of the 2004 American Customer Satisfaction Index (ACSI). Conducted by the National Quality Research Center at the University of Michigan Business School, the most recent ACSI survey found that customer satisfaction with VA's health care system was markedly above the satisfaction level for Federal Government services as a whole. Results released in December 2004 revealed that inpatients at VA medical centers recorded a satisfaction level of 84 out of a possible 100 points, while outpatients at VA clinics registered a satisfaction score of 83. Both of these are well above the government average of 72.

In addition, the results of a recent study conducted by the RAND Corporation revealed that patients in VA's health care system were more likely to receive recommended care than private-sector patients. Quality of care was better for VA patients on all measures except acute care, for which care was similar for both patient groups. RAND researchers examined the medical records of nearly 600 VA patients and about 1,000 non-VA patients with similar health problems. They compared the treatment received by both groups to well-established standards for medical care for 26 conditions. They found that 67 percent of VA patients received care that met the latest standards of the health care profession compared with 51 percent of non-VA patients. For preventive care, such as vaccination, cancer screening, and early disease detection and treatment, 64 percent of VA patients received the appropriate care compared to only 44 percent in the private sector. The RAND researchers attributed the difference in patient care to technological innovations, such as VA's computerized patient records, and to performance measurement policies holding top managers accountable for standards in preventive care and the treatment of long-term conditions.

As another means by which to ensure sufficient resources are available to address the health care needs of those veterans who count on us the most, VA is proposing to revise the eligibility criteria for long-term care services to focus on the following groups of veterans:

- Those injured or disabled while on active duty, including veterans who served in Operations Enduring and Iraqi Freedom
- Those catastrophically disabled
- Patients requiring short-term care subsequent to a hospital stay
- Those needing hospice or respite care.

These eligibility criteria would be applied to VA-sponsored long-term care services, including VA, community, and State nursing homes. This long-term care strategy will save approximately $496 million that will be redirected toward meeting the health care needs of veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs.

In 2006 the Department will continue to expand access to non-institutional long-term care services to all enrolled veterans with an emphasis on community-based and in-home care. In many cases this approach allows VA to provide these services to veterans where they live and to care for them in the comfort and familiar setting of their home surrounded by their family. During 2006 VA will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 35,500. This total is over 50 percent above the number of patients receiving this type of care in 2001. Funding for non-institutional long-term care in 2006 will be about 67 percent higher than the resource level devoted to this type of health care service in 2001.

VA's 2006 medical care request includes $1.2 billion (an additional $100 million over the 2005 enacted level) to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of

life. VA is already providing prosthetics and sensory aids to many military personnel who served in Operations Enduring and Iraqi Freedom and will continue to provide them as needed.

The President's 2006 budget includes $2.2 billion (an additional $100 million over the 2005 level) to continue our effort to improve access to mental health services across the country. These funds will help ensure VA provides standardized and equitable access throughout the Nation to a full continuum of care for veterans with mental health disorders.

We have included a management efficiency rate of 2 percent which will yield about $600 million in 2006. We continue to monitor and emphasize the need for performance that results in minimizing unit costs where possible, and eliminating inefficiency in the provision of quality health care. To that end, we have included within this savings target, $150 million that will be achieved through implementation of improved contracting practices with medical schools and other VA affiliates for scarce medical specialties. This is a long-standing issue for which the Department is aggressively implementing management changes to ensure fair pricing for the services provided by our affiliates.

As a result of continual improvements in our medical collections processes and the policy changes presented in this budget request, we expect to collect about $2.6 billion in 2006 that will substantially supplement the resources available from appropriated sources. This figure is $635 million (or 32.5 percent) above the 2005 estimate, with two-thirds of the increase due to the two important legislative proposals, and is more than 48 percent higher than the 2004 collections total. VA has an expanded revenue improvement strategy that focuses on modeling industry best performance by establishing industry-based performance and operational metrics, developing technological enhancements, and integrating industry-proven businesses approaches, including the establishment of centralized revenue operation centers. There are two electronic data initiatives underway that will add efficiencies to the billing and collections processes. The electronic and insurance identification and verification project is providing VA medical centers with an automated mechanism to obtain veterans' insurance information from health plans that participate in this electronic data exchange. We are pursuing enhancements which will provide additional insurance information stored by other government agencies. Our second initiative will result in electronic outpatient pharmacy claims processing to provide real-time claims adjudication.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

The President's budget request includes $750 million in 2006 to continue the CARES program that will renovate and modernize VA's health care infrastructure and provide greater access to higher quality care for more veterans, closer to where they live. About $50 million of this total relates to the sale of assets and enhanced use proceeds of the Lakeside hospital in Chicago. The budget request provides a 3-year (2004–2006) investment total of $2.15 billion committed to this historic transformation of our health care system. These resources will be used to address our prioritized list of major capital investments. The proposed projects for 2006 will advance the CARES program by providing construction funding for five projects for which design work has already started, as well as two additional projects to be initiated in 2006. All of these capital projects support the recommendations included in the CARES Decision report. About half of the CARES funding requested for 2006 will be devoted to three major construction projects:

- Las Vegas, Nevada, New Medical Facility—$199 million to complete phase two construction, providing up to 90 inpatient beds, a 120-bed nursing home care unit, ambulatory care center, and administrative and support functions, all of which will expand capacity and increase the scope of health care services available; VA is working with DoD to ensure mutual needs are met
- Cleveland, Ohio, Cleveland-Brecksville Consolidation—$87.3 million to complete phase two construction; this project will consolidate and co-locate all clinical and administrative functions of a two-division medical center at the Wade Park VA Medical Center, leading to annual cost savings of more than $23 million and enhancing the quality of care
- Pittsburgh, Pennsylvania, Consolidation of Campuses—$82.5 million to complete phase two construction; this project will consolidate a three-division health care delivery system into two divisions which will improve patient care by providing a state-of-the-art health care environment and reducing operating expenses.

Our capital investment planning process and methodology involve a Department-wide approach for the use of capital funds and ensure all major investments are based upon sound economic principles and are fully linked to strategic planning,

budget, and performance measures and targets. All CARES projects have been reviewed using a consistent set of evaluation criteria that address service delivery enhancements, safeguarding assets, support of special emphasis programs and services, capital portfolio goals, alignment with the President's Management Agenda, and financial priorities.

MEDICAL AND PROSTHETIC RESEARCH

The President's 2006 budget includes $786 million to support VA's medical and prosthetic research program. This resource level will fund nearly 2,700 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of aging, acute and traumatic injury, the effects of military and environmental exposures, mental illness, substance abuse, cancer, and heart disease.

The requested level of funding for the medical and prosthetic research program will position the Department to buildupon its long track record of success in conducting research projects that lead to clinically useful interventions that improve veterans' health and quality of life. Examples of some of the recent contributions made by VA research to the advancement of medicine are:

- Development of an artificial nerve system that enables a patient with upper-limb paralysis to grasp objects
- Creation of a new collaborative model for treating depression in older adults, the application of which potentially saves lives, reduces patients' level of pain, and improves their overall functioning
- The finding that proper intake of cereal fiber and vitamin D are among the best ways to prevent serious colon polyps that may lead to colorectal cancer
- Development of an oral drug that halts the deadly action of the smallpox virus.

In addition to VA appropriations, VA researchers compete and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2006. Through a combination of VA resources and funds from outside sources, the total research budget in 2006 will be nearly $1.7 billion.

VETERANS' BENEFITS

The Department's 2006 budget request includes $37.4 billion for the entitlement costs associated with all benefits administered by the Veterans Benefits Administration (VBA). This total includes an additional $812 million for disability compensation payments to veterans and their survivors for disabilities or diseases incurred or aggravated while on active duty. Recipients of these compensation benefits are projected to increase to 3 million in 2006 (2.7 million veterans and 0.3 million survivors, or 400,000 more than when the President came to office).

The President's budget request includes $1.26 billion for the management of the following benefits programs-disability compensation; pension; education; vocational rehabilitation and employment; housing; and life insurance. This total is $77 million, or 6.6 percent, over the 2005 level. As a result of the enactment of the Consolidated Appropriations Act, 2005 (Public Law 108–447), an additional $125 million will be made available to VBA (through a transfer of funds from medical care) for disability benefits claims processing. Of this total, $75 million will be used during 2005 and the remaining $50 million will be used in 2006. The overwhelming majority of these funds will be used to address the increased volume of compensation claims from both separating servicemembers and older veterans who had not previously submitted claims.

As a Presidential initiative, improving the timeliness and accuracy of claims processing remains the Department's top priority associated with our benefits programs. Last year the timeliness of our compensation and pension claims processing improved by 9 percent (from 182 days in 2003 to 166 days in 2004). While we were successful in reducing the time it takes to process claims for compensation and pension benefits, we were not able to improve timeliness as much as we had projected at the beginning of the year. Entering 2004, VA was well positioned to meet our performance goals pertaining to the timeliness of processing claims. However, a September 2003 decision by the Federal Circuit Court in the case of the *Paralyzed Veterans of America et. al.* v. *The Secretary of Veterans Affairs* required VA to keep veterans' claims open for 1 year before making a decision to deny a claim. As a result, decisions on over 62,000 claims were deferred, many for as much as 90 days. While the President signed correcting legislation in December 2003, the impact of the court decision in the early portion of 2004 was substantial, as the number of pending claims had grown dramatically. VA made significant progress during the last half of the year, but we were not able to fully overcome the negative effects from this court decision on our claims processing timeliness.

We have had to revise our claims processing timeliness goals for the next 2 years due, in part, to the lingering effect of the Federal Circuit Court decision. Also having an impact on the timeliness of processing is the increasing volume of disability claims. In addition, VA will continue to face the retirement of staff members highly experienced in processing claims. While we have established a sound succession plan, the new employees we are hiring will require both extensive training and substantial claims processing experience in order for them to reach the productivity level of those leaving the Department.

During 2005 we expect to reduce the average number of days to process compensation and pension claims to 145 days, an improvement of 12.7 percent from the 2004 performance level. With the resources requested in the 2006 budget, we will be able to maintain this improved timeliness in support of this Presidential initiative. In addition, we will reduce the number of pending claims for compensation and pension benefits to 283,000 by the end of 2006, a reduction of 12 percent from the total at the close of 2004.

We will increase our efforts to ensure the consistency of our disability evaluations from one regional office to another. VA has made significant improvements in both the accuracy and consistency of its benefit entitlement decisions due to increased quality assurance efforts and more focused training of claims adjudicators. However, more must be done to ensure the Department meets its commitment to treating every veteran's claim fairly and equitably. A system-wide review of the rating program for disability compensation is underway. In addition, our efforts are supported in the 2006 budget by a request for $1.2 million for skills certification testing and $2.6 million for continued development of computer-based training tools. These initiatives will complement other ongoing efforts supported by our budget that address the issue of consistency and accuracy. Among these are:

- Revision of all of the regulations that govern the compensation and pension programs in plain language to ensure that the rules can be applied consistently and fairly
- In-depth data analysis of benefit decisions to identify potential areas of inconsistency, increasingly possible with our new information technology applications and tools
- Centralized processing of appeals remanded by the Board of Veterans' Appeals, and ongoing quality reviews of appealed claims decisions.

An important and successful component of VA's vision for providing a seamless transition for servicemembers separating from active duty is the Benefits Delivery at Discharge (BDD) program. The BDD program enables active duty servicemembers to file disability compensation claims with VA staff at military bases, complete physical exams, and have their claims evaluated before, or closely following, their military separation dates. Transitioning servicemembers benefit greatly from the BDD program, which has been a vital part of the Department's strategy for improving timeliness and accuracy of disability compensation claims processing.

We believe the BDD program provides opportunities to not only benefit transitioning servicemembers through timely and accurate claims processing, but also to bring new processing improvements and efficiencies to the system through consolidation of claims evaluation activities. An initiative is currently underway to consolidate disability compensation rating and authorization actions on all BDD claims to two sites nationwide. VA staff will continue work with transitioning servicemembers at military bases to establish claims and arrange for timely medical exams, thereby retaining these successful aspects of the BDD program.

In support of the education program, the 2006 budget proposes $7.8 million for continued development and implementation of the Education Expert System. The requested funds will be used to first transition education processing to VBA's corporate environment, followed by the development and deployment of a processing system that receives application and enrollment information electronically and processes that information in the new corporate environment without human intervention. While it will be a number of years before this system is fully deployed, it will ultimately lead to substantial improvements in education claims processing timeliness.

In April 2004 the Department's Vocational Rehabilitation and Employment Task Force released its report containing more than 100 recommendations on how to improve service to disabled veterans. The focus of the report was on development and implementation of a new, integrated service delivery system based on an employment-driven process. In response to the task force's recommendations, VA is including $4.4 million in the 2006 resource request to be used for establishing a job resource lab in each regional office. These labs will include all of the necessary equipment, supplies, and resource materials to aid VA staff and veterans in conducting

comprehensive analyses of local and national job outlooks, developing job search plans, preparing for interviews, developing resumes, and conducting thorough job searches. These self-service job resource labs will assist veterans in acquiring suitable employment through the use of a comprehensive on-line employment preparation and job-seeking tool.

In order to make the delivery of VA benefits and services more convenient for veterans and more efficient for the Department, we are requesting $4.4 million for the collocation and relocation of some regional offices. This effort may involve collocations using enhanced-use authority, which entails an agreement with a private developer to construct a facility on Department-owned grounds and then leasing all or part of it back to VA. At the end of these long-term lease agreements, the land and all improvements revert to VA ownership.

BURIAL

The President's 2006 budget includes $290 million in discretionary funding for VA's burial program, which includes operating and maintenance expenses for the National Cemetery Administration, capital programs, the administration of mandatory burial benefits, and the State Cemetery Grants program. This total is nearly $17 million, or 6.4 percent, over the 2005 enacted level.

The 2006 request includes $167 million in administrative funding for VA's burial program, an increase of $7.3 million (or 4.6 percent) from the 2005 enacted level. Within this total, $156 million is for the operations and maintenance of VA's national cemeteries and $11 million is for the administrative processing of claims for burial benefits. The additional funding will be used to meet the growing workload at existing cemeteries, primarily by increasing staffing and contract maintenance.

Our budget request for the burial program includes $90 million for construction projects. Of this total, $65 million is for major projects and $25 million is for minor projects. Consistent with the provisions of the National Cemetery Expansion Act of 2003, we are requesting $41 million in major construction funding for land acquisition for six new national cemeteries in the areas of Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Sarasota, Florida; and southeastern Pennsylvania. The 2006 request also includes funding to develop an annex for the expansion of Fort Rosecrans National Cemetery in Miramar, California. In addition, this budget provides $32 million for the State Cemetery Grants program.

Our resource investments in the burial program produce positive results in service delivery to veterans and their families. We will expand access by increasing the percent of veterans served by a burial option within 75 miles of their residence to 82.2 percent in 2006, which is 6.9 percentage points above the 2004 figure. While our 2004 performance was extremely high in several key areas, we will continue to improve our performance in 2006 by increasing the percent of:

- Survey respondents who rate the quality of service provided by the national cemeteries as excellent from 94 percent to 96 percent
- Survey respondents who rate national cemetery appearance as excellent from 98 percent to 99 percent
- Graves in national cemeteries marked within 60 days of interment from 87 percent to 89 percent.

These performance improvements will further enhance the outstanding reputation of VA's National Cemetery Administration which, in 2004, earned the highest rating ever achieved by a public or private organization in the American Customer Satisfaction Index (ACSI). These results showed that the Department's national cemeteries produced a customer satisfaction rating of 95 out of a possible 100 points. This is two points higher than the last survey conducted in 2001 when VA's national cemeteries also ranked No. 1 among Federal agencies in customer satisfaction.

MANAGEMENT IMPROVEMENTS

VA continues to aggressively pursue a variety of initiatives aimed at ensuring we apply sound business principles to all of the Department's operations. Two of our most successful management improvement efforts during the last year focus on the strategic management of human capital and capital asset management.

As an integral component of our succession planning activities, we released a state-of-the-art "VA Recruitment" CD-ROM in September 2004 promoting the Department as an employer of choice. We distributed this to colleges and universities, military transition centers, veterans organizations, and VA vocational rehabilitation centers, offices, and medical centers. This initiative creates a corporate recruitment marketing approach that will give VA a competitive edge in attracting highly qualified career applicants. The CD-ROM uses graphics and video streaming to present

a wide spectrum of career opportunities and describes VA's goals and services, occupations, and the benefits of working for the Department. We will continue to focus on creative marketing initiatives and outreach to prospective applicants.

VA has also launched a Capital Asset Management System (CAMS) which is an integrated, Department-wide system that enables us to establish, analyze, monitor, and manage our portfolio of diverse capital assets through their entire lifecycle from formulation through disposal. CAMS provides a strategic view of existing, in-process, and proposed asset investments across all VA program offices and capital asset types. All offices now use this shared system to collect and monitor real property and capital asset information. In addition, VA has been approached by numerous agencies, including the Departments of Defense, Homeland Security, Commerce, and Interior to explore the replication of CAMS in their organizations.

VA's progress in this area places it in the forefront of other Federal agencies in terms of its ability to meet the real property performance measures and guidelines that were recently finalized by the newly created Federal Real Property Council.

We are currently in the process of fully evaluating all of the information gathered during the operational tests of the Core Financial and Logistics System (CoreFLS) conducted last year. This year we will complete a comprehensive analysis of the product and any existing configuration gaps, examine lessons learned from the pilot tests, and reevaluate our business processes. This will provide us with the information needed to refine the system as well as develop improved change management, training, and implementation procedures that are critical to successful deployment. In anticipation of an enhanced financial management system moving forward to full deployment at VA facilities nationwide, the Department's 2006 budget includes $70.1 million for this project.

In support of one of the primary electronic government initiatives for improving internal efficiencies and effectiveness, the Department's 2006 budget provides $8 million to continue the migration of VA's payroll services to the Defense Finance and Accounting Service (DFAS). This initiative will consolidate 26 Federal payroll systems down to 2 Federal payroll provider partnerships. VA is working with DFAS on all required tasks to ensure successful migration.

CLOSING

Mr. Chairman, our 2006 budget request of $70.8 billion will provide the resources necessary for VA to:

- Provide timely, high-quality health care to more than 5.2 million patients; 78 percent of all veteran patients will be veterans with service-connected disabilities, those with lower incomes, or veterans with special health care needs
- Maintain the 2005 performance level of 145 days, on average, to process compensation and pension claims
- Increase access to our burial program by ensuring that more than 82 percent of veterans will be served by a burial option within 75 miles of their residence.

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

That concludes my formal remarks. My staff and I would be pleased to answer any questions.

Chairman CRAIG. Thank you very much, Mr. Secretary. I would ask our colleagues to adhere to 5-minute rounds, and we will go as long as you wish in relation to the questions to be asked.

Let me start with that, Mr. Secretary. And let me start with the basics: is the analysis of the VA's budget proposal that I summarized in my opening statement, in your opinion, an accurate one?

Secretary NICHOLSON. Yes, it is.

Chairman CRAIG. Is it true that the Administration asked for an increase in appropriated funding of less than one half of 1 percent for VA medical care?

Secretary NICHOLSON. Well, yes, it is.

Chairman CRAIG. Would such a minimal increase leave VA approximately $1.8 billion short of its funding needs?

Secretary NICHOLSON. No, it will not in the totality of our budget request, no, sir.

Chairman CRAIG. Would you broaden on that for me, please?

Secretary NICHOLSON. Well, it will not if the other measures that we have for increased revenue sources, collections——

Chairman CRAIG. Put in that context.

Secretary NICHOLSON. Yes.

Chairman CRAIG. OK; as for now, VA would bridge the gap between the needs and its request, as I understand, the VA proposes a four-pronged strategy: to boost the efficiencies, to boost collection under current legal authorities, to generate new collections if Congress authorizes new fees and co-payments and to redefine eligibility for institutional long-term care services. First, is that an appropriate observation?

Secretary NICHOLSON. Yes, sir, I think that is appropriate.

Chairman CRAIG. Further, am I correct that VA can and will implement the first two prongs of this strategy with no Congressional action?

Secretary NICHOLSON. Yes, Mr. Chairman.

Chairman CRAIG. The efficiency side and then, of course, the collections under current authority, legal authority.

Secretary NICHOLSON. Yes, we will effect those efficiencies regardless, and we will continue to improve on our collections, primarily third-party co-pays.

Chairman CRAIG. That in itself, other than the co-pays, is really no different from where we have been and what we have pushed over the last good number of years, is it not, as it relates to health care modernization, outpatient care, all of those kinds of things in part? I mean, in part, what we have been pushing for some time is to generate those kinds of efficiencies in service and operation, is that not——

Secretary NICHOLSON. That is correct, and progress has been made, particularly in the collection of these third-party payer insurance provisions. They have done, I think, a spectacular job in recent years in increasing those collections.

Chairman CRAIG. And in going the direction I am going in, I guess the next follow-up question, Mr. Secretary, there are always efficiencies to be had to a point at which you then begin to impair delivery as you accomplish that, and we squeezed hard in the last few years. We have also modernized, and those who observe us have recognized that.

What are some of the proposals that VA will look at as it relates to generating greater efficiencies now, and will it improve, and how will it improve the management practices that are currently in place?

Secretary NICHOLSON. Mr. Chairman, I will answer that in a general way and refer to Dr. Perlin to give some more of the specifics as the head of our medical care operation and the discretionary part of it, but I know that we will continue in this move that we are on for more standardization.

We have 170-some medical centers or hospitals spread throughout the Nation, including one in the Philippines. We are on a path for more standardization, both in back office management, reporting, and purchasing, and I think considerable progress has been made particularly in the area of purchasing. There are, as you know, up in the neighborhood of 800 community outpatient clinics, which are also benefiting from some of the standardization prac-

tices that are being prescribed, and more is needed, and there are more opportunities for savings there.

I might, if I may, call on Dr. Perlin to be more specific about some of the medical practices.

Chairman CRAIG. Please.

STATEMENT OF DR. JONATHAN PERLIN, ACTING UNDER SECRETARY FOR HEALTH BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Dr. PERLIN. Good morning, Mr. Chairman, and thank you very much for the recognition that we have squeezed hard. We are operating very efficiently in areas such as our pharmacy benefit. Our pharmacy purchasing has really been recognized as a model.

But we can never take efficiency off the table. We believe there are greater efficiencies to be had and standardizations of the types of drugs that we do purchase. In fact, we believe that there may be another $100 million to $200 million in standardizing what we call our formulary or the menu of medications that we purchase.

The same thing holds true in medical-surgical supplies. For example, we purchase a number of different varieties of cotton gauze. Nobody really cares what brand it is as long as it is good quality, and as long as it is there. We can standardize in that regard, and with some of our capital equipment, standardize the maintenance that goes on behind our capital equipment, as well. Consolidation of our business office functions, where we have, for instance, billing activities in each and every hospital; perhaps it is more efficient to actually roll those up into one really highly trained, efficient, effective organization, consolidating some of the business functions there, too.

Our partnership with the Department of Defense, also, is an example of sharing, where we can leverage our scale and purchase more efficiently. The same holds true in our service contracting; again, consolidating our service contracting instead of one here, one there. And finally, we would never take productivity off of the table: our advanced clinic access and the community-based outpatient clinics that the Secretary just mentioned, our ability to see more patients more effectively is really increased by a national initiative known as Advanced Clinic Access.

Chairman CRAIG. Well, there is more in this area that I want to pursue. Thank you for those comments. Let me turn to my colleague, Senator Akaka.

Danny.

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

Mr. Secretary, Senator Craig addressed this by using percentages, and let me try to understand what the President is offering as an increase for VA health care. Set aside the possible increased revenue from insurance companies and the spending associated with new veterans fees. What is the amount the President is requesting that Congress appropriate for VA hospitals and clinics?

Secretary NICHOLSON. Well, I will ask Dr. Perlin to answer that question, Senator.

Dr. PERLIN. Senator, the overall appropriation this year will take us to $30.705 billion.

Senator AKAKA. And that is for hospitals and for clinics?

Dr. PERLIN. That is for the entire medical system, sir.

Senator AKAKA. I understand, as the Secretary mentioned, that the $70.8 billion of the President's budget includes an $880 million increase over last year's discretionary funding, but I am looking at specifics here of VA hospitals and clinics; also, another question in that area: what is the amount associated with payroll increases and inflation?

Secretary NICHOLSON. Go ahead and answer that.

Dr. PERLIN. Sir, the 3.5 percent national pay raise resulted in a cost increase of $374 million.

Senator AKAKA. The President's co-pay, Mr. Secretary, the President's co-pay increase and new enrollment fee are designed to literally drive veterans out of the system, and I say that because I have read that about 192,200-plus veterans have not been helped, and in Hawaii, there is a number of more than 500 who have not been given service. Two years ago, the President had no qualms about prohibiting enrollment for new middle-income veterans.

That policy continues today, and in fact, the testimony says that the President's enrollment decision was the most effective vehicle to manage health care resources. This budget takes a little different route, however. The goal is to make the cost of coming to VA prohibitively expensive. Either way, I have to question the priorities of this Administration. Why not provide sufficient resources to care for all veterans? Is this care not part of the cost of past wars and current conflicts in which we are engaged?

Secretary NICHOLSON. Senator Akaka, I think that probably everybody involved with veterans in a perfect world holds them in the esteem that you do and that I do and that would like to make all this available. The whole panoply of services that the Veterans Administration provides to many people, as we said, to 5.2 million people getting our medical services as well as the millions getting benefits.

But it is not possible, and we have to make tough decisions, and we have to prioritize. And the priority is to those people who count on us, who need us the most, who are those people who are disabled as a result of their service to our country, those who are down on their luck, and they are poor, and to those who have chronic illnesses and special conditions, such as spinal cord injuries.

And that is a large population of veterans, and it takes a great deal to tend to those people in the outstanding way that the VA is doing it. And in a context of a finite amount of resources, it is just compelling that we have to make those tough decisions.

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

Chairman CRAIG. Senator Akaka, thank you.

Now, let me turn to Senator Murray.

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

Mr. Secretary, I know you are new to this process and have just been on the job a couple of weeks, and I want to just give you an opportunity to put your stamp on this budget request. Last year, you might know that Secretary Principi actually acknowledged that the President's request was about $1.2 billion short of what was really needed. That was really helpful to us as we put our budget

together, and Congress was able to react and do what we needed to do to help the VA when it was really in some desperate straits.

We know that The Independent Budget has called for a $3.5 billion increase for fiscal year 2006. Tell me what you really think in terms of this budget: does it meet our needs, or is The Independent Budget closer to what we really need?

Secretary NICHOLSON. No, Senator, we spent a lot of time going over this and, of course, asking these experts a lot of questions. I have many of the same concerns, and I end up being satisfied that we can get the job done with this budget.

Senator MURRAY. Do you think there are any deficiencies within the request?

Secretary NICHOLSON. Are there any deficiencies?

Senator MURRAY. Deficiencies within the request?

Secretary NICHOLSON. Any efficiencies?

Senator MURRAY. Do you think there are any deficiencies within the President's budget request?

Secretary NICHOLSON. Well, you know, it is a matrix. When you are dealing with these millions of people that we are serving and the billions of dollars, it is a matrix, and you could probably disagree about a priority here or there which would affect the allocation or the request for that priority, but I think that this is a very fair, thorough, and doable budget that reflects the priority of this Administration to veterans.

As I have said in my opening testimony, there has been a very sharp incline since the Bush Administration came to government, and this budget does reflect, if you will, a pause in the stunning increases, because we are in a——

Senator MURRAY. Have you had a chance to look at The Independent Budget?

Secretary NICHOLSON. I have. I looked at it, I perused it, yes, Senator.

Senator MURRAY. Maybe you might not be able to right now, but perhaps you could get to us whether you agree or disagree with some of what they are requesting and the differences between what you have. But let me ask the question a little better. Senator Craig's staff gave us a chart which is really helpful in trying to understand what the real increase is. And when I look at it, what I see is actually a requested increase of less than $80 million, when you look at how this is put together, and that has to cover 7 million veterans, 170 hospitals, hundreds of outpatient clinics, medical inflation, payroll increases that you were asked about a few minutes ago.

Is there anything within this budget that gives you pause to say to us we are going to have a problem if we enact this as the President has requested?

Secretary NICHOLSON. Well, it is a tight budget, and people are going to have to operate that way. It is going to be challenging in the extended care area to make that transition and do that with, you know, the compassion and sensitivity that will be needed there. But that is doable. We have discussed that, and I think that we can operate this Administration on this budget and maintain the quality of care and the demands that will be on us, including those

returnees who are a priority of ours coming back from Iraq and Afghanistan.

Senator MURRAY. Well, one of the efficiencies that you plan to put in place is the reduction of 3,700 medical staff employees; is that correct?

Secretary NICHOLSON. I am going to ask Dr. Perlin to address that specifically.

Dr. PERLIN. This budget will reduce the total number of medical staff employees by about 3,700. There is also a $627 million increase in the area of mental health, another $26 million associated with DoD sharing. So in some areas, there will be extensive growth.

Senator MURRAY. Well, we know that we have many soldiers who are coming home who will become part of the veterans system. By some estimates, as much as 20 percent of them will need post-traumatic stress syndrome care. We know we have thousands of injuries today who will go out of service and into the veterans service, and you said yourself that we are going to be serving a million more than last year. How do you reduce medical staff employees by 3,700 people and serve a million more people?

Secretary NICHOLSON. Senator Murray, what I said was that we were going to be serving a million more than we did in fiscal 2001. There has been about a 50 percent increase in appropriations for a million increase in patients.

Senator MURRAY. Well, I would just say, Mr. Chairman, that I do not know how we are going to serve the people who are already in the system who are in a backlog by reducing medical staff by 3,700, but I know my time is running out. I did want to ask one more question, and that is we have a supplemental coming, $82 billion, I believe. We are just beginning to look at it, but from my read of it, it has no mention in it of covering any VA services. Would you consider veterans services for those soldiers who served us and are coming home to be part of the cost of war?

Secretary NICHOLSON. Well, I think that in our system, and because of the value that—I mean, we have values in this country, and I think veterans are one of them, that we hold them in a very high position of esteem and really care about them. You know, there are a lot of people who have been veterans who put on the uniform and were ready to be deployed that may not have gone into a war zone, but that were back in the zone of the interior who were providing very important services overall.

Senator MURRAY. And I appreciate that. When you and I met, you expressed the same concern and value for those who serve is that serving them when they come home is part of the cost of war. There is not one dime in the supplemental request for veterans. We are seeing backlogs; we know that we do not have enough services. Do you personally think that part of the supplemental should be to pay for the cost of war, which is veterans services?

Secretary NICHOLSON. Well, I have not looked at that supplemental. What I have been looking at is what we are asking for versus what we have to do, and I think they match up. I think we can get the job done with this budget request.

Senator MURRAY. Mr. Chairman, I think we have a disagreement, but I will look forward to hearing more from you in the future.

Chairman CRAIG. I appreciate that. Thank you for recognizing the time limit.

Senator Thune.

Senator THUNE. Mr. Chairman, thank you and thank you for your testimony, Secretary Nicholson.

As I said earlier, when I first came to Congress in 1997 as a Member of the House, the VA health care budget, I think, was $17 billion, and there were a couple of years, successive years there, in President Clinton's budget actually flatlined or froze that budget 2 years in a row at $17 billion. Today, we are talking about a $30 billion VA health care budget which was, when I came to Congress 8 years ago, to the House, a $13 billion increase, which, if my arithmetic is correct, that is about a 76 percent increase over an 8-year period or about 9.5 percent per year.

So I think in fairness, we have to say that Congress and the Administration have stepped up and realized that we have got to do more; we have got to put the resources behind this. And as has been noted earlier by Senator Murray, obviously, we have got a lot bigger universe of people that we are serving, and that is something that imposes some severe constraints on even the ramped up funding that we have had.

But this year's budget is clearly a slowdown from what we have seen in the past few years, and I guess I have a concern as to how that is going to affect rural health care. There are areas in my part of the world that are very remote geographically; present great obstacles to people who want to have access to facilities, and the community-based outpatient clinics have done a lot of good in terms of giving people that access. But I guess I am wondering what programs and technological advances will the VA continue to develop to bring care to veterans in Service Area 23 and other areas like it across the country that present those types of geographic challenges?

Secretary NICHOLSON. Senator, that remains a priority of the VA, and that is consistent with the—I hate to use a Navy metaphor, but the sea change that has gone on at the VA, for which I get no credit, but my predecessor should, because it has really been transforming to a hospital-based medical care delivery system to a community-based, and the outreach of that has just been phenomenal: the hundreds and hundreds of new community-based outpatient clinics that are out there where veterans are living and the convenience that it affords them and then, if needed, they are referred to specialty care from the primary care they are given at the clinics.

And we are now adding to that the capabilities that are available because of technology, and we talked about this some at my confirmation hearings, but there are these telemedicine devices that now make it possible to really—distance is not a constraint, because of the speed of the transmission, but a person can sit at a monitor and measure the blood sugar and the heart rate, the blood pressure, look at the pupil dilation, if that is relevant, of a veteran that might be in western South Dakota, and they would be doing it in Sioux Falls, and they can do that on a daily basis, and the

data is transmitted automatically and then logged in their electronic medical record, so that that caregiver who is looking after that veteran knows the trend and can then take steps accordingly.

This has really enhanced our ability to treat more people and to do it more efficiently and more cost-effectively as well.

Senator THUNE. I appreciate the steps that have already been taken, and we worked on some telemedicine, telehealth issues while I was a Member of the House, and I see great opportunity, great benefit in one of the new frontiers of medicine not only in VA health care, but in health care generally in rural areas and being able to treat and diagnose with the benefit of technology. So I look forward to working with you on that, and as I said earlier, will want to, as the budget process moves forward, give careful consideration to how this proposed budget will impact specifically rural areas. That is a particular concern of mine, and I know you are fully aware of that.

So, Mr. Chairman, I yield back.

Chairman CRAIG. Senator Obama.

Senator OBAMA. Thank you, Mr. Chairman. Mr. Secretary, thank you for your testimony.

I would like to pursue the issue of long-term care just for a moment, and my understanding, at least, and I may not have absorbed this correctly, is that under this budget, we are intending to eliminate the current per diem rate that is provided to States for long-term care or reduce it—pardon me, reduce it sufficiently that we are looking at significant losses to the State in terms of Federal funding, and I am wondering, Doctor, maybe you can elaborate on what the rationale for that is and how you would anticipate the States dealing with this or absorbing this.

Dr. PERLIN. Thank you, Senator Obama. I appreciate the question.

First, let me start that the VA's overall approach to long-term care, to needs of older veterans or veterans with frailties is really to provide care in the least restrictive environment, care that helps them maintain social, community and even, for some of the older veterans, 50, 60-year spousal relationships. Some of the technologies that the Secretary just mentioned support veterans in their homes, and so, there is an absolute focus on meeting the needs in the best possible place.

What we are seeking to do is to make sure we have parity among the three different settings of institutional care, VA nursing homes, community nursing homes, and State veteran homes. This policy would create parity among these three environments. Just to be sure, it provides care for those veterans 70 percent service connected or greater. It provides care for those veterans with special needs, such as those who require ventilators. It provides care for those veterans who need hospice care or for families who need a respite in caring for a critically ill veteran. It provides care for veterans who need care after hospitalization, and it provides care for veterans who need a brief rehabilitation period as well. It takes care of all of those veterans.

Senator OBAMA. No, I understand that the veterans with significant disabilities and who need significant assistance of the sort that you described are still going to be receiving care, but what is

also true is that currently, we have a system in which there are a range of veterans who might not fall into some of the categories that you outlined, but are part of the veterans long-term care system, and States have been getting reimbursement for their care. Is that accurate?

Dr. PERLIN. It is.

Senator OBAMA. OK; and under this proposed budget, some of that Federal support to the States for that long-term care would be eliminated; is that accurate?

Dr. PERLIN. That is correct.

Senator OBAMA. OK; so, do you have an estimate in terms of the amount of money that is being reduced in your budget that is currently going to States, or, Secretary, if you have it, whoever wants to answer the question, what kind of shortfall are we essentially shifting over to the States?

Secretary NICHOLSON. Dr. Perlin will answer that.

Senator OBAMA. OK.

Dr. PERLIN. I believe it will be about a $293 million expenditure associated with those veterans.

Senator OBAMA. OK; so right off the bat, it is fair to say, then, that close to $300 million of funding that is currently going to States to provide for veterans is going to be eliminated, and the States are basically going to have one of two options: either they simply stop providing the service to veterans and figure out how those veterans are to fend for themselves, or the States have to come up with this additional money. Or is there an alternative?

And let me say this, because I think this is a point that you were making at the outset: I am a big believer in assisted living. To the extent that we can reduce institutionalized care, oftentimes, that can be a positive thing. But that also costs money. It is not free. You do not suddenly send folks into a community-based setting with no resources. Typically, you are going to have to provide some kind of in-home care; there are a range of other things that have to be done.

So I, at least, was not clear that there were a set of provisions whereby we were going to ensure that the States were going to be able to do that. Maybe I am missing something.

Dr. PERLIN. No, thank you, Senator, and thank you for your endorsement of the non-institutional care. It really is the wave of the future.

This budget does allow for an increase of in excess of 18 percent, from $339 million just over $400 million for increased non-institutional care in support of veterans. That occurs, in addition to another program, our Care Coordination Program, which increases in the year ahead from 4,500 to in excess of 21,000 veterans supported using technology such as Senator Thune mentioned earlier. But for every veteran who might not use State-supported care or might not use a State veterans home for care, we will work with that veteran, using social workers, working with the State, working with other Federal programs, both Medicare and Medicaid, to make sure that those veterans who do require institutional care have the support that is necessary.

Senator OBAMA. Mr. Chairman, I am out of time. I would just note that—and I appreciate some of the changes that we may want

to consider to be more creative in how long-term care is provided. This budget, as I see it, and I do not think it has been contradicted in this: this is going to eliminate $300 million worth of funding that is currently going to States, approximately $16 million in receipts going to the State of Illinois.

And I suspect that every Member here who has these long-term facilities or is getting some sort of reimbursement is going to see those same reductions. I think that is something that should be a source of concern at a time when States are at least as cash-strapped as the Federal Government is. We are passing the buck.

Thank you, Mr. Chairman.

Chairman CRAIG. Senator, thank you.

Senator Jeffords. Jim, questions?

Senator JEFFORDS. Thank you, Mr. Chairman.

I want to talk about the mental health needs of the veterans returning from Iraq. Commencing this war was the most controversial, I think, in this history. It is reasonable to assume that as many of 30 percent of Iraq veterans will have mental health needs. As you point out, the Veterans Administration is working hard to meet these needs to head off serious mental health conditions, but a great deal will still fall on the VA, particularly assistance for Guard members and Reservists who are not near military bases or existing mental health facilities.

As you can tell, the budget only provides a small increase for mental health services of $100,000. But this just does not seem adequate to meet the needs of nearly one-third of Iraq veterans. I also do not see a corresponding increase on research on post-traumatic stress disorder, research that is critical to both the DoD and the VA and knowing how to treat the soldiers that are being exposed to such stress and trauma.

I am from Vermont, and Vermont, as is traditional, has had the highest number of deaths per capita of any State. And I am concerned about those who have lost their legs and arms and have visited the hospitals and just knowing the great stress that is going to be—I wonder, is there a corresponding increase in research for such post-traumatic stress disorders and how to handle these veterans who are going to go home with missing limbs?

Secretary NICHOLSON. Yes, Senator Jeffords, there is an increase in research. This is a real priority of the VA's. We share the concern about PTSD in our returning servicemembers from OIF and OEF. You are well aware of the excellent research being done right in your State at White River Junction. We have other centers conducting research in both the behavioral side and the biological side and clinical across the country. There are several.

And this budget does have an increase of $100 million in it to deal just with this, with the mental health aspects of our care and what will be needed specialty-wise for these sufferers of PTSD.

Senator JEFFORDS. Thank you for that information. I have been a veteran and alive during all the wars, I think, we have had, but this is the first time I have seen so many coming back who have lost limbs, and of course, Vermont has the highest deaths per capita of any State, and I think that probably extends to the blown-off limbs as well from my trips to the hospital. So I am glad you

are aware of that, because I think it is an area that needs considerable care.

Chairman CRAIG. Jim, thank you very much.

Senator Salazar, questions.

Senator SALAZAR. Thank you, Senator Craig.

Secretary Nicholson, as you know, we have been working on the possible new hospital in Colorado, Fitzsimmons. From my point of view, I see that as the crown jewel of medical service for our veterans as well as research on how we can best serve our veterans and our country, and I think it is the kind of facility that will have a benefit way beyond the borders of Colorado and become the crown jewel, if you will, of the West and what we can do with respect to helping our veterans, and I would appreciate if you could just give me and other Members a quick update on the status of that new hospital.

Secretary NICHOLSON. I share your concern for that new hospital also in my own home State, but the wheels were already turning on that before I took over this Department 2 weeks ago, as you know, Senator. And I share the hope that we can collocate that hospital on the old Fitzsimmons Army Hospital campus and thus with the University of Colorado Health Science and Medical School.

As we speak here this morning, I have the senior subordinate in Denver conducting meetings on that. I talked to him last night. I feel quite positive that we will be able to put that together, but I cannot tell you for certain. There are some major issues there, principal among which are that there is enough land to put a hospital of this size, which is contemplated at being 1.5 million square feet, with the sharing, I think, of 100,000 square feet with DoD.

We want that hospital to have a spinal cord injury clinic, which means that it has to have certain grade level capabilities, which means that people have to enter at grade level; have to have parking at grade level. That requires more land than what would be required with structural parking, you know, or underground parking, and we also need some more campus-like environment outside for our patients to be able to go outside and enjoy that.

So land and the amount of land is an issue. But I am feeling quite optimistic that we are making progress, and I would like it probably no more than you if we could put that together and then get underway with the architectural land planning and get that hospital built.

Senator SALAZAR. Let me just say that I will do everything I can to get that accomplished.

Secretary NICHOLSON. Thank you.

Senator SALAZAR. And I appreciate Andy Love's work on it, and we look forward to moving forward with it.

But I think in general, there are issues that the Committee would have with the budget, whether it is funding or covering priority 7 and 8 veterans or some of the cutbacks on veterans nursing homes or other things. It is not a perfect budget, and I would imagine that if I was sitting as Secretary of the VA or had my staff putting together a budget, it might include things that actually were not included in the final budget. And so, if this thing went forward to the White House for review that there might have been some

priorities that you included from the VA perspective that actually were not funded.

Jim, because this preceded your time; you are defending a budget that was prepared by your predecessor. What would have been some of those priority items that would have been included in that budget submission to the White House that really are not now included within the budget that you are defending before the Committee? Let us just take the top three.

Secretary NICHOLSON. Well, I think that, you know, a budget like this, and all of the Cabinet Departments, I think are collaborative efforts, as you know, Senator, between that agency and the Administration and the Office of Management and Budget, and I have had discussions with my senior staff, my teammates, and, you know, there are variables, but I think what was always in mind is what is it going to take to get the job done for those people that Congress has called upon us to provide the services that they absolutely need and are depending on, and that, again, is those people who have been injured or become ill as a result of their service to our country and those that served and are poor, chronically poor or have some chronic special health needs.

That is the core priority group, and that is what has driven this budget. That does not mean that all of the other things and people are not important, but as we have said before, there is a finite amount of resources.

Senator SALAZAR. And that, Jim, led to the conclusion that this budget will be an adequate budget to do what needs to be done. But if you had, you, as the Secretary today and the staff that put this together, I imagine that there are other things that you would have wanted in this budget to serve our veterans if, in fact, you had that leeway. And I am wondering if you might give us some help in understanding what some of those priorities would have been.

Secretary NICHOLSON. Well, what I could do is we could confer and have some discussions and possibly get back to you with some of that, but I think essentially, what you see in this budget is the end product of people who very seriously, conscientiously put down what is the bottom line in this resource-constrained environment that we are in that we need to do our mission, and that is what we have submitted.

Senator SALAZAR. I know my time is up, but if I could just make this statement, I think there are additional things that we can be doing for our veterans and should be doing for our veterans, and obviously, as the budget process takes place through Congress, we will be seeing some of that. But it strikes me that in these fiscally constrained times of our Nation that the one thing that is appropriate for us to ask is for our Nation to make sure that we are doing everything we can for our veterans, whether it is in medical research or the provision of medical services and so on.

And I do not see that, in the President's budget, what he has done is to ask the American people to sacrifice, that we are doing everything that we can for the veterans who have served our Nation. It may be that this budget will get us through for this next year, but this budget may not do all of those things that we need and should be doing to honor our Nation's veterans. And so, one

of the things that I hope to do is to figure out ways of working with you and working with those who are concerned to see how we can better serve the needs of all of our veterans.

Secretary NICHOLSON. I would agree with that, sir.

Chairman CRAIG. Ken, thank you. Now, let us turn to Senator Burr.

Richard, you were not here for opening comments. Do you want to incorporate those with any questions you might have? Please proceed.

Senator BURR. Thank you, and thank you, Mr. Chairman, and I appreciate that offer. I would like to keep it on questions, if I could, and I would like to start with a congratulatory note, and that is the fact that Jim Lehrer and the News Hour highlighted the VA's ability to institute a sterilization program systemwide that in many cases, the private sector has been unable to do. And I think it tells us that there is innovation, and there is a real commitment within the VA to provide a higher level of care.

Now, having said that, let me say, personally, I would like to see more money in veterans health. I would have liked to see it in this budget. But I understand that we on this Committee look at one piece; the Administration must look at an entire budget. So I have got some very specific questions I would like to ask you, Mr. Secretary. Do you believe that the VA has asked and the Administration has provided sufficient funds to, one, reduce the waiting times for individuals to see physicians?

Secretary NICHOLSON. Yes, we have. This budget contemplates a reduction in the waiting times and, if approved, we will have the resources in there for us to do the training and the sessions that we need for some more people to do that.

Senator BURR. Do you believe it provides sufficient funds to reduce the waiting times for the appeals process?

Secretary NICHOLSON. Yes, it does, yes, Senator.

Senator BURR. Do you believe that it provides sufficient funds to address the return of servicemen and servicewomen currently serving in Iraq and Afghanistan?

Secretary NICHOLSON. Absolutely. That is one of our priorities, and that is contemplated in this budget.

Senator BURR. OK; I am not as concerned with the reduction of 3,700 medical professionals. I think every facility across this country went through a period of new efficiencies, and those new efficiencies meant that the personnel makeup's changed. I do not think that necessarily a cut suggests a lower level of care or less of a priority to certain ones. Dr. Perlin, let me ask specifically: you talked about new efficiencies and the savings through consolidation of specifically the purchasing functions at the VA.

I may have missed it, and you may have said here is what you project those savings to be. If you have a number, I would like to hear it. I would also like to ask if we do not achieve that level of savings, where do you plan to get the money from?

Dr. PERLIN. Senator, first, thank you very much for your acknowledgement of the advances in quality and safety. That has been a mission of VA to provide the highest quality care. The efficiencies, we believe, are realistic. They continue on our trend of establishing new efficiencies. $150 million of the $590 million that

are listed in that budget come through improvements in contracting. The remainder come from approximately $200 million in pharmaceutical standardization, and another $50 million to $60 million, particular in the area of commodity standardization. Billings and collections improvements will provide additional savings.

You have indicated that there will be some lower numbers. I need, for the record, to state that this will not be the physicians and nurses who do things like reduce waiting times. In fact, sometimes, to be more efficient, we need to add those sorts of personnel. So we believe that our track record is one of really being at the forefront, of using electronic technologies to produce efficiencies, so we believe these efficiencies will be achieved.

Senator BURR. I hope that the budget—I know you highlighted the savings from drug purchases. I do not think there is any area of health care we look at today where even with savings, we do not look at prescription drugs as a net increase in the overall expenditures that any facility is going to use. I hope, in fact, you have taken that into account, especially as we talk about absorption of the men and women in Afghanistan and in Iraq.

Let me state for the record that North Carolina is the largest, the fastest or largest growing veterans population in the country, so we are certainly very interested in seeing successful initiatives come out of the VA. Let me end in commending you once again for incorporating telemedicine. Mr. Secretary, I believe that what you have done there really will enable us to provide health care where we currently struggle to and as transportation continues to be a challenge, especially as it relates to the veterans population.

I would also say we can learn on the other side of the Federal health care in Medicare and in Medicaid, where we do not reimburse currently for telemedicine, and I think it has stymied the development of potentially what we could reach, and clearly, it has limited us as to the outlets that we have additional telemedicine popping up.

Mr. Chairman, I thank you.

Chairman CRAIG. Richard, thank you very much.

The Ranking Member and I have concurred. We want to get on to our next panel. There are those who have additional questions, Mr. Secretary, and they will be submitted to you in writing, and we would ask for your response to them.

Let me recognize my Ranking Member, but let me say in closing, thank you for your openness, your frankness. I think you heard almost if not unanimously, I read it to be a unanimous concern on the part of this Committee that this budget has some inadequacies as it relates to sustaining our level of care and increasing it in targeted areas for new veterans coming in.

Both you and I have agreed, and I had the commander of our Marine Corps in yesterday. We see a level of health care out in the field today that are bringing young men and women home to us who would not have survived to come home in a war in Vietnam or elsewhere. This is modern medicine at the front line today that is bringing these young people home to us in situations and under conditions that are going to demand a great deal of us, of you, of the service, and of the Veterans Administration in providing for

them. So we will work closely with you in the coming days as we finalize our efforts with this budget and with your efforts.

Thank you.

Senator Akaka.

Senator AKAKA. I, too, want to say thank you, Mr. Secretary, for your responses. I thank your staff as well.

And Dr. Perlin, may I with regard to my first question on the amount of the new VA health care money from fiscal year 2006, I would like you to review the transcript, as, again, I asked for the amount of the health care money only in my first question. So again, I want to say thank you.

Mr. Chairman, I have questions that I will submit for the record on VA nursing homes, health care providers as well as State veterans homes, VA research, mental health, national cemeteries, life insurance that I will submit.

Thank you.

Chairman CRAIG. Thank you.

Again, to all of you, thank you very much for being with us, and we will work closely with you in the coming days.

Secretary NICHOLSON. Thank you very much, Mr. Chairman.

Chairman CRAIG. We will excuse you and ask our second panel to come forward, please.

Jeff, could we get that door closed, please?

Well, welcome before the Committee. I am pleased that you gentlemen are with us today. I say without reservation that the service organizations of this country are the guardians of our veterans and our veterans needs. Your record is long and complete in your advocacy, and I appreciate it greatly, as I know that the Ranking Member does and the work that your organizations have done over the years in defense of and in protection of our veterans needs.

So let me welcome all of you to the Committee, and I understand that we have a priority of presentations so that the presentations are effectively interlocked, and I think I have that priority right, so let me start with Richard Jones, National Legislative Director for AMVETS. Richard, have I assumed that correctly?

Mr. JONES. Yes, sir, The Independent Budget, Chairman Craig, will make a presentation right after the American Legion.

Chairman CRAIG. OK.

Mr. JONES. Chairman Craig, Ranking Member Akaka, we thank you very much for this opportunity. My name is Richard Jones, AMVETS' National Legislative Director and Chairman of The Independent Budget steering committee. With your consent, as you have agreed, we will follow the American Legion presentation with the IB.

Chairman CRAIG. We have it here in front of us, or I do.

Mr. JONES. PVA will make the health presentation, Disabled American Veterans, the benefits. Veterans of Foreign Wars will make the construction and CARES process. AMVETS will follow with burial benefits, so we proceed, sir, with your approval with the American Legion, followed in that order.

Chairman CRAIG. Fine enough; please proceed. Oh, excuse me, Peter; make sure that in doing that, because I have not introduced all of you to the Committee, that you would state your name again and the organization you are representing.

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

Mr. GAYTAN. Yes, sir. I am Peter Gaytan. I am Director of Veterans Affairs and Rehabilitation Division of the American Legion.

Chairman CRAIG. Thank you.

Mr. GAYTAN. The American Legion applauds the efforts of our colleagues and their development of The Independent Budget, and the American Legion also has our individual, independent assessment of the needs of the VA health care system. I will outline those specific concerns of the American Legion with the 2006 fiscal year budget for VA right now.

Chairman CRAIG. Thank you. Please proceed.

Mr. GAYTAN. Thank you for the opportunity to express the views of the 2.7 million members of the American Legion regarding the Department of Veterans Affairs 2006 budget request. The American Legion continues a proud tradition of advocating for proper funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable service to this country.

As American servicemembers continue to fight for our freedoms in more than 130 countries worldwide, it is the responsibility of this Committee as well as the entire Congress to provide a budget that will allow VA to fulfill its mission. The American Legion urges this Committee to fund VA at a level that will ensure that all veterans have access to the VA health care system. The VA budget must reflect the true demand for care.

Mr. Chairman, the quality of care provided through the VA health care system has improved considerably in the past few decades. VA has recognized the need to treat the Nation's veterans with the highest quality of care possible, and today, VA hospitals are consistently recognized as the top providers of health care in America. Although the quality of VA health care has improved, the current problem facing today's veterans who are turning to VA for their health care needs is inaccessibility. In recent years, veterans have experienced incredibly long wait times at VA health care facilities.

In early 2003, the backlog of veterans waiting to be seen at VA health care facilities reached 300,000. The American Legion responded to this health care crisis by implementing the I am not a number campaign that identified veterans who were dealing with long wait times, canceled appointments and long commutes to VA health care facilities. It was our intention to remind VA that patients of the VA health care system are individual veterans deserving of care and not simply numbers on a list.

Through these facility visits, the American Legion is learning that one of the main issues of concern is the increase in medical care collection fund targets. Medical center directors are concerned over the significant increases in their MCCF goals and what impact the restriction on enrolling any priority group 8 veterans will have on their ability to meet those goals. The American Legion shares this concern, and we are also concerned about the impact of certain proposals included in the fiscal year 2006 budget request

that seek to generate increased revenue for VA through the pockets of veterans instead of through the allocation of Federal funds.

The American Legion opposes the implementation of a $250 annual enrollment fee for non-service connected priority group 7 and 8 veterans. This newly imposed fee would simply charge currently eligible veterans without providing any guarantees of improvement in access to care at the very system created to treat their very unique needs. The American Legion would urge Congress to once again reject this proposal, just as it did last year.

While the American Legion applauds the initiatives to eliminate co-payments for hospice care, to exempt former POWs from co-payments, and for VA to pay co-pays for emergency care for enrolled veterans at private hospitals, we do not support increasing the pharmacy co-pays from $7 to $15 for priority group 7 and 8 veterans. While the American Legion realizes the importance of adequately funding VA, we support other options that would create additional revenue streams for VA, such as Medicare reimbursement.

The American Legion would rather VA seek reimbursements from CMS for all enrolled Medicare eligible veterans being treated for non-service connected medical conditions before trying to balance the budget on the backs of priority group 7 and 8 veterans. The American Legion is very concerned with the proposed elimination of the 1998 nursing home capacity requirement established in Public Law 106–117. As America's greatest generation rely on long-term care, VA must be prepared to meet those needs. The American Legion supports the provisions of the Millennium health care bill, and eliminating long-term care beds is not the answer.

The American Legion recommends $34.1 billion for VA medical care. We continue to advocate for all MCCF collections to be added to the budget numbers and not treated as an offset to the budget. The American Legion opposes restricting eligibility for State veterans homes per diem payments for long-term care to veterans in priority groups 1 through 3 and catastrophically disabled priority group 4 veterans. The State veterans homes have been a successful cost sharing program between VA, the States, and the veterans. This proposal would spell financial disaster for the State veterans homes and would result in a new population of homeless, elderly veterans on our streets, especially in those States with poor Medicaid nursing home reimbursement rates.

In closing, the American Legion would like to express full support for mandatory funding of the VA health care system. We fully support designating VA medical care as a mandatory item within the Federal budget. Mr. Chairman, the American Legion is fully committed to working with this Committee to ensure that America's veterans receive the entitlements they have earned. Thank you again for the opportunity to appear before you this morning.

[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:

Thank you for this opportunity to present The American Legion's views on the Department of Veterans Affairs' fiscal year 2006 budget request. The American Legion continues to advocate for adequate funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable service

to this country. With young servicemembers currently deployed to more than 130 countries, it is the responsibility of this Committee to ensure VA is indeed capable of meeting its obligation to provide for America's veterans. The American Legion commends the Committee for holding this hearing to discuss this important matter.

Mr. Chairman, the quality of care provided through the VA Health Care System has improved considerably in the past few decades. VA has recognized the need to treat the Nation's veterans with the highest quality of care possible and today VA hospitals are consistently recognized as the top providers of health care in America.

Although the quality of VA health care has improved, the current problem facing today's veterans who are turning to VA for their health care needs is inaccessibility. In recent years, veterans have experienced incredibly long wait times at VA health care facilities. In early 2003, the backlog of veterans waiting to be seen at VA health care facilities reached 300,000. The American Legion responded to this health care crisis by implementing the "I Am Not A Number" campaign that identified veterans who were dealing with long wait times, canceled appointments and long commutes to VA facilities. It was our intention to remind VA that patients of the VA health care system are individual veterans deserving of care and not simply numbers on a list.

As a result of the "I Am Not A Number" campaign, leadership and staff of The American Legion visited VA health care facilities nationwide to meet with VA Administration and gain a better perspective of the challenges faced by VA in providing timely access to health care. The American Legion is continuing those visits and as of June of this year, The American Legion will have visited all VA hospitals within the continental United States. In July of this year, National Commander Tom Cadmus will be issuing the third in a series of Reports on the Condition of VA Health Care in America that reflect the findings of the visits.

It is important that VA be funded at a level that will allow it to improve accessibility not only to the current population of veterans, but to those servicemembers who are currently serving to protect the freedoms of this Nation.

Once again, Congress has been given a proposed budget for VA that includes provisions that would place more of the burden of payment on the veteran. The fiscal year 2006 Proposed VA Budget would require a $250 annual enrollment fee for Priority Groups 7 and 8 veterans. Under this budget proposal, two groups of eligible veterans would now be required to pay an annual fee to access the very health care system that was created to treat their unique needs. Those Category 8 veterans who escaped the shut out in 2003 and are currently enrolled in VA would now find themselves paying out of pocket to be treated at VA.

The fiscal year 2006 Proposed VA Budget would also raise the pharmaceutical copayment for Priority Groups 7 and 8 veterans to more than twice the current rate.

While The American Legion understands all too well the funding crisis within VA, the solution to this problem is not to balance the VA budget on the backs of America's veterans. The solution is to provide guaranteed funding for VA.

As a Nation at war, The American Legion advocates increasing VA funding in fiscal year 2006 to meet the increased health care demand of America's veterans. In response to the overwhelming backlog of veterans seeking care at VA, former VA Secretary, Anthony Principi was forced to prohibit enrollment of new Priority Group 8 veterans. Many of the recently separated servicemembers, especially Reservists and National Guard personnel, will qualify as Priority Group 8 veterans and will be denied enrollment, unless they served in theaters of operation. However, this new demand for services places even greater demands on VA to provide timely access to quality medical care. In light of this demand, The American Legion recommends the following discretionary funding levels for fiscal year 2006.

Budget Proposals for Selected Discretionary Programs for Department of Veterans Affairs for Fiscal Year 2006

Program	VA fiscal year 2005 [1] Appropriation	VA fiscal year 2006 Request	Legion's Fiscal Year 2006 Request
Medical Care	$29.98 billion	$30.75 billion	$34.1 billion (includes MCCF)
Including:			
Medical Services	$19.08 billion	$22.37 billion	
Medical Administration	$4.64 billion	$4.43 billion	
Medical Facilities	$3.65 billion	$3.88 billion	
Medical Care Collections	$1.95 billion (Offset)	$2.16 billion [2] (Offset)	Supplement [3]
DoD/VA HCIF		$15 million	

Budget Proposals for Selected Discretionary Programs for Department of Veterans Affairs for Fiscal Year 2006—Continued

Program	VA fiscal year 2005 [1] Appropriation	VA fiscal year 2006 Request	Legion's Fiscal Year 2006 Request
Medical and Prosthetics Research.	$393 million	$365 million	$447 million
Construction	$578 million	$750 million	$ 1.58 billion
Major	$442 million	$590 million	$327 million
CARES (dedicated)	($341 million)		($1 billion Major and Minor)
Minor	$212.3 million	1$160 million	$261 million
CARES (dedicated)	($167million)		
State Extended Care Facilities	$104.3 million	Moratorium	$124 million
State Veterans' Cemeteries	$32 million	$32 million	$42 million
NCA	$273 million	$290 million	$274 million
Departmental Management	$1.3 billion	$1.1 billion	$1.8 billion

1 Includes 0.8% rescission.
2 Proposed $250 enrollment fees and increased prescriptions co-payments ($424 million) not included.
3 Third-party reimbursements should supplement rather than offset discretionary funding.

MEDICAL CARE

Today, there are nearly 25 million veterans. As more choose to use VA as their primary health care provider (over 8 million veterans enrolled or waiting to enroll), the strain on the system continues to grow. The American Legion fully supported the enactment of Public Law 104–262, the Veteran's Healthcare Eligibility Reform Act that opened enrollment in the VA health care system. Many veterans who, until this time, were ineligible for VA health care were now able to enroll. Veterans recognize that VHA provides affordable, quality care that they cannot receive anywhere else.

The astronomical growth of Priority Groups 7 and 8 veterans seeking health care at their local VA medical facility resulted in over 300,000 veterans being placed on waiting lists regardless of their assigned Priority Group. Fiscal year 2003 saw the suspension of enrollment of new Priority Group 8 veterans due to this growth in enrollees. The American Legion does not agree with the decision to deny health care to veterans simply to ease the backlog. Denying earned benefits to eligible veterans does not solve the problems resulting from an inadequate budget.

Additionally, VA must be capable of providing health care to the new era of veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom. These young servicemembers have earned the right to health care through VA and we as a Nation must ensure that that right is protected by fully funding VA. According to VA as of January 2005, 48,733 veterans of Operation Iraqi Freedom have presented themselves to VA for medical care. The cost of treating these veterans, and all enrolled veterans, is a continuing cost of war that cannot be ignored.

The American Legion recommends $34.1 billion for Medical Care in fiscal year 2006.

MEDICARE REIMBURSEMENT

Under current law, VA is required to seek third-party reimbursements for the treatment of enrolled veterans' non-service-connected medical conditions. Upon enrollment, veterans are asked to provide information on their health care insurance coverage. Over half of the enrolled VA patient population lists the Centers for Medicare and Medicaid Services (CMS). However, current law prohibits VA from collecting from CMS for the treatment of enrolled Medicare-eligible veterans.

The American Legion recommends Congress authorize VA to collect third-party reimbursements from the Centers for Medicare and Medicaid Services.

MEDICAL CARE COLLECTION FUND

Public Law 105–33, the Balanced Budget Act of 1997, established the Department of Veterans Affairs (VA) Medical Care Collections Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited into this fund. The MCCF is a depository for funds collected from third party insurance, outpatient prescription co-payments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Government.

Funds collected through MCCF are also used as an offset rather than as a supplement to appropriations for the medical care budget. The efficient and timely collec-

tion of these reimbursable costs would greatly benefit the VHA in helping meet the demands for a severely impacted veteran's health care system. The American Legion adamantly opposes offsetting annual VA discretionary funding by the MCCF recovery. By off-setting these funds the VA loses valuable funding that is not representative of the veteran population in VERA allocations (Priority Groups 7 and 8) nor does it allow for the full utility of collecting from Medicare, the largest health insurance provider.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF treasury account, but remain within VHA and are used for operating funds. Instead, in developing a budget proposal, it appears that the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect to the VISNs and VAMCs.

The American Legion opposes reducing annual VA discretionary funding by the MCCF recovery estimate.

MANDATORY FUNDING OF VA MEDICAL CARE

The simple fact is that the Veterans Health Administration (VHA) does not have the funding needed to treat all veterans seeking care from VA. VHA operates under a constant cloud of fiscal uncertainty. Over the last several years, VHA has struggled to meet the increased demand for care while staying within budget constraints. These budgetary uncertainties create problems within VA's health care system. Future spending projections, staffing levels, equipment purchases, structural improvements are all stalled if the funding is not a certainty.

In an effort to provide a stable and adequate funding process, The American Legion has joined with Nine other Veterans Service Organizations in support of mandatory funding for veterans' medical care.

The American Legion and the Partnership of veterans' service organizations adamantly believe VA Medical Care should receive annual guaranteed appropriations to meet the health care needs of VA's enrolled patient population. The adverse impact of continued inadequate discretionary funding on VA's ability to provide timely access to quality health care is well documented. The President's Task Force to Improve Health Care Delivery for our Nation's Veterans advanced two proposals—one advocates re-designation of VA medical care as mandatory funding (like Medicare or Social Security), rather than discretionary funding; the other recommends creation of an independent board to recommend the VA medical care annual funding needs.

The American Legion supports guaranteed funding of the VA health care delivery system.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES) AND MEDICAL CONSTRUCTION

Major Construction Under CARES

Over the past 4 years, The American Legion has carefully followed the progress of the Secretary of Veterans Affairs' Capital Asset Realignment for Enhanced Services (CARES) process. CARES has been an incredibly complex national process to reorganize VA through a data driven assessment of veterans' health care needs through the years 2012 and 2022. CARES is the future of VA health care delivery of services that will, ostensibly, meet veterans' current and future health care needs. The American Legion has participated at each stage of the process by gathering information on VA Medical Centers throughout the country to make certain medical facilities were not closed simply to save money.

In May 2004, then-Secretary Principi released his final CARES decisions and the implementation process is going forward. While The American Legion was not in total agreement with all the decisions made so far, we feel the process was fair due in large part to the hard work and input of The American Legion leadership, membership and national staff and that of numerous other stakeholders. As the implementation process continues, The American Legion is prepared to remain vigilant to assure that veterans are not deprived of their earned health care.

The CARES decision supports establishing new hospitals in three locations—Orlando, Las Vegas, and Denver. It also supports new bed towers in Tampa and San Juan, 156 new community clinics in 33 states and territories, a new multi-specialty outpatient clinic in Columbus, four new or expanded spinal cord injury centers and two new blind rehabilitation centers. Included in the plan are the closures of the Highland Drive (PA), Brecksville (OH) and Gulfport (MS) facilities.

The American Legion believes VA should exercise caution during the planning phases for these closures. No doors should be closed for services before new services

are in place and functioning. Contingency planning needs to take place and stakeholders should be involved in all aspects of the implementation of these closures. Through the CARES process over one hundred major construction projects were identified and submitted for review. VA prioritized these major capital investments through fiscal year 2010. A plan of this magnitude requires a significant amount of resources to include trained and experienced personnel. This will have a major impact on VA's ability to move forward with the construction projects, even if they have the needed funding.

To successfully implement the CARES decision, VA has estimated that it will require an infusion of a $1 billion per year for the next 6 years, with continuing substantial infrastructure investments well into the future. The American Legion is opposed to the CARES funding coming out of the discretionary medical care account. The American Legion believes the CARES implementation must occur in the context of a fully utilized VA health care system. It must take into consideration VA's role in emergency preparedness, organizational capacity for "special emphasis programs" like mental health, long-term care, domiciliary and homeland security. Further, there must be continued oversight of the integration of the CARES process into the strategic planning process.

CARES Implementation

Of the amount appropriated for medical care in fiscal year 2005, P. L. 108–477 authorizes the Secretary of Veterans Affairs (Secretary) to divert $400,000,000 for the implementation of CARES under the Major Construction account. The American Legion strongly opposes the use of needed medical care funding for the implementation of CARES.

The American Legion recommends $1.58 billion for Major Construction in fiscal year 2006, including $1 billion for CARES.

The American Legion supports a separate appropriation of $1 billion per year for the next 6 six fiscal years for the implementation of CARES.

Minor Construction

Similar to VA's major construction program, VA's minor construction program has likewise suffered significant neglect over the past several years. The requirement to maintain the infrastructure of VA's buildings is no small task. When combined with the added cost of the CARES program recommendations and the request for minor infrastructure upgrades in several research facilities, it is easy to see that a major increase over the previous funding level of $211 million is crucial.

The American Legion recommends $261 million for Minor Construction in fiscal year 2006.

MEDICAL AND PROSTHETICS RESEARCH

VA's Medical and Prosthetic Research Service has a history of productivity in advancing medical knowledge and improving health care not only for veterans, but for all Americans. VA research has led to the creation of the cardiac pacemaker, nicotine patch, and the Computerized Axial Tomography (CAT) scan, as well as other medical breakthroughs. Over 3800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects.

The VA Medical and Prosthetic Research budget has not kept pace with inflation during the past 15 years. It is essential that Congress and the Administration support strong medical and prosthetic research programs within VA so that veterans and all citizens continue to benefit from the exceptional research capability of the Department.

The American Legion supports adequate funding for VA biomedical research activities. Congress and the Administration should encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans—such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others—jointly with the Department of Defense (DoD), the National Institutes of Health (NIH), other Federal agencies, academic institutions.

The American Legion recommends $447 million for Medical & Prosthetics Research in fiscal year 2006.

LONG-TERM CARE

This year, VA adds three new legislative initiatives toward minimizing its financial responsibility to America's aging veterans.

ELIMINATE VA NURSING HOME CARE UNITS MANDATORY CENSUS REQUIREMENTS UNDER 38 U.S.C. § 1710B(b).

The Veterans Millennium Health Care and Benefits Act of 1999, P.L. 106–117, 113 Stat. 1545 (1999), (Millennium Act) (codified at 38 U.S.C. §1710B(b)), requires VA to maintain its in-house Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. The American Legion does not believe this requirement of law constitutes a "baseline for comparison"; rather we maintain that the language in the law is quite clear.

(b) The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during fiscal year 1998.

This capacity has significantly eroded rather than maintained. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimates it will have only 9795 beds in fiscal year 2006.

This issue has a contentious recent history.

It was charged in the House Veteran's Affairs Committee's (HVAC) fiscal year 2004 Budget Views and Estimates that VA plans to do away with a large part of its existing LTC beds, to wit:

The Committee has been in regular communication with the Secretary concerning a noted decline in VA nursing home beds (approximately 2,000 beds). On May 8, 2002 the Secretary made a commitment to restore these beds to their prior level, provided that Congress appropriates an increase in VA's medical care appropriation for fiscal year 2003. In the omnibus appropriation approved by Congress on February 13, 2003, VA received $1.1 billion more than what was requested by the President for the period.

The Committee is disappointed by the Secretary's proposal in this budget to close thousands of additional VA nursing home beds. VA's own long-term care model, based on the medical needs of its users, indicated a need for 17,000 new nursing home beds by 2020. The Committee does not believe that VA can replace 5,000 nursing home beds with outpatient programs for elderly, chronically ill veterans.

VA has never fulfilled the promise of its landmark mid–1980s study, Caring for the Older Veteran. That study recommended large increases in both inpatient and alternative programs, such as respite, hospice, adult-day and home-based care, so that VA could approach the needs of World War II veterans with meaningful, health and end-of-life care programs, on both institutional and non-institutional bases. This has not been achieved.

In order to aid the Department in maintaining its current nursing home bed level, the Committee recommends that VA's budget request be augmented by an additional $297 million. Furthermore, VA should fund effective alternatives to long-term care and reopen long-term care nursing beds that have been closed.

VA has claimed that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act. In a February 2002 letter to HVAC Ranking Democratic Member Lane Evans, Secretary of Veterans Affairs Anthony Principi stated:

"I have come to the conclusion that as long as we continue to use VA inpatient average daily census (ADC) as the singular measure for long-term care capacity, it will not be possible for VA to meet the requirements of P.L. 106–117 without adversely affecting our ability to provide other essential health care services to veterans on a timely basis."

On March 20, 2002, the Secretary forwarded a plan to HVAC to restore VA NHCU bed capacity to the 1998 level including "substantial implications" for doing so. The cost was to be offset by forgoing planned expansion of contract community nursing care, decreasing education and research programs, reprogramming technology infrastructure requirements, transferring a portion of the SVH construction budget and converting intermediate medicine beds to NHCU beds. Following these "threats", HVAC replied on March 26 that it was prepared to recommend appropriation of additional funds to enable VA to comply with the law.

VA has made clear its determination not to expand it's own Nursing Home Care Unit bed capacity; in fact, VA has defied Congress' mandate to maintain its 1998 bed capacity of 13,391. Instead VA's inpatient nursing home bed count now stands at 9795.

The American Legion supports the maintenance of VA Nursing Home Care Unit bed capacity at the 1998 level of 13,391.

STATE VETERANS HOMES PER DIEM

VA's Budget Request for fiscal year 2006 contains a legislative proposal that would restrict eligibility for State Veterans Homes (SVH) Per Diem payments for long term (maintenance) care to veterans in Priority Groups 1 through 3 and cata-

strophically disabled Priority Group 4 veterans. Non-catastrophically disabled Priority Group 4 and Priority Groups 5 through 8 would be entitled to only short-term care. This is unacceptable to The American Legion.

The State Veteran Homes have been a successful cost-sharing program between VA, the States and the veteran. Veterans in SVHs tend to be without family, indigent and requiring of Aid and Attendance. One SVH has estimated that these eligibility criteria would cut its Average Daily Census by over 50 percent and cost the facility $2 million per year. This proposal would spell financial disaster for SVHs and would result in a new population of homeless elderly veterans on our streets, especially in states with poor Medicaid nursing home reimbursement rates. It has also been suggested that a surge in claims for service connection would ensue as SVHs scramble to qualify veterans for inclusion in Priority Groups 1 through 3 and catastrophically disabled Priority Group 4.

The American Legion supports increasing the amount of authorized per diem payments to 50 percent of the cost of nursing home and domiciliary care provided to veterans in State Veterans Homes and full reimbursement for veterans with 70 percent or greater service-connected disabilities. The American Legion also supports the provision of prescription drugs and over-the-counter medications to veterans with 50 percent or greater service-connected disabilities, along with the payment of authorized per diem to State Veterans Homes. The National Association of State Veterans Homes and VA should develop mutual planning efforts, enhanced medical sharing agreements, and enhanced-use construction contracts with qualified providers.

The American Legion opposes any legislative changes in the eligibility criteria for receipt of State Veterans Homes Per Diem.

STATE EXTENDED CARE FACILITY GRANTS PROGRAM

The fiscal year 2006 VA Budget Request contains zero dollars for the State Extended Care Facility Grants Program; instead VA would impose a 1-year "moratorium" on grants for new facilities construction while VA completes a nationwide infrastructure assessment study of its institutional long term care. The American Legion agrees that such a study is long overdue; projections for long-term care inpatient capacity were largely left out of the CARES process. We fail to see the utility in suspending payment of construction grants in fiscal year 2006, especially in states having never previously applied and in states having significant need.

State Veterans Homes were founded for indigent and disabled Civil War veterans beginning in the late 1800s and have continued to serve subsequent generations of veterans for over one hundred years. Under the provisions of 38 USC, VA is authorized to make payments to states to assist in the construction and maintenance of State Veterans Homes. Today, there are 109 State Veterans Homes facilities in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. The State Veterans Home Program has proven to be a cost-effective provider of quality care to many of the Nation's veterans and this program is an important adjunct to VA's own nursing, hospital, and domiciliary programs. The Grants for Construction of State Extended Care Facilities provides funding for 65 percent of the total cost of building new veterans homes. VA has not been able to keep pace with the number of grant applications; currently there is over $120 million in unfunded new construction projects pending.

Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative health care provider to the VA system.

The American Legion recommends $124 million for the State Extended Care Facility Grants Program in fiscal year 2005.

NATIONAL CEMETERY ADMINISTRATION (NCA)

The National Cemetery System

VA's National Cemetery Administration (NCA) is comprised of 120 cemeteries in 39 states and Puerto Rico as well as 33 soldiers' lots and monuments. NCA was established by Congress and approved by President Abraham Lincoln in 1862 to provide for the proper burial and registration of graves of Civil War dead. Since 1973, annual interments in NCA have increased from 36,400 to over 84,800. Annual burials are expected to increase to more than 115,000 in the year 2010 as the veteran population ages. Currently 59 national cemeteries are closed for casket burials. Most of these can accept cremation burials, however, and all of them can inter the spouse or eligible children of a family member already buried. Another 22 national cemeteries are expected to close by the year 2005, but efforts are underway to forestall some of these closures by acquiring adjacent properties.

Congress must provide sufficient major construction appropriations to permit NCA to accomplish its stated goal of ensuring that burial in a national or State cemetery is a realistic option by locating cemeteries within 75 miles of 90 percent of eligible veterans.

P.L. 107–117 required NCA to build six new National Cemeteries. Fort Sill opened in 2001 under the fast-track program, while the remaining five, Atlanta, Detroit, South Florida, Pittsburgh and Sacramento are in various stages of completion. Additional acreage is currently under development in 10 national cemeteries, columbaria are being installed in 4 and additional land for gravesite development has been acquired at national cemeteries in 5 states. 9 national cemeteries are expected to close to new interments between 2005 and 2010. The rate of interments in national cemeteries has increased from 36,400 in 1978 to 84,800 in 2001. This rate is expected to rise to 115, 000 in 2010.

The average time to complete construction of a national cemetery is 7 years. The report of a study conducted pursuant to the Millennium Act concluded that an additional 31 national cemeteries will be required to meet the burial option demand through 2020. Legislation is currently pending in this session that will authorize the establishment of 10 new national cemeteries in areas of the country facing a shortage of burial space. Together with the 6 national cemeteries under development, this will go a long way toward fulfilling this need. NCA will be able to keep pace with current demand for burial space if this legislation is enacted and fully funded this year.

The American Legion urges Congress to provide sufficient major construction appropriations to permit NCA to accomplish its mandate of ensuring that burial in a national cemetery is a realistic option for 90 percent of our nations veterans.

NATIONAL SHRINE COMMITMENT

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding; however, adequate funding is key to maintaining this very important commitment. At the rate that Congress is funding this work, it will take twenty-eight years to complete. The American Legion supports the goal of completing the NCA's National Shrine Commitment in 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 National Cemetery Administration to fulfill this Commitment.

The American Legion recommends $274 Million for the National Cemetery Administration in fiscal year 2006.

STATE CEMETERY GRANTS PROGRAM

The National Cemetery Administration (NCA) administers a program of grants to states to assist them in establishing or improving state-operated veterans cemeteries through VA's State Cemetery Grants Program (SCGP). Established in 1978, the matched-funds program helps to provide additional burial space for veterans in locations where there are no nearby national cemeteries. Through fiscal year 2002, more than $169 million in grants have been awarded to states and the Territories of Guam and the Northern Marianas, including 5 new State cemeteries and the improvement and/or expansion of 9 existing ones.

Under the Veterans Programs Enhancement Act of 1998, P.L. 105–261, VA may now provide up to 100 percent of the development cost for an approved project. For establishment of new cemeteries, VA can provide for operating equipment. States are solely responsible for the acquisition of the necessary land.

The American Legion recommends $42 Million for the State Cemetery Grants Program in fiscal year 2006.

VETERANS BENEFITS ADMINISTRATION

The Department of Veterans Affairs has a statutory responsibility to ensure the welfare of the Nation's veterans, their families, and survivors. Each year, the 58 regional offices of the Veterans Benefits Administration (VBA) receive over 100,000 new and reopened benefits claims. A majority of these claims involve multiple issues that are legally and medically complex and time consuming to adjudicate. Whether a case is complex or simple, these offices are expected to develop and adjudicate veterans' and survivors' claims in a fair, legally proper, and timely manner.

CLAIMS BACKLOG

Last year we expressed concern about the probable effect of a major cut back in regional office staffing slated for fiscal year 2004 and a further smaller reduction proposed for fiscal year 2005. It did not appear that the available staffing resources were going to be sufficient to handle the additional workload associated with legislation enacted by this Congress affording new benefit entitlements, along with liberalized VA policy on diseases related to Agent Orange and required support for DoD's Combat Related Special Compensation Program (CRSC). There has also been an influx of new claims for service connection, due to the fact that enrollment in VA's medical care system remains closed to some Category 8 disabled veterans. Much of the overall increased workload, however, stems directly from the required rework of tens of thousands of pending and previously decided cases, due to precedent decisions of both the United States Court of Appeals for Veterans Claims and the United States Court of Appeals for the Federal Circuit.

The Veterans' Claims Assistance Act of 2000 (VCAA), P.L. 106–475, was designed to overcome deficiencies in the claims adjudication process, improve the way VBA communicates with claimants, and the way in which claims were developed. The basic goal was to ensure that VA regional offices provided individuals essential information concerning their claim, so that they would know what evidence they were expected to submit and what evidence VA would try and obtain. This legislation was expected to result in claims that were more fully developed and which could be adjudicated in a more expeditious and accurate manner. There was also an expectation that these improvements would increase claimant's satisfaction with the decision received and reduce the appeals workload for the Decision Review Officers and the Board of Veterans Appeals.

VBA has, over the last 3 years, begun aligning its policies and procedures to conform to the letter and intent of VCAA, and has directed most of the regional offices' time and effort toward reducing claims processing time and reducing the backlog of pending claims. Achievement of former Secretary Principi's stated goal of 100 days to process a claim, on average, and a backlog of 250,000 pending claims by the end of fiscal year 2003 has been and continues to be VBA's No. 1 priority. To fulfill mandated production quotas, regional office management and adjudicators have been put in the difficult and unenviable position of having to choose between deciding thousands of cases as quickly as possible or going through the more time consuming steps necessary to comply with VCAA and provide the claimant full due process.

In October 2003, Former Secretary Principi announced that the claims backlog had been reduced to the promised target level. Claims processing times were also trending down toward the 100-day goal and the error rate was improving. From VBA's perspective, these results showed that regional office service had improved dramatically. Part of Secretary Principi's promise was, once the backlog goal had been achieved, VBA would be able to shift time and attention to improving the quality of claims adjudication. However, experience has once again shown that "faster is not always better."

Unfortunately for thousands of veterans and their families, their rights under the VCAA have been subordinated to bureaucratic convenience for the sake of an arbitrary administrative goal. This persistent disregard of the law prompted thousands to file otherwise unnecessary appeals. Since judicial review of veterans' claims was enacted in 1988, of those cases appealed to the United States Court of Appeals for Veterans Claims (CAVC), the remand rate, historically, has been about fifty percent. In a series of precedent setting decisions by the CAVC and the United States Court of Appeals for the Federal Circuit, the courts have invalidated a number of long-standing VA policies and regulations because they were not consistent with the statute. In response to the these decisions, VBA provided the regional offices with revised templates for VCAA notices to conform to the directives of the court. Unfortunately, VA's notices still do not adequately fulfill the notice requirements of the VCAA.

These court decisions immediately added thousands of cases to regional office pending workloads, since they require the review and reworking of tens of thousands of completed and pending claims. Between October 2003 and December 2003, the case backlog increased from 250,000 to 350,000. From January to August 2004, the number of pending claims has been reduced only by some 25,000 cases. However, over the same period, the number of appeals pending in the regional offices has grown by 20,000 cases. Data on regional office performance appear to contradict VBA's description of improvements in service to veterans.

LACK OF QUALITY DECISION MAKING IN VBA

The adequacy of regional office staffing has as much to do with the actual number of personnel as it does with the level of training and competency of the adjudication staff. VA's fiscal year 2005 budget request noted the fact that VBA has lost much of its institutional knowledge base over the past 4 years, due to the retirement of many of its 30-plus year employees. Retirements among this group are expected to continue at a significant rate in 2005. As a result, staffing at most regional offices is now made up mostly of trainees, with less than 5 years of experience. Over this same period, as regional office workload demands escalated, these trainees have been put into production units as soon as they completed their basic training.

The American Legion's visits to regional offices have found that, frequently, there have been too few supervisors or inexperienced supervisors to provide trainees necessary mentoring, training, and quality assurance. In addition, at many stations, ongoing training for the new hires as well as the more experienced staff would be postponed or suspended, so as to focus maximum effort on production. Despite the fact that VBA's policy of "production first" has resulted in many more veterans getting faster action on their claims, the downside has been that tens of thousands of cases have been prematurely and arbitrarily denied. As a consequence, the appeals burden at the regional offices, the Board and the Appeals Management Center (AMC) continues to grow. What must also be kept in mind is that there is a disabled veteran, most often with a family, behind each one of these appeals, who has been fighting the VA system for a year, 2 years, or more to get what he or she feels they are rightfully entitled to.

The American Legion was very disturbed by information presented at the July 2004 VBA Leadership Conference about regional office adjudicators' job performance. VBA had two groups of Veterans Service Representatives (VSRs) take a job skill certification test. There were 650 individuals tested. They were GS 10 and GS 11 with three to 5 years of regional office claims experience and were considered to be proficient workers. It was, therefore, very disconcerting to learn that only 25 percent of the GS 10's and 29 percent of the GS 11s passed the open book test. If these individuals are supposed to be VBA's best and brightest adjudicators, it is little wonder that appeal workload continues to rise, the combined overturn rate at the Board of Veterans' Appeals continues to be extremely high. From these results, it appears that, despite having spent millions on its adjudicator-training program, this effort has not succeeded in correcting the many problems that contribute to poor quality decisionmaking and create unnecessary appellate work. Rather than providing a solution to the problem, the deficiencies in training and the lack of effective quality assurance continue to fuel the growing backlogs.

APPEALS MANAGEMENT CENTER

As a result of a successful legal challenge to the establishment of a unit at the Board of Veterans' Appeals (Board or BVA) to undertake needed development of appeal cases, VBA established the AMC. Its purpose is to provide more expeditious action on remands and also to relieve the regional offices of the workload burden associated with remands. The AMC basically functions as a national regional office for this type of case. It undertakes the additional development of evidence specified by the Board and readjudicates the claim. With a staff of 82 FTEs the AMC is overwhelmed by a growing volume of cases. Initially, 16,484 cases were inherited from the now-defunct BVA development unit and, currently, the AMC has a total of 22,002 remands under development. As a result, VBA recently established AMC resource centers in St. Petersburg, Cleveland, and Huntington to assist with its enormous backlog. Although it is too early to comment on the productivity or quality of work produced by these resource centers, questions remain as to the AMC 's overall ability to produce quality and timely work in the face of the continually increasing backlog and the growing pressure to reduce it.

While the AMC is an admirable attempt by VBA to improve service to veterans, it does nothing to address the problems underlying the continued rise in the number of appeals and remands by the Board of Veterans Appeals. In our view, the very necessity of the AMC's existence begs the question—why hasn't VBA mandated the regional offices to correct their own mistakes?

This new super regional office is now responsible for correcting errors that the regional offices were unwilling or unable to do. However, the AMC has no authority to prevent the same type of error, which prompted the appeal and remand, from occurring again. It is worth noting that regional offices did not receive any work credit for remand actions. This should have been an incentive for local management to try and improve decisionmaking and avoid appeals and potential remands. Experience has shown just the opposite.

Since production work on new claims were the highest priority and there was no work credit for remands, many regional offices simply ignored their appellate workload with remands pending for two and 3 years. Now, there is still no clear incentive for the regional offices to improve quality. They are continuing to forward new cases to the Board where almost sixty percent are being remanded to the AMC. VBA must ensure that the regional offices are held accountable for the poor quality of initial decisionmaking and development of appeals and not allow them to shift the workload onto the Board of Veterans Appeals and, ultimately, the AMC.

BOARD OF VETERANS' APPEALS

The BVA is a separate entity within VA. Its responsibility is to render a final decision on the propriety of a regional office decision. If the Board determines a final decision cannot be made on a case due to inadequate or incomplete development, including lack of due process, it has the authority to remand the case back to agency of original jurisdiction, which now includes the AMC, for additional required development and readjudication.

Regional office appeals and dispositions by the Board are a direct reflection of the level of claimant satisfaction or dissatisfaction with and confidence or lack thereof in the fairness and propriety of regional office adjudication. It is, therefore, painfully obvious that the level of dissatisfaction is substantial and growing, in view of the increasing number of new appeals coming into the system.

To ensure VA and VBA are meeting their responsibilities; The American Legion strongly believes that Congress must scrutinize VBA's budget requests more closely. Given current and projected future workload demands, regional offices clearly will need more rather than fewer personnel and The American Legion is ready to support additional staffing. However, VBA must be required to provide better justification for the resources it says are needed to carry out its mission and, in particular, how it intends to improve the level of adjudicator training, job competency, and quality assurance.

Mr. Chairman, this concludes my testimony. I again thank the Committee for this opportunity to express the views of The American Legion on VA's fiscal year 2006 Budget Request and look forward to working with you and the Members of the Committee to ensure VA is funded at a level that will allow all veterans to receive the care they have earned through their service.

Chairman CRAIG. Peter, thank you for being cognizant of that time. Of course, all of your full statements will be a part of the record. Thank you.

Please proceed.

Mr. FULLER. I believe I am next, Mr. Chairman.

Chairman CRAIG. That is right.

STATEMENT OF RICHARD B. FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. FULLER. I am Richard Fuller. I am National Legislative Director of the Paralyzed Veterans of America.

Chairman CRAIG. Yes.

Mr. FULLER. And, Mr. Chairman, and Senator Akaka, in the 19 years since The Independent Budget was published, Paralyzed Veterans of America has coordinated the medical care portion, and I will confine my remarks to that particular area.

The overview of the Administration's 2006 budget request provides very little, if any, new appropriated dollars for the VA health care system, I think as you have pointed out, Mr. Chairman. It relies on overly optimistic third-party collections, accounting gimmicks, and punitive and totally unrealistic management efficiencies to drive its budget figures. The Independent Budget, using a clear assessment of the coming need and rising costs of health care, projects that VA will need a $3.4 billion increase in fiscal year 2006. At 12 percent, this increase is actually below the 13 or 14 percent the previous Under Secretary for Health testified before

the House Veterans' Affairs Committee that he needed just to keep the system afloat.

In the interests of time, I would like to make three points: for the last 2 years, the Members of this Committee, its counterpart in the other body and likewise the appropriations committees have realized that both the $250 user fee and a $15 prescription co-pays were unduly onerous to the veteran patients and were rejected, and I would like, instead of just referring to them as category 7s or 8s, try to put a human face on exactly who these people are, and I think if you look at the figures, this would affect 2 million currently enrolled veterans.

And the statement is made, oh, well, do not worry; it is only category 7s and 8s, but it is not. What they are not telling you is that there are veterans who are enrolled in category 4, who have catastrophic disabilities, many of them PDA members with spinal cord injuries who need to go to the VA because the VA is the only place that they can get the specialized care that they need who are enrolled in category 4, but VA makes the determination because these people with severe disabilities are able to get out there and try to work and earn a living to support themselves and their family and not stay home and live on the dole, have incomes that might rise above $25,000 or $30,000.

And these individuals have to pay all the co-payments, have to pay all the fees for outpatient, inpatient visits and would be severely affected by this increase in fees, because they are high-end users of the system: multiple prescriptions, multiple supplies, multiple equipment. So it is not just category 7s and 8s that they are talking about, and we urge the Committee to reject these proposals.

Second, the effect of the proposed drastic reductions in long-term care funding would be catastrophic. Eliminating the traditional per diem contribution to support the vast majority of veterans in State nursing homes, as Senator Obama pointed out, could very well force the closure of many of these homes. Reductions in contract nursing homes and VA's own nursing home capacity will put many sick and disabled veterans actually out on the street, not necessarily back in home care.

I know, Mr. Chairman, from your work in the Select Committee on Aging that you are well aware of the long-term care problems facing Americans today. And fortunately, the VA has always developed an enlightened and innovative long-term care program that could stand as an example to the rest of the Nation. This attack on these programs would severely damage the long-term care safety net the VA has provided, and with proposed changes and reductions in Medicaid coming down the pike in the 2006 budget, many veterans would have nowhere else to turn.

And finally, Mr. Chairman, it is true, as has been stated several times here today, that the Congress in recent years has rightly understood the demands on the VA health care system and provided additional resources. But you cannot just turn off the tap and say look what we did for you last year. VA is an ongoing health care provider. Yet, it is forced every year to start with a clean budget slate in the competition for discretionary dollars. The needs do not change; the demands do not change; but as we see with this year's budget request, political pressures, the demands of other Federal

programs and deficit concerns can drastically alter the amount requested and provided for VA health care programs from 1 year to the next.

These wild swings in funding from 1 year to the next make managing a health care system extremely difficult, and for these reasons and others, we continue, as we have in the past, to urge the Congress to provide a guaranteed funding plan mechanism to cover the cost of veterans health care.

This concludes my remarks, and I would be happy to answer any questions you may have.

[The prepared statement of Mr. Fuller follows:]

PREPARED STATEMENT OF RICHARD B. FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and Members of the Committee, as one of the four veterans services organizations publishing The Independent Budget, Paralyzed Veterans of America (PVA) is pleased to present the views of The Independent Budget regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for fiscal year 2006.

This is the 19th year, PVA, along with AMVETS, Disabled American Veterans and Veterans of Foreign Wars have presented The Independent Budget, a policy and budget document that represents the true funding needs of the Department of Veterans Affairs. The Independent Budget uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year, the document is endorsed by 26 veterans' service organizations, and medical and health care advocacy groups.

This fiscal year 2006 budget request for health care is a shocking one, providing once again a woefully inadequate funding level for sick and disabled veterans. The Administration request of $27.8 billion amounts to an increase of $111 million in appropriated dollars—less than one-half of 1 percent over the amount provided in fiscal year 2005. Last year's request was the smallest health care appropriation request in nearly a decade. This year's request is even lower. Health care is not a luxury, but this budget request treats it like it is. Keep in mind that the VA itself has testified in the past that it requires a "13 or 14 percent per year increase in the money available to take care of just our core population of veterans." (Department of Veterans Affairs Health Care System: Hearing Before the House Committee on Veterans' Affairs, 108th Congress, January 29, 2003).

In place of dollars we are presented with a budget that relies far too heavily on gimmicks, accounting tricks, and on forcing some veterans to pay for the health care of other veterans. Shifting costs onto the back of other veterans is not the way to fulfill this Nation's responsibilities to veterans. Once again, the Administration has proposed a $250 annual enrollment fee, and increased pharmaceutical co-payments, ideas soundly rejected in the past by Congress. The budget also estimates that the VA will find $590 million in management efficiencies, requiring major cutbacks in personnel and services at VA hospitals across the country. Last year, VA estimated "savings" of $340 million. Absent a detailed list or plan to achieve these savings, we can only assume that these are only included to mask the true extent of the funding chasm faced by the VA in the upcoming fiscal year.

Punitive co-payments, enrollment fees, and other charges are designed not so much to raise revenues as they are meant to deter veterans from seeking their care at VA medical facilities. The VA estimates that its enrollment fee and co-payment proposals will cause more than 213,000 veterans to disenroll. In fact, if this budget submission is enacted, the VA expects enrollment to drop by nearly one-million veterans, a decrease of 12 percent, during fiscal year 2006. This is not a lean budget, rather, it is a budget designed to strangle a health care system relied upon by sick and disabled veterans.

The Independent Budget is adamantly opposed to increasing co-payments. Veterans should not be forced to pay for the health care of their fellow veterans. Although Congress has given the Secretary of Veterans Affairs the authority to set and raise fees, what was once thought of as only an administrative function has now become, in times of tight budgets, an expedient way to find the dollars needed to fund health care for veterans. Providing health care to veterans is a Federal responsibility, and we look to Congress to provide the necessary resources to provide this care.

If this budget tells veterans that they better not get sick, what is it telling to veterans in need of long-term care? Although the true extent of the VA's cuts to long-term care may be difficult to fully discern, it is clear that this budget would gut long-term care, and violate the VA's statutory responsibility to maintain the capacity to provide long-term care.

The VA has proposed zeroing out grants for the construction of State extended care facilities, while slashing the per diem grants it provides State homes by $229 million, a loss of revenue that could very well lead to closures in certain circumstances. The VA estimates that close to 30,000 fewer veterans will be treated under its proposals. The VA proposes $124 million in cuts by "revising" eligibility criteria for long-term care. In the VA's budget submission in a chart summarizing obligations by activity, nursing home care is shown as being cut by $351 million, and it is estimated that the VA's proposed budget would eliminate 5,000 nursing home beds. These cuts would have a drastic effect on some of our neediest veterans.

It is clear that the Administration's budget does not begin to meet the health care needs of veterans, nor does it reflect the resources needed by the VA to provide this care. We believe that The Independent Budget provides a conservative estimate that more accurately represents the needs of the VA.

For fiscal year 2006, we are recommending a total appropriation for medical care of $31.2 billion, an increase of $3.5 billion. This reflects an increase of close to 13 percent. This estimate does not include funds attributed to MCCF, which we believe should be used to augment a sufficient appropriated level of funding and not used to replace appropriated dollars.

The VA health care system, in order to fully meet all of its demands and to ameliorate the effects of chronic under-funding, could use many more dollars. The Independent Budget recommendation provides for the impact of inflation on the provision of health care, and mandated salary increases of health care personnel. It would provide the resources to begin to meet the demands of specialized services and programs, as well as the ever-increasing influx of new veterans entering the system. It is estimated that of the more than 168,000 Iraq veterans who are no longer on active duty, sixteen percent have sought VA health care. The full impact of the 2-year grant of priority health care for these veterans is yet to be fully felt. We also believe that The Independent Budget recommendation, if enacted, would allow the VA to begin enrolling Category 8 veterans once again.

For Medical and Prosthetic Research, The Independent Budget is recommending $460 million. This represents a $58 million increase over the fiscal year 2005 amount. The Administration has proposed a $9 million cut. Research is a vital part of veterans' health care, and an essential mission for our national health care system.

In closing, the VA health care system faces two chronic problems. The first is a budget submission that ignores the costs of providing care while advocating draconian health care rationing. The second is a lack of consistent funding. The budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of not only how much money it is going to get, but, equally important, when it is going to get it. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they need them. Far too often veterans' funding is the subject of an omnibus bill that is enacted months after the start of the fiscal year.

Health care delayed is health care denied. If the health care system cannot get the funds it needs when it needs those funds the resulting situation only fuels efforts to deny more veterans health care and charge veterans even more for the health care they receive.

The only solution we can see is for this Committee and the Congress as a whole to approve legislation removing VA health care from the discretionary side of the budget process and making annual VA budgets mandatory. The health care system can only operate properly when it knows how much it is going to get and when it is going to get it.

We look forward to working with this Committee in order to begin the process of moving a bill through the Senate, and the House, as soon as possible.

It is easy to forget, when dealing with dollars and budgets, that we are ultimately dealing with real people, people who will be affected personally by the cuts and so-called "savings" proposed by this Administration. We ask that you remember these men and women, these veterans who have sacrificed so much for us, when you are drawing up 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 CRAIG. Thank you very much.
Joe.

STATEMENT OF JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. VIOLANTE. Mr. Chairman and Members of the Committee, good morning. I am Joe Violante with Disabled American Veterans, and Mr. Chairman, Senator Akaka, let me say congratulations to both of you for your leadership roles and promise you that we will work with you and your staff this year to ensure that our Nation's disabled veterans and other veterans are cared for.

As with DAV's primary responsibility in The Independent Budget, I will address mainly the recommendations for the benefit programs. This year, in the President's budget, the only legislative proposal is for a COLA, a 2.3 percent COLA increase. We certainly support that. I will not attempt to cover those other items in The Independent Budget where we have made recommendations to other programs. I will just ask the Committee and the staff to refer to my written testimony and to The Independent Budget for the specifics and the reasons for those recommendations.

Though our benefit programs mostly just need some fine tuning to make them better serve their purposes, persistent problems with the delivery of benefits diminish their effectiveness. I am concerned under general operating expenses that since we began our war in Iraq in 2003, VA has lost roughly about 600 full time employees from the Veterans Benefits Administration if the proposals in this year's budget go through.

We are a Nation at war. We have another generation of brave young men and women fighting in Iraq and Afghanistan, not only to protect our freedoms and guarantee our safety, but to bring freedom to other people around the world. Every day, some of these men and women return to this country sick, disabled, some severely disabled, and I do not believe that this budget is adequate to care for their needs.

It is interesting to note in the dialog that took place with the Secretary and the line of questioning that the Secretary indicated with Senator Murray's questioning that this budget will be a challenge, and what I would like to say, if VA is challenged in meeting the demands, what that means for veterans and their families is that their health and well-being is placed at risk. It is unconscionable that we have dedicated VA employees who are on the front line providing care and services to veterans and have to, because of shortfalls in resources, tell these veterans, in many cases fellow veterans that there is just not enough money to take care of their needs.

Within a month or two of the recent passage of the 2005 appropriations, we have seen stories from around the country of shortfalls in medical facilities, in hiring freezes, in cutbacks in services. If that is the case with the 2005 appropriations that increased 2004 by $1.5 billion, I hate to see what is going to happen if something is not done with the current budget proposal.

Senator Thune has indicated that since he came to Congress as a Representative, VA budget has increased annually by about 9 percent. As Mr. Richard Fuller pointed out, VA has indicated that they need 13 to 14 percent annually, so we are losing ground there. If the proposals that are contained in this budget go through, such as the enrollment fees and increased co-pays, what we are doing is forcing the VA to treat the sickest of the sick and the poorest of the poor, and that is going to affect the quality of care, and as you pointed out, Senator, in that article, the quality of VA health care has improved greatly, but I think we place it at risk if we follow this current proposal.

And if we are trying to be fiscally-minded and ensure that taxpayers' money is used properly, I will just remind you that the cost of care at VA is a lot less than when we force these Medicare-eligible veterans out into the Medicare system or into Medicaid.

I want to thank you, and again, we will work with you to assure that there is adequate funding and these programs are properly staffed.

[The prepared statement of Mr. Violante follows:]

PREPARED STATEMENT OF JOSEPH A. VIOLANTE,
NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee, I come before you today to present the views of the Disabled American Veterans (DAV) and its Auxiliary on the President's fiscal year (FY) 2006 budget for veterans' programs. In addition to our assessment of the President's budget recommendations, I will also provide the Committee with our own budget and program recommendations as contained in The Independent Budget (IB). The IB is a budget and policy document that sets forth the collective views of the DAV, AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW).

The budget for veterans' programs, and therefore this hearing, is one of the most important activities of the Committee. In our view, this Committee has some of the most important responsibilities of any in Congress. Before discussing the budget, I want to congratulate you, Senator Craig, on your selection as Committee Chairman, and you, Senator Akaka, on your selection as Ranking Member. DAV's staff and members look forward to our work and association with you.

The President's fiscal year 2006 budget requests $70.8 billion in budget authority for the Department of Veterans Affairs (VA). This total consists of $37.4 billion for mandatory spending in the benefit programs and $33.4 billion for discretionary funding. The mandatory funding includes $478.3 million to cover the 2.3 percent cost-of-living adjustment (COLA) the budget recommends for disability compensation. The discretionary funding includes $30.7 billion for veterans' medical care, of which $2.6 billion would be from projected co-payments, enrollment fees, and other collections. The remaining $2.7 billion in discretionary funding would cover general operating expenses, some construction costs, and medical research.

The President's budget seeks no improvements in the benefits programs other than an annual COLA for compensation. Based on a projected increase in the cost of living as measured by the Consumer Price Index, disability compensation, as well as dependency and indemnity compensation (DIC) and the annual clothing allowance, also included in the compensation account, would be increased 2.3 percent. Increases in monthly benefits for compensation and DIC would be effective December 1, 2005. As we observe in the IB, these benefits must be adjusted periodically to keep pace with inflation. Veterans whose earning power is limited or completely lost due to service-connected disabilities must rely on compensation for the necessities of life. Similarly, surviving spouses and dependent children of veterans who died of service-connected causes often have little or no income other than DIC. The rates are modest, and any erosion due to inflation has a direct detrimental impact on recipients with fixed incomes. We therefore recommend in the IB and support the Administration's recommendation that Congress enact legislation to increase the rates of these benefits.

In the IB, we also recommend that Congress reject any suggestion or move to permanently extend provisions that, for the next several years, require rounding down

of compensation COLAs to the nearest whole dollar amount. Congress has historically increased disability compensation and DIC rates each year to keep these benefits even with the cost of living. However, as a temporary measure to reduce the Federal budget deficit, Congress enacted legislation to require monthly payments, after adjustment for increases in the cost of living, to be rounded down to the nearest whole dollar amount. Finding this a convenient way to meet budget reconciliation targets and fund spending for other purposes, Congress seemingly has become unable to break the habit of extending this round-down provision and has extended it even in times of budget surpluses. Inexplicably, VA budgets have recommended in previous years that Congress make the round-down requirement a permanent part of the law. While rounding down compensation rates for 1 or 2 years may not seriously degrade its effectiveness, the cumulative effect over several years will substantially erode the value of compensation. Moreover, extended rounding down is entirely unjustified. It robs monies from the benefits of some of our most deserving veterans and dependents, who must rely on their modest compensation for basic needs.

In the IB, we make several other recommendations for legislation to improve the compensation program, and we take positions against certain detrimental proposals that have been offered or entertained in the past. We recommend adjustments in the grants for specially adapted housing and home adaptations provided to certain veterans with the more serious service-connected disabilities. Similarly, we recommend an increase in the grant for purchase of specially equipped automobiles provided to veterans with service-connected disabilities that require certain adaptations. Due to a lack of regular adjustments for inflation, these special benefits have lost much of their value. We recommend legislation to authorize use of modern mortality tables in setting premium rates for Service-Disabled Veterans' Insurance (SDVI). The intended benefit of offering life insurance to disabled veterans at standard rates is defeated by the continued use of 1941 mortality tables as a basis for premiums. We recommend that Congress increase the $10,000 maximum to $50,000 for SDVI policies to more meaningfully correspond to today's income replacement needs of survivors. We also recommend improvements for the education, vocational rehabilitation, and home loan programs. We ask the Committee to refer to the IB for these recommendations and give them full consideration.

The administrative expenses for the benefit programs are included in the discretionary funding for the VA's Veterans Benefits Administration (VBA), which together with funding for Departmental Administration, traditionally made up the General Operating Expenses (GOE) appropriation. Because Congress has resisted adopting the new budget account structure for VA employed in the President's budget beginning with fiscal year 2004, we continue to observe in the IB the traditional account structure under GOE.

The level of funding sought in the President's budget would reduce VBA staffing again for the third consecutive year. In fiscal year 2006, VBA would have 76 fewer fulltime employees (FTE) under the President's budget than it had in fiscal year 2005, and 539 fewer than it had in fiscal year 2003. Even this net reduction of 76 FTE does not present a true picture of the impact of the President's budget because it would cannibalize other benefit lines to partially alleviate critical staffing shortages in the Compensation and Pension (C&P) and Vocational Rehabilitation and Employment (VR&E) Services. Loan Guaranty Service would lose 205 FTE, Education Service would lose 14 FTE, and Insurance Service would lose 6 FTE.

According to the "Budget Highlights" in the President's Budget Submission, one of VA's highest priorities is to "[i]mprove the timeliness and accuracy of claims processing." The Budget Submission states: "Funds are included in the Veterans Benefits Administration to sustain progress made under the Secretary's priority of improving timeliness and accuracy of claims." We assume the intent was to say that the funds requested are sufficient to continue the course of improving claims processing timeliness and accuracy. In another statement, the Budget Submission declares: "As a Presidential initiative, improving the timeliness and accuracy of claims processing remains the Department's top priority associated with our benefit programs." However, it appears that this budget abandons efforts to improve on the intolerable situation in which VA has large backlogs of pending claims and in which benefits awards to veterans are delayed as a consequence. The Budget Submission for fiscal year 2004, for example, set a goal of reducing the average processing time for compensation and pension claims from a projected 165 days in fiscal year 2003 to 100 days in fiscal year 2004, with a strategic target of 90 days. The Budget Submission for fiscal year 2005 set a goal of reducing the average processing time for compensation and pension claims from a projected 145 days in fiscal year 2004 to 100 days in fiscal year 2005, with a strategic target of 90 days. The fiscal year 2006 Budget Submission revises these figures to show that average was actually 166 days

in fiscal year 2004, that the time will be reduced to 145 days in fiscal year 2005, and that the goal for fiscal year 2006 is also 145 days. The strategic target has been increased from 90 days to 125 days. This demonstrates that the resources requested are insufficient to meet a goal that VA portrays as a "top priority." These figures call into question the genuineness of this stated goal.

The IB has recommended that C&P Service be authorized 8,929 FTE, the fiscal year 2004 staffing level. In addition, C&P Service had 174 FTE for adjudication of burial benefit claims, making the fiscal year 2004 total 9,103 FTE. The President's budget requests 9,087 FTE for C&P. While this is an increase over the 8,959 FTE authorized for fiscal year 2005, the failure to meet timeliness goals demonstrates that the President's request for fiscal year 2006 is insufficient. At a minimum, C&P Service should be authorized 9,103 FTE.

For Education Service, the IB recommended staffing of 770 direct program FTE, an increase of 33 FTE over the fiscal year 2005 staffing level. As it has with its other benefit programs, VA has been striving to provide more timely and efficient service to its claimants for education benefits. However, with the inability to hire new employees during fiscal year 2004, Education Service timeliness in processing original and supplemental education claims declined during fiscal year 2004. In addition, legislation authorizing a new education benefit for members of the National Guard and Reserve pressed into active service for 90 or more days will add to the existing workload during fiscal year 2005 and future years, making it even more difficult to address the education caseload in a timely manner. In fiscal year 2003, the average time to process original education claims was 23 days. The strategic target was 10 days. The Budget Submission estimates that the average time to complete original education claims in fiscal year 2006 will have grown to 27 days. Without an increase in staffing adequate to meet the existing and added workload, service to veterans seeking educational benefits will continue to decline. The President's budget would reduce direct program FTE from 737 in fiscal year 2005 to 717 in fiscal year 2006. The President requests 53 fewer FTE than the IB recommends. Based on experience with the average number of claims decisions a claims examiner can process and the average number of telephone and Internet contacts an employee can handle, to meet its workload demands in a satisfactory fashion, VBA must increase direct program staffing in its Education Service in fiscal year 2006 to 770 FTE.

For VR&E Service, the President's budget seeks funding for 963 direct program FTE. The IB recommends 1,017 direct program FTE for this business line. During fiscal year 2005 and continuing into fiscal year 2006, VR&E's workload is expected to increase primarily as a consequence of the war in Iraq and ongoing hostilities in Afghanistan. Also, given its increased reliance on contract services, VR&E needs approximately 60 additional FTE dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA Vocational Rehabilitation and Employment Task Force recommended in its March 2004 report the creation of new staff positions and training for this purpose. Other new initiatives recommended by the Task Force also require an investment of personnel resources. To meet its increasing workload and implement reforms to improve the effectiveness and efficiency of its programs, it is projected that VR&E will need a minimum of 1,017 direct program FTE in fiscal year 2006, 54 more than the President requested.

The IB recommends funding for continued development and deployment of modern information technology (IT). The President's budget appears to have abandoned many of VA's IT initiatives. We recommend that Congress provide $4 million for predeployment testing of new IT applications at VA's Hines Information Technology Center. Automated testing of new IT at the Hines test center avoids diverting field office staff from their regular duties to test the new applications and avoids the pitfalls of deploying untested software to VA field offices. We recommend $1 million for training to keep VA's IT staff abreast of changes in IT systems.

For new subsystems in C&P Service to be integrated into VETSNET, we recommend that Congress provide $12 million. To continue document preparation and scanning at VA's pension maintenance centers and to continue evaluating VA's electronic imaging system, "Virtual VA," for eventual nationwide deployment, we recommend an appropriation of $2 million in fiscal year 2006.

We recommend that Congress provide $2 million to cover the costs of necessary enhancements of Education Service's Imaging Management System (TIMS). TIMS is Education Service's system for electronic education claims files, storage of imaged documents, and workflow management. VA needs to consolidate four separate TIMS data bases into one data base accessible by the Internet and add capacity to meet increased workload demands. This will make the system fully interactive nationwide and will include the critical additional capacity necessary for continued viability of the system.

To allow for more efficient award processing and sharing of information with contractors, employment services, and outside partnership entities by deploying a Web-based version of VR&E's case management system, WINRS, we recommend that Congress provide $3 million. To allow it to receive enrollment information from schools and to enable it to have online contact between veterans and case managers, we recommend that VR&E be provided $2 million for its "Internet Application" initiative.

We recommend a $2 million appropriation for upgrading and expansion of the "Loan Servicing System" to allow claimants direct access to Loan Guaranty Service's Automated Certificate of Eligibility application. As we noted, the President's budget would reduce staffing in Loan Guaranty Service by 205 FTE in fiscal year 2006. An annotation to budget briefing documents provided to congressional staff and veterans organizations states: "FTE decreases are offset by productivity improvements such as information technology, training, management efficiencies, etc." Yet the President's budget provides no money to allow claimants access to an Automated Certificate of Eligibility, an initiative that would be consistent with some reduction of FTE. Experience would suggest that management efficiencies can only be quantified accurately and can only be counted on to increase productivity after they have been attained. It appears that when requested resources fall short of what is necessary to meet workload demands, VA simply declares that it can achieve management efficiencies in the amount of savings necessary to fill the obvious gap between resources needed and appropriations requested. In short, the amount of savings projected appears to correspond to the funding shortfall rather than being derived from any actual calculation based reasonably on expected new efficiencies.

In connection with the funding request for medical care, the President's budget assumes savings of $590 million in management efficiencies. Again, we believe such a convenient assumption is unjustified. As another means to bridge the gap between the resources requested and the resources necessary, the budget would shift the shortfall onto veterans themselves. It would impose a $250 annual enrollment fee for "all" Priority 7 and 8 veterans. It would increase pharmacy co-payments to 214 percent of the current amount, from $7 to $15. A veteran would be required to pay this co-payment on each of his or her prescriptions for a 30-day supply of medications. Such user fees are nothing more than a disguised tax upon veterans' benefits. In addition, the budget would continue the suspension of enrollment of new Priority 8 veterans.

These initiatives would accommodate lower appropriations by bringing revenues from collections into the system, by driving large numbers of veterans away from VA, and by preventing any growth in patient load from priority 8 veterans. VA projects that the enrollment fee and higher co-payments will increase collections by $424 million and repulse 213,000 veterans from the VA medical care system. Assuming all of these changes, the fiscal year 2006 budget would provide for the Veterans Health Administration only a 2.41 percent increase over fiscal year 2005 budget authority in constant, or nominal, dollars. Appropriated dollars would account for only 0.4 percent of this increase. According data in the Budget Submission, VA experienced a 4.1 percent growth rate in patients treated in fiscal year 2004, and VA projects a 7 percent growth of enrollees between fiscal years 2004 and 2006. The Budget Submission for VA states that it includes policy changes to "assure sufficient resources" are available to continue to provide care to all enrolled veterans.

We often hear Government officials repeating Lincoln's words to communicate its solemn mission, "to care for him who shall have borne the battle. . . ." Many veterans in Priority Groups 7 and 8 have borne the battle with the good fortune not to be wounded, and some have service-connected disabilities, but this budget does not care for them. It employs verbal extenuation to masquerade as an honorable and positive action its efforts to abandon these veterans and drive them from the system. The Budget Submission for VA states that the budget supports a continued focus on health care needs of VA's "core group of veterans." Unlike Lincoln's positive words urging the Nation to honor its moral obligation to veterans, this statement of exclusion seeks to disavow the Nation's obligation for political expedience. A medical care system that treats only the sickest of the sick and the poorest of the poor is not sustainable and would be undesirable. Such restricted focus would in the end seriously erode the quality of care for today's and tomorrow's veterans.

Though we wanted to express our concerns about the glaring inadequacy and obvious bad policy of this budget for veterans' medical care, we will defer to our partners from PVA to present more specifically the IB's views and recommendation of mandatory funding for veterans' medical care. To avoid unnecessary duplication, we also defer to our IB colleagues from AMVETS and the VFW to cover the budget for the National Cemetery Administration and construction.

We should not forget veterans in times of peace following conflicts, but this is certainly a time that our national commitment to veterans should be at its highest, a time that providing adequately for them should be foremost in the minds of Members and on the agenda of Congress. This budget does not provide adequately for veterans programs. We urge this Committee and Congress to correct its deficiencies and fulfill our commitment to veterans.

Chairman CRAIG. Thank you, Joe.

STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Good morning, Chairman Craig, Senator Akaka. I am Dennis Cullinan. I am the Legislative Director for the Veterans of Foreign Wars of the United States, and we, too, look forward to working together with you in the service of America's veterans.

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars and our auxiliaries, I would express our deep appreciation for being included in today's important hearing to discuss the budget for the Department of Veterans Affairs. As a constituent member of The Independent Budget for VA, the VFW is responsible for the construction program, so I will limit my testimony to that area. Also, for the purpose of today's discussion, I will limit my discussion to two main areas: CARES and long-term care.

In light of the Administration's totally inadequate budget request for VA, the VFW and the IB VSOs are very concerned that Congress may not adequately fund all of CARES proposed changes when CARES implementation costs are factored into the appropriations process. This will only further worsen current obstacles impeding veterans timely access to quality health care. It is our opinion that VA should not proceed with the final implementation of CARES until sufficient funding is appropriated in a separate account for the construction of new facilities and renovations of existing hospitals as deemed appropriate and pertinent.

Supporting this view is the fact that the Administration budget would pull $539.8 million out of major construction and $160 million out of minor construction for their total funding of $699.8 million for CARES. This would mean that there is no appropriations support for non-CARES projects. It defies credibility and good reason that VA will suspend all non-CARES related construction projects to include essential, non-recurring maintenance, seismic corrections and so forth.

So clearly, both will receive short shrift, and the system and veterans will suffer in the process. And it is for this reason, that we urge CARES be funded separately, to provide sufficient funding and to avoid the temptation to engage in this budgetary sleight of hand. The VFW and IB VSOs recommend that Congress appropriate, not including funding specific to CARES, $563 million for major construction account for fiscal year 2006.

This amount is needed for seismic corrections, clinical environmental improvements, National Cemetery Administration construction and land acquisition. The VFW and the IB further recommend that Congress appropriate $716 million to the minor construction account for fiscal year 2006. These funds contribute to construction projects costing less than $7 million. This appropriation also pro-

vides for regional office account, the National Cemetery Administration account, improvements and renovation in VA's research facilities, staff office accounts and emergency fund accounts, increases provided for inpatient-outpatient care and support infrastructure, physical plant, and historic preservation projects.

With respect to long-term care, we are equally dismayed. The budget proposes slashing $351 million from veterans nursing homes by serving 28,000 fewer residents and completely eliminating the $104 million in State grants. It would also provide, as has already been mentioned, per diem support only to those categories 1, 2 and 3. This would have a devastating consequence for veterans in need of long-term care and for the State long-term care program itself. We would also note here that the VA also intends to downsize its own long-term care bed census at this very juncture.

VA has an obligation to provide for the full continuum of care for those who served this country, and long-term care is an essential part of this. This budget abdicates this responsibility.

We look forward to working with you, Mr. Chairman, and the other Members of this Committee to come to the aid of this Nation's veterans in need and reject this proposal. That concludes my testimony.

[The prepared statement of Mr. Cullinan follows:]

PREPARED STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Committee, on behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. and our Auxiliaries, I would express our deep appreciation for being included in today's important legislative hearing to discuss the budget for the Department of Veterans Affairs (VA). As a constituent member of the Independent Budget for VA, the VFW is responsible for the Construction portion of the VA budget so I will limit today's testimony to that area.

The Department of Veterans Affairs (VA) construction budget includes major construction, minor construction, grants for construction of State extended-care facilities, grants for State veterans' cemeteries, and the parking garage revolving fund. VA's construction budget annual appropriations for major and minor projects decreased sharply to an all-time low in fiscal year 2003. Over the past several years, there has been political resistance to funding of any major projects before the Capital Assets Realignment for Enhanced Services (CARES) process was completed. The prospect of system-wide capital assets realignment through the CARES process continues to be used as an excuse to hold all construction projects hostage.

VA has recently completed another phase of CARES, which is a national process to reorganize the Veterans Health Administration (VHA) through a data-driven assessment of its infrastructure and programs. Through CARES, an ongoing process, VA is evaluating the demands for health-care services and identifying changes that will help meet veterans' current and future health-care needs. The CARES process included the development of sophisticated actuarial models to forecast tomorrow's demand for veterans' health care and the calculation of the supply and identification of current and future gaps in infrastructure capacity. This resulted in a Draft National CARES Plan (DNCP) to rectify deficiencies through the realignment of VA's capital asset infrastructure.

Since the publication of the fiscal year 2005 Independent Budget, the commission has been actively evaluating the DNCP proposed by VA. The CARES Commission report was published in March 2004. The Secretary of Veterans Affairs formally accepted the CARES Commission report with the publication of the Secretary's CARES decision document in July 2004.

Initially, the DNCP market plans included flawed projections for outpatient mental health services and questionable projections for inpatient mental health services. The plans did not include any projections for long-term care other than catastrophic care. Accordingly, the commission recognized the importance of mental health services and long-term care to the veteran population and acknowledged in the CARES

Commission report that VA must make modifications to its projections to include mental health services and long-term care.

Also last year, during the initial stages of the CARES process, The Independent Budget veterans service organizations (IBVSOs) suggested that further data be obtained to support various CARES recommendations that would either close or change the mission of some VA facilities. We appreciate then Secretary Principi's efforts in establishing a CARES Implementation Board and the plan to begin further feasibility studies of the 22 VA facilities identified for possible mission adjustments in the secretary's CARES decision document. However, as stakeholders, we would like to remind VA that it is imperative that veterans service organizations remain involved in all phases of this new CARES study, which will be divided into three different segments: a health-delivery study, a comprehensive capital plan, and an excess property plan identifying new land usage or disposal.

Mr. Chairman, we remain supportive of the CARES process as long as the primary emphasis is on the "ES" portion of the acronym. We understand that the locations and missions of some VA facilities may need to change to improve veterans' access, to allow more resources to be devoted to medical care rather than to the upkeep of inefficient buildings, and to accommodate modern methods of health-service delivery. Accordingly, we concur with VA's plan to proceed with the feasibility study of the remaining 22 facilities contained in the Secretary's decision document.

In light of the Administration's totally inadequate budget request for VA, the IBVSOs are very concerned that Congress may not adequately fund all CARES proposed changes when CARES implementation costs are factored into the appropriations process. This will only further exacerbate the current obstacles impeding veterans' timely access to quality heath care. It is our opinion that VA should not proceed with the final implementation of CARES until sufficient funding is appropriated for the construction of new facilities and renovations of existing hospitals, as deemed appropriate and pertinent.

The VFW and IBVSOs recommend that Congress appropriate, not including funding specific to CARES, $563 million to the Major Construction account for fiscal year 2006. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition and claims, as follows:

Construction, Major Projects Recommended Appropriation

[FY 2006 Recommendation by type of service—Medical Program (VHA)]

	Dollars (in thousands)
Seismic Improvements	$315,000
Clinical Improvements	$26,250
Patient Environment	$10,500
Advance Planning Fund	$63,000
Asbestos Abatement	$63,000
National Cemetery Admistration	$85,050
Recommended Fiscal Year 2006 Appropriation	$562,800

The VFW and IBVSOs recommend that Congress appropriate $716 million to the Minor Construction account for fiscal year 2006. These funds contribute to construction projects costing less than $7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, staff offices account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects:

Construction, Minor Projects Recommended Appropriation

[FY 2006 Recommended by Type of Service—Medical Program (VHA)]

	Dollars (in thousands)
Inpatient Care Support	$136,000
Outpatient Care and Support	$105,000
Infrastructure and Physical Plant	$157,000
Research Infrastructure Upgrade	$52,000
Historic Preservation Grant Program	$21,000

Construction, Minor Projects Recommended Appropriation—Continued

[FY 2006 Recommended by Type of Service—Medical Program (VHA)]

	Dollars (in thousands)
Other	$26,000
Architectural Master Plans Program	$100,000
VBA Regional Office Program	$36,000
National Cemetery Program	$36,000
VA Research Facility Improvement and Renovation	$47,000
IB Recommended fiscal year 2006 Appropriation	$716,000

It is here painfully evident just how inadequate the Administration's VA construction request is as compared to the VFW/IB identified need:

	FY 2005	FY2006 Admin.	Difference Admin & 2005	FY2006 IB	Difference IB & Admin
Construction Programs					
Construction Major	455,130	607,100	151,970	562,800	-44,300
Construction Minor	228,933	208,726	-20,207	720,000	511,274
Grants for Extended Care Facilities	104,322	0	-104,322	150,000	150,000
Grants for Construction of State Vets Cemeteries	31,744	32,000	256	37,000	5,000
Subtotal, Construction Programs	820,129	847,826	27,697	1,469,800	621,974

It is equally and most painfully clear that long-term care for veterans is to bear the brunt of the proposed cutbacks in the budget, including the elimination of Federal spending on State-run homes that provide veterans with long-term care. The program, which dates back to the Civil War, received $104 million this fiscal year. The White House plan would also trim nursing home care by $351 million, which would eliminate approximately 5,000 beds in VA-run nursing homes. These cuts, at a time when demand for VA long-term care services is increasing on the rise with a rapidly aging veteran population, are unconscionable and absolutely reprehensible.

In another area, good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs—such as seismic correction, compliance with the Americans With Disabilities Act (ADA) and Joint Commission of Accreditation of Health Care Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES— VA's construction budget continues to be inadequate.

The Independent Budget for Fiscal Year 2005 cites the recommendations of the interim report of the President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF). That report was made final in May 2003. To underscore the importance of this issue, we again cite the recommendations of the PTF:

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only $246 million annually, a recapitalization rate of 0.64 percent of the $38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2 percent of plant replacement value for its entire facility infrastructure. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the Department of Defense adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

Mr. Chairman, the PTF also recommended that "an important priority is to increase infrastructure funding for construction, maintenance, repair and renewal from current levels. The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure."

The PTF goes on to state; "Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other

lifecycle components of maintenance and restoration. VA does not have a strategic facility focus, but instead submits an annual top 20–facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within four years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program."

The PTF articulates that VA must accomplish three key objectives: (1) invest adequately in the necessary infrastructure to ensure safe, functional environments for health-care delivery; (2) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and (3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

We of the IBVSOs concur with the provisions contained in the PTF final report. If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high-quality services in old and inefficient patient care settings.

Mr. Chairman and distinguished members of the Committee, Congress must ensure that there are adequate funds for the major and minor construction programs so the VHA can undertake all urgently needed projects.

I will here briefly articulate our view that in those instances where no impediment arises in providing veteran's care and services the extensive inventory of historic structures must be protected and preserved. VA's historic structures illustrate America's heritage of veterans' care, and they enhance our understanding of the lives of the soldiers and sailors who have shaped our country. Of the almost 2,000 historic structures VA owns, many are neglected and deteriorate further every year. These structures must be stabilized, protected, and preserved. As the first step in addressing this responsibility, VA must develop a comprehensive national program for its historic properties. Because most heritage structures are not suitable for modern patient care, the Capital Asset Realignment for Enhanced Services planning process did not produce a national preservation strategy. VA must undertake a separate initiative for this purpose immediately.

VA should inventory its historic structures, classify their current physical condition, and evaluate their potential for adaptive reuse by either the medical centers, local governments, nonprofit organizations, or private-sector businesses. To accomplish these objectives, we recommend that VA establish partnerships with other Federal departments, such as the Department of the Interior, and also with private organizations, such as the National Trust for Historic Preservation. Such expertise should prove helpful in establishing this new program. VA must also expand its limited preservation staffing.

For its adaptive reuse program, VA needs to develop models and policies that will protect historic structures that are leased or sold. VA's legal responsibilities, for example, could be addressed through easements on property elements, such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully assisted the Department of the Army in managing its historic properties.

We recommend that specific funds should be included in the FY 2006 budget to develop a comprehensive program with detailed responsibilities for the preservation and protection of VA's inventory of historic properties.

The last issue I will address here today is the view that VA should avoid the temptation to reuse empty space inappropriately. Studies have suggested that the VA medical system has extensive empty space that can be cost-effectively reused for medical services, and that one medical center's unused space may help address another's deficiency. Although these space inventories are accurate, the basic assumption regarding viability of space reuse is not.

Medical design is complex because of the intricate relationships that are required between functional elements and the demanding requirements of equipment that must be accommodated. For the same reasons, medical facility space is rarely interchangeable. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a second-floor space deficiency because there is no functional adjacency. Medical space has very critical inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care. In order to preserve these relationships, departmental expansions or relocations usually trigger "domino" effects on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Medical space's permanent features, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading cannot be altered. Different medical functions have different requirements based on these characteristics. Laboratory or clinical space, for example, is not interchangeable with ward space because of the need for different column spacing and perimeter configuration. Patient wards re-

quire natural light and column grids that are compatible with room layouts. Laboratories should have long structural bays and function best without windows. In renovation, if the "shell" space is not suited to its purpose, plans will be larger, less efficient, and more expensive.

Using renovated space rather than new construction only yields marginal cost savings. Build out of a "gut" renovation for medical functions is approximately 85 percent of new construction cost. If the renovation plan is less efficient or the "domino" impact costs are greater, the savings are easily lost. Remodeling projects often cost more and produce a less satisfactory result. Renovations are appropriate to achieve critical functional adjacencies, but they are rarely economical.

Early VA centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most hospitals have been consolidated into large, tall "modern" structures. Over time, these central towers have become surrounded by radiating wings with corridors leading to secondary structures. Many medical centers are built around prototypical "Bradley buildings." The VA rushed to build these structures in the 1940s and 1950s for World War II veterans. Fifty years ago, these facilities were flexible and inexpensive, but today they provide a very poor chassis for the body of a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to-floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts. The Bradley hospital's central core has a few small elevator shafts that are inadequate for vertical distribution of modern services.

Much of the current vacant space is not situated in prime locations, but is typically located in outlying buildings or on upper floor levels. The permanent structural characteristics of this vacant space often make it unsuitable for modern medical functions. VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved. Some space may be suitable for enhanced use. Some should be demolished. Each medical center should develop a plan to find suitable uses for its nonhistoric vacant properties.

VA should develop a comprehensive plan for addressing excess space in properties that are not suitable for medical or support functions due to its permanent characteristics or location.

Mr. Chairman and distinguished Members of this Committee, this concludes my statement and I will be happy to respond to any questions you may have.

Chairman CRAIG. Thank you.

Richard.

STATEMENT OF RICHARD JONES,
AMVETS NATIONAL LEGISLATIVE DIRECTOR

Mr. JONES. As co-author of The Independent Budget, AMVETS is pleased to give you our best estimates on the resources necessary to carry out a responsible National Cemetery Administration budget for the coming year. The members of the individual budget recommend Congress provide $204 million in fiscal year 2006 for the operational requirements of NCA, the National Shrine Initiative and the backlog of repairs. This is an increase of approximately $40 million above the Administration request.

The Independent Budget supports the Administration request for additional work force in the burial budget. The request would increase the work force by 13 percent over the current fiscal year. Additional employees and additional outside contracts are necessary to meet construction requests for new national cemeteries in Atlanta, Detroit, Miami, Oklahoma City, Pittsburgh and Sacramento.

The Administration's recommendation in the 2006 budget also contains $41 million of additional funding for land acquisition and related costs for six additional cemeteries authorized in last year's

Congress. It also recommends the provision of $19.5 million for expansion at Fort Rosecranz National Cemetery.

The Independent Budget supports the Administration's land acquisition and cemetery expansion requests. Accelerating cemetery construction will help answer the increasing number of families who seek VA for interment of their loved ones. But there are repair and upgrades needed also. Pursuant to past legislation, VA awarded some years ago a contract to the Logistics Management Institute to conduct an assessment of veterans burial needs.

One of their reports, entitled National Shrine Commitment, dealt with capital improvements needed at existing veterans cemeteries. It identified 928 restoration and repair projects estimated to cost approximately $280 million. The Independent Budget veterans service organizations recommend funding be accelerated to correct current issues. We all know that delayed maintenance results in exponential increases in the costs of repair. We need to attend to these as quickly as possible.

The members of The Independent Budget and more than 25 veterans and military groups who endorse the recommendations ask Congress to establish a five-year, $250 million program to restore and improve the condition and character of NCA cemeteries. In total, our funding recommendations represent a $40 million increase over the request of the Administration.

In addition, the State Cemetery Grants Program is a vital program. It has greatly assisted States in increasing burial services to veterans. We are very pleased to see that there are currently six new cemeteries under construction. One of these includes the construction of a cemetery in Boise, Idaho. The development of this cemetery in your home State, Mr. Chairman, is the last State in the Nation without a veterans cemetery. We look forward to completion of that cemetery.

The Independent Budget veterans service organizations also request Congress review a series of burial benefits that have seriously eroded in value over the past years. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973. The recommendations are, of course, contained in The Independent Budget, but I would like to highlight one matter: with the heightened interest in increasing servicemembers' death gratuity to $100,000 or more from the current level of $12,000, The Independent Budget veterans service organizations want you to recognize that deaths also result from military wounds and those wounds carried by veterans long after the last shot has been fired.

We therefore recommend a modest increase in the service-connected benefits from $2,000 to $4,000. That is one-third of what it used to be at $12,000, and a mere portion of what Congress is considering today for those killed in military service. The deaths sometimes result long after that last shot. This request would restore the allowance to its original proportion of burial expenses and tell veterans their sacrifice that they have given is appreciated and well-deserved.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Jones follows:]

PREPARED STATEMENT OF RICHARD JONES,
AMVETS NATIONAL LEGISLATIVE DIRECTOR

Chairman Craig, Ranking Member Akaka, and members of the Committee:

AMVETS is honored to join fellow veterans service organizations at this hearing on the VA's budget request for fiscal year 2006. My name is Richard A. Jones, National Legislative Director, and I am pleased to provide you our best estimates on the resources necessary to carry out a responsible budget for the fiscal year 2006 programs of the Department of Veterans Affairs. AMVETS testifies before you today as a co-author of The Independent Budget.

For over 19 years AMVETS has worked with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce a working document that sets out our spending recommendations on veterans' programs for the new fiscal year. Indeed, we are proud that over 40 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our Nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans must not be forced to wait for the benefits promised them. Veterans must be assured of access to high quality health care. Veterans must be guaranteed access to a full continuum of healthcare services, including long-term care. And, veterans must be assured burial in a State or national cemetery in every State.

It is our firm belief that the mission of the VA must continue to include support of our military in times of emergency and war. Just as this support of our military is essential to national security, the focus of the VA medical system must remain centered on specialized care. VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans healthcare system and to the advancement of American medicine.

In addition, the VA healthcare system is responsible for great advances in medical science, and these advanced benefits all Americans. The VHA is the most cost effective application of Federal healthcare dollars, providing benefits and services at 25 percent lower cost than other comparable medical services. In times of national emergency, VA medical services can function as an effective backup to the DoD and FEMA.

Noting the mission of the VA, it is important to understand the areas where VA funding must be increased. The VA budget must address the pending wage increases for VA employees. It must address the continuing backlog in veterans waiting for health care and it must address, as well, VA's benefits casework backlog. There are severely disabled veterans and those needing home-based healthcare in those backlogs, and I think we can all agree that this situation should be addressed and corrected.

As we look to fiscal year 2006, we witness a live lesson about the challenges inherent to inadequate funding. VA says that action was taken, due to inadequate resources, to ban healthcare access to tens of thousands of veterans who are eligible to enroll in the very system put in place to serve them. The resource situation reaches the absurd when, after blocking entry to these so-called "high income" veterans, VA directs its workers under VHA Directive 2003–003, January 17, 2003, to send banned veterans to Community Social Work for assistance. For those brave men and women who once served to defend America's freedom, welfare has replaced their earned benefit.

Looking at the 2006 budget, released last week, AMVETS notes that the Administration is proposing an $880 million increase in VA health care. More than 85 percent of the Administration's proposed increase, $768 million, comes directly from the wallets of veterans using the system, in the form of a new user tax and a doubling of prescription co-payments for about 2 million veterans.

When stripped of the proposed new user tax and increased co-pay, the budget recommendation presents a paltry one-half of one percent increase above last year's funding—$111.2 millionnot even enough to cover the president's proposed Federal pay raise for the medical staff that delivers veterans' health care. The result of these proposals, according to VA, would push 215,000 former servicemembers out of the very system designed for their care.

To avoid implementation of the proposed exclusion of these veterans, The Independent Budget recommends Congress provide $31.2 billion to fund VA medical care for fiscal year 2005, an increase of $3.5 billion over the Administration's request. We ask Congress to recognize that the VA healthcare system can only bring quality health care if it receives adequate funding. It is an excellent investment for America.

Not only would adequate funding allow VA to achieve its mission of providing veterans health care, young Americans will see that our Nation does not abandon its responsibilities to those who have served in armed defense of our Nation. It would send a message that the contributions of servicemembers are appreciated above the priorities of non-defense, non-homeland security, and other non-veteran spending programs.

It is also important to clearly state that AMVETS along with its independent Budget partners strongly supports shifting VA healthcare funding from discretionary funding to mandatory. We recommend this action because the current discretionary system is not working. Moving to mandatory funding would give certainty to healthcare services. VA facilities would not have to deal with the whimsy of discretionary funding, which has proven inconsistent and inadequate. Mandatory funding would provide a comprehensive solution to the current funding problem. Once healthcare funding matches the actual average cost of care for veterans enrolled in the system, with annual indexing for inflation, the VA can fulfill its mission.

THE NATIONAL CEMETERY ADMINISTRATION

Before I address budget recommendations for the National Cemetery Administration (NCA), which is AMVETS's primary responsibility in the development of The Independent Budget, I would like Members of the Committee to know that AMVETS is truly grateful to those who serve on this important Committee. Through your work, you represent the veteran's voice. And as you lead the country in addressing issues important to veterans and their families, you may be assured that we will work with you and help report your leadership to the Nation.

The members of The Independent Budget recommend that Congress provide $204 million in fiscal year 2006 for the operational requirements of NCA, the National Shrine initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed Forces. This recommendation includes the start of a five-year $250 million program to restore and improve the condition and character of NCA cemeteries and, in total, is an increase—almost entirely aimed at improving the NCA Shrine initiative—of $40 million over the Administration's request for next year.

Clearly, the aging veteran population has created great demands on NCA operations. Primarily because of the mortality rate of World War II and Korean War veterans is increasing, as is the usage of burial services by Vietnam War Veterans, actuarial projections do not suggest a decline in these demands for many years. From current interment levels of 100,000 per year, the VA interment rate is projected to increase successively over the next several years peaking at 109,000 in the year 2008.

The National Cemetery Administration maintains more than 2.6 million gravesites in approximately 14,000 acres of cemetery land and inters more than 100,000 veterans annually. The NCA management responsibilities include 120 cemeteries: of these, 60 have available, unassigned gravesites for burial of both casketed and cremated remains; 26 allow only cremated remains; and 34 are closed to new interments.

Progress is underway at several sites around the country to complete construction of new national cemeteries. Funding is already in place for the Georgia National Cemetery, Atlanta, Georgia; the Great Lakes National Cemetery, Detroit, Michigan; the Southern Florida's National Cemetery, Miami, Florida; the Ft Sill National Cemetery, Oklahoma City, Oklahoma; the National Cemetery of the Alleghenies, Pittsburgh, Pennsylvania; and the Sacramento National Cemetery, Sacramento, California.

The Administration's recommendations in the 2006 budget contain $41 million of additional funding for land acquisition and related costs for six new cemeteries authorized under Public Law 108–109 to include sites at Bakersfield, California; Birmingham, Alabama; Columbia/Greenville, South Carolina; Southeastern, Pennsylvania; and Sarasota, Florida.

We ask for your strong commitment in supporting the Administration's request for these funds in the congressional budget and final appropriations for the new year. With the opening of these new national cemeteries and State cemeteries, too, the percentage of veterans served by burial option within 75 miles of their residence will rise to 85 percent from a level of 73 percent in 2001, almost doubling the number of gravesites during this period.

The members of The Independent Budget are encouraged by the Administration's recommended increase in NCA resources for Fiscal Year 2005. It should be recog-

nized, however, that while the Administration's proposal adequately addresses employment increases and equipment needs, it does not serve to address problems and deficiencies identified in the Study on Improvements to Veterans Cemeteries, a comprehensive report submitted in 2002 by VA to Congress on conditions at each cemetery.

Volume 2 of the Study identifies over 900 projects for gravesite renovation, repair, upgrade, and maintenance. According to the Study, these project recommendations were made on the basis of the existing condition of each cemetery, after taking into account the cemetery's age, its burial activity, burial options and maintenance programs. The total estimated cost of completing these projects is nearly $280 million, according to the Study.

As any public facilities manager knows, failure to correct identified deficiencies in a timely fashion results in continued, often more rapid, deterioration of facilities and increasing costs related to necessary repair. The IBVSOs agree with this assessment and request Congress carefully consider this report to address the condition of NCA cemeteries. We recommend that Congress and VA work together to establish a timeline for funding these projects based on the severity of the problems to ensure they remain respectful settings for deceased veterans and visitors. We recommend an establishment of a 5–year $250 million program to complete projects identified in the Study.

Volume 3 of the Study describes veterans cemeteries as national shrines saying that one of the most important elements of veterans cemeteries is honoring the memory of America's brave men and women who served in the Armed Forces. "The commitment of the Nation," the report says, "as expressed by law, is to create and maintain national shrines, transcending the provisions of benefits to the individual. . .even long after the visits of families and loved ones."

Indeed, Congress formally recognized veterans cemeteries as national shrines in 1973 stating, "All national and other veterans cemeteries. . .shall be considered national shrines as a tribute to our gallant dead." (P.L. 93–43:24 1003(c)) Moreover, many of the individual cemeteries within the system are steeped in history and the monuments, markers, grounds and related memorial tributes represent the very foundation of these United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Unfortunately, despite NCA continued high standards of service and despite a true need to protect and nurture this national treasure, the system has and continues to be seriously challenged. The current and future needs of NCA require continued adequate funding to ensure that NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the Nation.

THE STATE CEMETERY GRANTS PROGRAM

For funding the State Cemetery Grants Program, the members of The Independent Budget recommend $37 million for the new fiscal year, an increase of $5 million over the Administration proposal. The State Cemetery Grants Program is an important complement to the NCA. It helps States establish gravesites for veterans in those areas where NCA cannot fully respond to the burial needs of veterans. The enactment of the Veterans Programs Enhancement Act of 1998 has made this program very active and attractive to the States.

Clearly, the enactment of the Veterans Benefits Improvements Act of 1998 has heightened the interest in the State cemetery grants program and increased participation of States in establishing fully equipped cemeteries for veterans. In fiscal year 2004, the State cemetery grant program had helped provide burial space for 19,246 burials of veterans and their eligible family members, an increase of nearly 5.6 percent over the prior year.

Currently, six new cemeteries are under construction in Boise, Idaho (the last State in the Nation without a veterans' cemetery); Wakeeny, Kansas; Winchendon, Massachusetts; Killeen, Texas; and Suffolk, Virginia (serves 200,000 veterans in the Tidewater area). As before the 1998 legislative change, States remain totally responsible for operations and maintenance expenses to ensure conditions remain in a manner appropriate to honor the memory of veterans.

To augment support for veterans who desire burial in State facilities, members of The Independent Budget support increasing the plot allowance to $745 from the current level of $300. The plot allowance now covers less than 6 percent of funeral costs. Increasing the burial benefit to $745 would make the amount nearly proportional to the benefit paid in 1973. In addition, we firmly believe the plot allowance should be extended to all veterans who are eligible for burial in a national cemetery not solely those who served in wartime.

The Independent Budget veterans service organizations (IBVSOs) also request Congress review a series of burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973, when they were initiated.

The IBVSOs recommend an increase in the service-connected benefits from $2,000 to $4,100. Prior to action in the last Congress, increasing the amount $500, the benefit had been untouched since 1988. The request would restore the allowance to its original proportion of burial expense.

The IBVSOs recommend increasing the non-service-connected benefit from $300 to $1,270, bringing it back up to its original 22 percent coverage of funeral costs. This benefit was last adjusted in 1978, and today covers just 6 percent of burial expenses.

The IBVSOs also recommend that Congress enact legislation to index these burial benefits for inflation to avoid their future erosion.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Chairman CRAIG. Well, gentlemen, thank you for that comprehensive testimony and let me also thank you for this. It serves as an excellent template from which to work through the task we have at hand to compare it and what you believe to be reasonable levels of service in relationship to the Administration's budget, and I am sure in the coming days, we will be doing just that as we work through these issues.

Let me ask this question and possibly, well, maybe Richard, I guess Richard Fuller and Peter could respond to this: in our advocacy for veterans, and I do not step back nor do any of you in that role, is VA's proposal to outline exactly who is eligible for VA-provided care and who is not eligible not much more fair than what I call the hit and miss system of today?

Mr. FULLER. Well, I think in the VA's effort to try to draw that line and make distinctions between the veterans, a couple of tales might be told. I mean, one, you could basically have a veteran in category 8 who scaled the cliffs of Normandy, but did not get shot, did not get wounded, and escaped, coming home without any service-connected disability. Is his service any less honorable than the individual who got shot during D-Day?

Trying to make these distinctions now is rather strange, because all of these people were always eligible for VA health care going back 25 years. Prior to 1986, when they instituted the first means test, all veterans, any veteran over age 65 was eligible for VA health care, because they were determined to be totally and completely disabled at that age.

Even when they instituted the means test, you had category A, B and C veterans, and the C veterans were basically the 7s and 8s, they were still eligible to get into the VA and utilize those services as well, international after eligibility reform in 1996. The contingency was made to try to be able to take care of these people.

What happened is that the VA became wildly popular. It became, as you say, a credit to health care in the United States. But more than that, and not just in eligibility reform; subsequent to eligibility reform, VA changed how it provided that care, and they opened up 800 outpatient clinics across the country. Prior to that, it took an act of Congress to open an outpatient clinic, because the Office of Management and Budget said if you open that, it is going to create more demand, and so, if you open up 800 of them, 800

McDonald's, you can sell a lot more cheeseburgers than you could before you opened them up.

Why should the VA not be a haven for veterans?

Basically, we are not talking about people driving up in their Cadillacs; we are talking about people with very human needs. And health care in the United States today has become more expensive and less effective for Americans than ever before in recent history, and naturally, the VA should be a viable resource at a time of need.

Chairman CRAIG. Please, any comment that you wish to make on that?

Mr. GAYTAN. Yes, Mr. Chairman, on behalf of the American Legion, thank you for the question. And I think we could ask any veteran, if they feel that those individuals who they served with, who they served beside and with and who may or may not have survived as well or have suffered a disability that they had suffered, you could ask any veteran to make that assessment: is the person that they served with any more qualified to receive care through the VA health care system?

And the American Legion supports the definition of eligible veteran as defined in the Health Care Eligibility Reform Act. And also, the American Legion is quite concerned that the approach to funding VA in recent years has gone from providing a budget that meets the patient population. The American Legion supports that approach as opposed to tailoring the patient population to meet the budget. The funding should be there to treat those veterans who are eligible for care with the VA.

When determining the budget levels, we should not have to take into consideration how many we can treat. Those eligible veterans, the budget should be tailored to meet the care that those eligible veterans have earned through their service to our country.

Chairman CRAIG. Well, with 53 seconds left in my round, I will turn to Senator Akaka.

Danny.

Senator AKAKA. Thank you very much, Mr. Chairman. This is a question for all members of the panel. I would like to hear your comments on VA's $250 user fee and increase in the prescription drug co-payment for priority 7 and 8 veterans, a plan the Administration has tried to implement for the past few years. In your testimony, Mr. Gaytan, I believe you described this as an attempt to, and I am quoting, balance the VA budget on the back of American veterans, unquote.

Given that Congress rejected these proposals last year, what do you think of the Administration proposing them again this year, and do you believe that Congress should be more receptive this year?

Mr. GAYTAN. Thank you, sir.

The American Legion's position of opposition against these proposals has not changed. We trust that Congress will do as they have done in the past and oppose those provisions that would indeed seek to increase the VA budget and to eliminate the enrollment levels by implementing a $250 co-pay as well as the increase in the pharmaceutical costs. The American Legion does not—again, it falls back on the budget, the actual allocation of funds.

The funds should be there to allow the VA to meet their obligations to treat these veterans without calling on them to pay for an earned benefit that they have earned through their service to their country.

Mr. Cullinan.

Mr. CULLINAN. Thank you, Senator Akaka.

The VFW feels it is just plain wrong to attempt to change the rules at this stage in the process. The category 8 and 7 veterans who rely on VA health care, with only a few exceptions, very few exceptions in the category 8 group are not wealthy individuals. Category 7 veterans, by definition, are not wealthy, and there is a good question whether these individuals can actually afford to make such co-payments.

A major concern, of course, with the enrollment fee is they would actually be driven out, and I believe VA has factored that right into their budget calculations. We strongly oppose it.

Senator AKAKA. Mr. Violante.

Mr. VIOLANTE. Thank you, Senator.

DAV is also opposed to that. Some of our members, disabled veterans rated zero percent, fall into category 7s and 8s. Some of our members who have not received service connection through the VA for various reasons, VA does not accept their evidence, also fall into that category, and as Mr. Cullinan pointed out, it is a way to drive veterans out of the system, and we oppose that process.

Senator AKAKA. Mr. Fuller.

Mr. FULLER. Senator, Paralyzed Veterans of America, as we testified before, is adamantly opposed to these fee increases. The enrollment fee, we consider to be a health care tax, and adding in the doubling of the prescription fee could cause certain veterans with catastrophic disabilities, high-end users of the system, hundreds of dollars a month.

The other factor, which is the principal of the thing, and we are talking about separating veterans into categories; all of a sudden, you have one category of veterans who is deemed less worthy than others, who then is required to pay additional fees in order to generate revenue for the system, in order to pay for the health care of the others who are considered to be more deserving. We find this, one veteran paying for the health care of another, a complete anathema and oppose the fees on all grounds.

Senator AKAKA. Mr. Jones.

Mr. JONES. Yes, sir. It is a user tax. It would drive 216,000 veterans currently enrolled in the system out of the system. We need some wisdom here. We have a program that was put in place last year, a four-year, $1 billion program to pay the health care costs of illegal aliens. That is $250 million a year over the next four years, and we are asking veterans—we are telling veterans that we do not have money for their health care, veterans who developed this country, brought us prosperity, cherished its freedom and defended it everywhere around the globe.

We are paying $250 million a year for illegal alien health care? We need some wisdom in this budget, sir. Do not put us in a box. The box is not limited. It is artificial. It is an OMB box. Make sure you take a good look at your budget, gentlemen.

Thank you so very much.

Senator AKAKA. Well, I really appreciate your responses, and I must tell you that you are in concert with your statements here, and thank you very much for them.

My time is almost up, and I want to turn it back to the Chairman.

Chairman CRAIG. Just a couple more questions of you.

For a moment, because I agree with so much of what you are saying, I am going to be a bit of a devil's advocate, because I think it is important to build a record from which we can work to try to resolve this issue. I think we all know that the dollars and cents we are going to try to achieve this year are going to be a bit of a struggle, and getting there is not going to be easy, but we will make every effort to do so.

Some of you have said that the current fee proposal, enrollment fee, would put about 1.1 million veterans off the rolls. VA says that at least 900,000 of these veterans would be those who do not use the system now, but are enrolled into the system and are therefore not recipients of it. My devil's advocacy says it seems to me that non-users of VA health care are neither sick or disabled. If they are neither sick nor disabled—if they were, they would be users of the system. Is that not correct?

Mr. CULLINAN. Senator——

Chairman CRAIG. Yes.

Mr. CULLINAN. I would like to speak to that issue. If you look at the category 8 veterans, many of these individuals, as I mentioned awhile ago, are not wealthy individuals.

Chairman CRAIG. I concur.

Mr. CULLINAN. However, they may not be sick at the time, but VA represents their only health care option. If they drop out of the system, they cannot get back in again. So they are effectively shut out. Category 7 veterans, the situation is similar. It is not that they could not get back in again, but oftentimes, they do not want to surrender their health care option. Once they are out of the system, even if they can get back in, it could be a hard time and take too long to do it.

So that is the key issue right there. It is all good and well for VA to say it will save money by pushing non-users out, but these individuals are, in fact, potential users, and VA represents their only health care option.

Chairman CRAIG. Is a $250 a year fee not by far the cheapest access to the finest health care system in the world?

Mr. CULLINAN. Senator, I have to agree with that. However, there are still individuals who cannot afford to pay it. I wish that my premium was $250 a year.

Chairman CRAIG. Likewise.

Mr. CULLINAN. That would be terrific. That is not the case.

The thing is I am economically a little bit better off than these individuals are. And for them, it is a lot of money. And then, there is also, two, the whole issue of differentiating between veterans: who is worthy, who is not worthy.

Chairman CRAIG. I appreciate that, and Congress has always struggled, if you will, with a means test versus universality in coverage of certain things. We have struggled with that; we have breached that line a year ago in looking at Medicare and prescrip-

tion drugs for the first time, largely because of overall costs and budget concerns, and I struggle here with looking at what is being proposed and suggesting we might start drawing lines, and is that an appropriate thing to do? So I appreciate your advocacy.

Peter, you wish to comment?

Mr. GAYTAN. Yes, sir; thank you.

The need for enrollment was created by VA. Those individuals must enroll in it. Dennis mentioned specifically what I wanted to reiterate as well, which is that category 8s, if they do—the VA health care system for those who are considered under priority group 8s. They cannot enroll if they disenroll. If they decide that that $250 enrollment fee, they just cannot cover it, once they get out, that is it. They just cannot get back into the system.

Closing the door on any veterans who are prior eligible to receive health care at the VA health care system, the American Legion does not support.

Chairman CRAIG. Well, I have a good many other questions. I am getting squeezed on time now.

Danny, do you have any other question you would want to ask before we consider adjourning?

Senator AKAKA. Yes, Mr. Chairman.

Again, for The Independent Budget representatives with us here today, I direct this question towards each of you: in its current budget request, VA has proposed achieving management efficiencies in the neighborhood of $600 million. You have folks on the ground in hospitals and clinics. Do you think there is still so-called low-hanging fruit, easy and painless management efficiencies that can be achieved without hurting the quality of care for VA patients and specialty programs?

Mr. VIOLANTE. Senator, the short answer to that is no. We are hearing from VA people from around the country that most of the efficiencies have been found, and we all certainly know that there might be other ways to save some money, but nowhere in the neighborhood of what VA is proposing.

Mr. FULLER. Senator, from Paralyzed Veterans of America's point of view, this is nothing more than just another budget gimmick, and we see it in the budget every single year. For instance, the previous—in this year, they were asking for $340 million in management efficiencies. They have now jumped that up to $590 million. And it is fine, well, we are going to buy gauze pads in quantity and all these kinds of things, but in talking with people in the field, what normally happens to these budget estimates is that the word goes out from Washington, and each hospital is then assessed a certain amount to come up with in savings.

In talking to one hospital director yesterday, he estimated that of a major tertiary care facility, a VA hospital around the center, reconciliation instructions of this kind would cause them to reduce their budget next year by $6 million. Now, you cannot get that out of proverbial fraud, waste and abuse. He says you have got to cut staff. You have to cut programs, and you have to cut staff, and it is the only way to meet your target.

Mr. JONES. AMVETS supports, of course, every effective, efficient process we can find. We want that delivery to be as low cost, but yet as high quality as possible. But just take a look at the budget

this year, 2005. VA has already recognized that they are $187 million short of what they need to carry out their mission this year. How have they gone about it? Have they found new efficiencies? No.

Their new efficiencies, sir, are to take away funds that are designed for replacing medical equipment and also maintenance. They are raiding their maintenance and replacement of equipment funds to carryout their medical mission. $187 million, sir; we would love to see that as part of the supplemental. That is for this year.

Mr. CULLINAN. Senator, for the VFW, I would just reiterate something that Senator Obama referenced earlier today. The fact is that VA does not realize these savings, which, in all likelihood, it will not, it comes out of care and services. It hurts veterans, and it hurts the VA.

Mr. GAYTAN. If I may, sir, even though the American Legion is not part of the IB VSOs, we feel strongly in agreement with what my colleague Dennis Cullinan just stated, that any efficiencies will most likely negatively effect the quality of care. You can look at the drastic cuts in FTEs for long-term care. We are talking about over 4,000 employees being cut from long-term care. That is elimination of care that veterans are depending on. If that is labeled as an efficiency, I think we are going down the wrong path to save funds for VA.

Senator AKAKA. Thank you for your responses on that. We have been alluding to a system only for the service-connected. The President is clear on who should be eligible for VA health care: those with service-connected needs. Do you think the system as we know it today can survive if eligibility is severely narrowed? Can we continue to train nearly half of all physicians in the U.S., maintain specialty programs unparalleled in the community, and teach the rest of the health care system about quality maintenance if eligibility is limited to service-connected health needs?

Mr. CULLINAN. Senator, there are a number of issues here. It has long been understood that it is important with respect to maintaining certain specialty services, spinal cord, blinded, that the system needs to maintain what is known as a critical mass of patient load. In addition to that, one of the things that draws this Nation's top physicians in the VA is the fact that they have an array of patients to work with. If the system were suddenly limited to only service-connected, that benefit, that clinical and learning benefit would be gone.

Mr. VIOLANTE. Senator, I would like to respond to that also, and I agree with Dennis. You know, my members, at least currently, would be provided for. However, we do have serious concerns about the new veterans coming back who will need this system 50, 60 years from now, and where will the system be if we start to erode its base now? We will not have a viable system, and those veterans with service-connected disabilities from Iraq and Afghanistan and wherever else our war on terror takes us will not have the system we have now, and we have serious concerns about just caring for, as I said, the sickest of the sick and the poorest of the poor.

Senator AKAKA. Thank you, Mr. Violante.

Mr. Fuller.

Mr. FULLER. I think, again, trying to carve veterans up into little boxes is really quite dangerous, and it gets into the mentality of the system. And even the discussions that we are having about this about worthy veterans and not-so-worthy veterans leads systemically into the VA system. I was talking with someone yesterday who said that already, reports of surgeries in VA hospitals, drawing up surgery schedules where you provide the operations to the service-connected veteran first before you provide the services for the non-service-connected veteran.

Now, I think this is in violation of medical practice, if you would ask me, but it also shows me that there is this spirit which is now beginning to pervade the system that in order to avoid providing the resources to take care of these people, we need to cut back on the number of people we take care of.

Mr. GAYTAN. Thank you, sir.

Narrowing down the patient population for VA would not only negatively affect America's veterans who have earned the right to treatment through the VA health care system, but it would negatively affect the overall health care system of America. If you look at the research investments and the research accomplishments of the VA, it is outstanding. It does not only benefit those who have worn the uniform, but it also benefits all Americans and people worldwide.

The medical school affiliations that VA enjoys are outstanding. As part of the American Legion's System Worth Saving report, where our national commander in tandem with our field service staff visits every single VA health care facility, and in fact, by June of this year, in the past 3 years, the American Legion staff with the national commander will have visited every single VA health care system within the continental United States, and we will publish that report in July.

In those visits, we have seen first-hand the benefits of the medical school affiliations and as well as the research developments. And to limit the population would also limit the accomplishments of both of those programs.

Mr. JONES. I had a Valentine's Day conversation last night with my father, who is a World War II veteran. I told him where I would be today, and he was very pleased. I told him what we were fighting for and what we were looking for, and he asked me to tell you this: that he was never asked about income when he served in the armed forces. He has only been asked about his income when he sought his earned benefits. That is what we are fighting for.

He is a World War II veteran who is old. He probably had some injuries, but he never took them to the benefit service people, because he, frankly, thought the system was meant for those more deeply wounded. But now, he is older. He probably needs a little bit of care, a little bit of help. He served once, but now, because the bar is down, the wall has been constructed between the veterans 1 through 7 and veterans in priority 8, he just cannot have access.

So we would ask you to tear down that wall.

Senator AKAKA. Thank you very much, all of you, for your responses.

Chairman CRAIG. I apologize, gentlemen, but we are out of time. This is not the last bite on or at this apple, as we work collectively together to continue to assure adequate and appropriate service to our veterans.

We will leave the record open for a period of time for the introduction of the questions that I will have, but again, let me thank you for the work here and the work that lies ahead of us as we push to assure the sustainability of the quality and the service of the Veterans Administration health care system.

Thank you all very much. The hearing will stand adjourned.

[Whereupon, at 12:34 p.m., the hearing adjourned.]

A P P E N D I X

PREPARED STATEMENT OF LOURDES E. ALVARADO-RAMOS, PRESIDENT, NATIONAL ASSOCIATION OF STATE VETERANS HOMES

I am pleased to submit testimony on behalf of the National Association of State Veterans Homes ("NASVH") with respect to the President's fiscal year 2006 budget proposal for the Department of Veterans Affairs. I am the Assistant Director of the Washington State Department of Veterans Affairs, and I serve as the 2004–2005 President of NASVH.

As the largest deliverers of long-term care to our Nation's veterans, the State Veterans Homes system plays an indispensable role in ensuring that eligible veterans receive the benefits, services, long-term health care, and respect that they have rightfully earned by their service and sacrifice to our country. We greatly appreciate this Committee's commitment to the long-term care needs of veterans, your understanding of the vital role that State Veterans Homes play, and your strong support for our programs.

NASVH's membership consists of the administrators and staff of State-operated veterans homes throughout the United States. We currently operate 119 veterans homes in 47 States and the commonwealth of Puerto Rico. Nursing home care is provided in 14 homes, domiciliary care in 52 homes, and hospital-type care in 5 homes. These homes presently operate over 27,500 resident beds for veterans and provide over 50 percent of long-term care workload for the Department of Veterans Affairs ("VA").

We work closely with the VA, State governments, the National Association of State Directors of Veterans Affairs, veterans service organizations, and other entities dedicated to the long-term care of our veterans. Our goal is to ensure that the level of care and services provided by State Veterans Homes meet or exceed the highest standards available.

ROLE OF THE STATE VETERANS HOMES

State Veterans Homes first began serving veterans after the Civil War. Faced with a staggering number of soldiers and sailors in critical need of long-term medical care, and with the capacity of the Federal veterans home system unable to meet that demand, several States established veterans homes to provide for those residents who had served honorably in the military.

In 1888, Congress first authorized Federal aid to States which maintained homes in which certain disabled American soldiers and sailors received long-term care. At the time, the payments amounted to about 30 cents per resident per day. In the years since, Congress has made several major revisions to the State Veterans Homes program to expand the base of payments to include specialized hospital, nursing home, and domiciliary care.

For many years, State Veterans Homes have operated under a program administered by the VA which offers construction grants and per diem payments to support State Veterans Homes. Both the VA construction grants and the VA per diem payments are essential components of this support. Each State Veterans Home meets stringent VA-prescribed standards of care, which exceed standards prescribed for other long-term care facilities. The VA conducts annual inspections to ensure that these standards are met and to certify the proper disbursement of funds. Together, the VA and the State Homes represent a very effective and financiallyefficient Federal-State partnership in the service of our veterans.

Construction grants are authorized by 38 D.S.C. §§ 8131–8137. The objective of such grants is to assist the States in constructing or acquiring State Veterans Home facilities. Construction grants are also utilized to renovate existing facilities, and to ensure continuing compliance with life safety and building codes, and this recently has become a more important activity. Construction grants made by the VA may not exceed 65 percent of the estimated cost of construction or renovation of facilities, including the provision of initial equipment for any such project. State funding covers at least 35 percent of the cost.

The per diem payments to State Homes are authorized by 38 U.S.C. §§ 1741–1743. They are intended to assist the States in providing for the higher level of care and treatment required for eligible veterans residing in State Veterans Homes. As you know, the per diem rates are established annually. They are currently $59.36 per day for nursing home care and $27.44 per day for domiciliary care. State Veterans Homes have experienced a period of sustained growth—the result of increasing numbers of elderly veterans who have reached that point in life when long term care is needed. In fact, we face the largest aging veterans population in our Nation's history, with our aged veteran population growing substantially each year, and creating a growing demand for long-term health care service to veterans. The State Veterans Homes program will fill the existing unmet need for longterm care beds for veterans in certain States and will respond to the annual absolute increase in the number of veterans eligible for such care nationally.

Specifically, the VA has identified 10 States as having either a "great" or "significant" need to build new State Veterans Homes beds immediately. These 10 States are Florida, Texas, California, Pennsylvania, Ohio, New York, Hawaii, Delaware, Wyoming, and Alaska. In response to this need, Florida has five new homes in the planning stages, and Texas has four additional homes in the planning stages and two additional homes in the final stages of construction. California has three new homes approved. Delaware and Alaska are planning their first State Homes, and Hawaii expects to open its first State Home next year.

The State Veterans Homes construction and renovation program is working very well. According to priorities set by the Veterans Millennium Health Care and Benefits Act of 1999 (Public Law 106–117), up to 35 construction or renovation projects that will improve the State Veterans Homes system are either underway or planned in 19 States, including Florida, New York, New Hampshire, California, Texas, Hawaii, Connecticut, Arkansas, Minnesota, and Ohio.

Most importantly, the State Veterans Homes system can construct and operate these long-term care facilities for veterans at substantially less cost to taxpayers than can the Federal Government. The average daily cost of care for a veteran at a long-term care facility run directly by the VA has been calculated nationally to be $423.40 per day. The cost of care to the VA for the placement of a veteran at a contract nursing home is approximately $194.90 per day. The same daily cost to the VA to provide long-term care at a State Veterans Home is far less—only $59.36per day for nursing care and only $27.44 per day for domiciliary care.

This substantially lower daily cost to the VA of the State Veterans Homes system compared to other available long-term care alternatives led the VA Office of Inspector General to conclude in a 1999 report: "the SVH [State Veterans Home] program provides an economical alternative to Contract Nursing Home (CNH) placements, and VAMC [VA Medical Center] Nursing Home Care Unit (NHCU) care" (emphasis added). In this same report, the VA Office of Inspector General went on to say: A growing portion of the aging and infirm veteran population requires domiciliary and nursing home care. The SVH [State Veterans Home] option has become increasingly necessary in the era of VAMC [VA Medical Center] downsizing and the increasing need to discharge long term care patients to community based facilities. VA's contribution to SVH per diem rates, which does not exceed 50 percent of the cost to treat patients, is significantly less than the cost of care in VA and community facilities.

VA BUDGET PROPOSAL FOR FY06

The President's FY06 budget would devastate the State Veterans Homes system and the thousands of veterans who currently use the system. The budget proposal would: 1) slash the per diem eligibility requirements for the State Veterans Homes so that the vast majority of veterans who currently reside in State Veterans Homes would suddenly be ruled ineligible for per diem benefits; and 2) impose a moratorium on grants to fund construction of new State Homes, stopping plans for many new Homes, life and safety projects, and renovations where a need has been justified or required by State or Federal regulatory authorities.

The change in the per diem criteria would have the most profound impact on the State Homes system. Under the President's budget proposal, per diem payments for care at State Veterans Homes would be limited to veterans in priorities 1–3 and those in priority 4 who are catastrophically disabled.

According to the VA's average daily census for long-term care, there are estimated to be more than 19,000 individuals in State Veterans Home nursing care this year. The President's budget documents claim that Veterans eligible for per diem payments in FY06 would drop to 7,217—a 62 percent decline in just one year, according to the VA.

NASVH has polled its members and concluded that the President's proposal represents an even more devastating cut. Data from nearly all of the State Veterans Homes shows that the proposal would actually rule ineligible approximately 80 percent of the current population of the State Veterans Homes. More than 14,000 of the 19,000 veterans in State Veterans Homes would be denied the per diem benefit.

These veterans are often frail, elderly, and afflicted with mental health and complex medical conditions. Some are admitted to the homes following chronic homelessness or from more restrictive settings such as mental health hospitals or rehabilitation programs. These veterans are able to thrive in the Veterans Home environment where they are among their comrades who provide support and where they are attended to by staff experienced in the management of their unique issues. Most State Home residents would not be able to afford such care without the support of the per diem.

Attached is a chart that shows, on a State-by-State basis, the human impact of this proposal on the residents of the State Veterans Homes.

The proposed budget virtually abandons the Federal Government's commitment to the State Veterans Homes system. It would also force veterans into overburdened State systems increasing exponentially the cost to the Medicaid and Medicare programs. NASVH members have found it difficult to calculate the number of residents who would qualify as "catastrophically disabled" under the proposal. There have been inconsistencies in the definitions provided by the VA, and in some States, VA hospitals have refused to provide information to the State Homes to assist in this calculation, citing privacy concerns, falls far short of the commitment that we have made to our veterans and fails to recognize adequately the service of veterans to our Nation. This shortfall will eventually impact the recruitment and retention of military personnel. Those who aspire to serve in the military should rest assured that their government will care for them well after they retire their uniforms.

The President's proposal would abrogate a long-term partnership with the States. State taxpayers have paid millions of dollars to help construct the State Veterans Homes system with the understanding that the Homes would remain a long-term Federal/State partnership. With no consultation with the States or with the State Veterans Homes, however, the President's budget abruptly and needlessly abandons this arrangement and places the Homes in an untenable financial position.

The impact of the President's proposal would be felt not only by those veterans who no longer qualify for per diem payments. The President's proposal also would jeopardize the future of the State Veterans Homes system and could lead to the closure of many State Veterans Homes. By denying the per diem Federal support for the majority of State Home residents, the budget proposal would threaten the financial viability of the State Veterans Homes system, which was designed to share costs between the State and Federal Governments in the most economical manner possible. The proposals in the President's budget obviously frustrate the intent of Congress and the partnership with the States in establishing the State Veterans Homes system in the first place. The changes would jeopardize care for thousands of aging veterans and put at risk the entire State Veterans Homes system, which has proven its fiscal and health care value to veterans and the Federal Government for more than 100 years.

We applaud both the House and Senate Veterans Affairs' Committees for objecting to the cuts in the per diem for the State Veterans Homes. Chairman Craig, in his "views and estimates" letter, wrote that "severe restrictions in per diem support for State homes is, in my estimation, an unsound idea." He concluded: "I cannot endorse a cutting of per diem assistance to State homes to which needy veterans will increasingly turn for care."

Chairman Buyer's views and estimates letter described the "long-standing partnership between the VA and States for cost-sharing in caring for veterans in State nursing homes" and noted that the "VA's per diem reimbursement to the States for nursing home care compares favorably to the cost of VA operated and community nursing homes." With respect to the per diem proposal, Chairman Buyer concluded: "Therefore, the Committee does not expect to act on the legislative proposal."

The Senate Democratic views and estimates letter likewise expressed support for the per diem program: "It is our view that eligibility for per diem payments to [State Veterans Homes] should remain intact." Democrats on the House Veterans' Affairs Committee reached the same conclusion in their views and estimates: "We also are greatly dismayed by proposals in the President's budget that could literally bankrupt many of the 109 veterans' State homes throughout the Nation. For more than 40 years, VA and States have viewed State homes as a mutually beneficial means of providing veterans with a long-term care safety net."

The bipartisan support for the per diem program was demonstrated during Senate debate on the FY06 budget resolution. An amendment by Senators Craig, Ensign,

Hutchison, and Vitter to increase funding for veterans benefits was adopted by a vote of 96 to 4. The amendment was described by the sponsors as intended to provide sufficient funding to, among other goals, "protect those in veterans nursing homes" by "rejecting the proposal to scale back State nursing home per diem payments made by VA."

NASVH is grateful for the support of the Veterans Service Organizations, which also oppose the proposed cuts to the per diem payments. The American Legion testified before Congress that "this proposal would spell financial disaster for [State Veterans Homes] and would result in a new population of homeless elderly veterans on our streets." The Veterans of Foreign Wars recently told the Veterans Affairs' Committees that "the States have been excellent partners with VA in caring for aging veterans and have picked up VA's slack for the last few years. And now, VA plans to abandon the States, which will result in dramatic cuts in the number of available nursing home beds at the State level."

In conclusion, we thank you for your support of the State Veterans Homes and urge that the Committees work toward a final budget resolution and with the Appropriations Committees to ensure that the VA has the resources to maintain the per diem program in its current form, without the cuts proposed by the President's budget.

We remain concerned that the VA may seek to implement these cuts administratively, without legislative action by your Committees or specific instructions by the Appropriations Committees. We look forward to working with you and the VA to maintain and improve the service we provide to America's veterans.

Impact of Per Diem Proposal on Veterans Receiving Nursing Home Care in State Veterans Homes

State	No. of Veterans in SVH-NHC	No. Eligible for per diem Under Proposed Criteria	No. Ineligible for per diem Under Proposed Criteria	Percent of residents who would be denied per diem	Estimated Cost
Alabama	425	159	366	86	$ 7,929,902
Arkansas	51	13	38	75	823,323
Arizona	189	111	78	41	1,689,979
California	464	79	385	83	8,341,564
Colorado	246	43	203	83	4,398,279
Connecticut	N/A	N/A	N/A	N/A	N/A
Florida	466	85	381	82	8,254,898
Georgia	495	90	405	82	8,774,892
Idaho	265	46	219	83	4,744,942
Illinois	324	44	280	86	6,066,592
Indiana	131	48	83	63	1,798,311
Iowa	350	92	258	74	5,589,931
Kansas	134	30	104	78	2,253,306
Kentucky	502	84	418	83	9,056,555
Louisiana	335	29	306	91	6,629,918
Maine	421	61	360	86	7,799,904
Maryland	193	25	168	87	3,639,955
Massachusetts	250	22	228	91	4,939,939
Michigan	779	158	621	80	13,454,834
Minnesota	586	201	385	66	8,341,564
Mississippi	559	67	492	88	10,659,869
Missouri	1139	190	949	83	20,561,414
Montana	147	26	121	82	2,621,634
Nebraska	473	75	398	84	8,623,227
Nevada	149	7	142	95	3,076,629
New Hampshire	169	35	134	79	2,903,298
New Jersey	812	104	708	87	15,339,811
New Mexico	179	30	149	83	3,228,294
New York	919	86	833	91	18,048,111
North Carolina	130	21	109	84	2,361,638
North Dakota	34	7	27	79	584,993
Ohio	517	74	443	86	9,598,215
Oklahoma	1366	450	916	67	19,846,422
Oregon	125	22	103	82	2,231,639
Pennsylvania	1226	192	1034	84	22,403,058
Puerto Rico	65	3	62	95	1,343,317
Rhode Island	220	36	184	84	3,986,618

Impact of Per Diem Proposal on Veterans Receiving Nursing Home Care in State Veterans Homes—Continued

State	No. of Veterans in SVH-NHC	No. Eligible for per diem Under Proposed Criteria	No. Ineligible for per diem Under Proposed Criteria	Percent of residents who would be denied per diem	Estimated Cost
South Carolina	285	38	247	87	5,351,601
South Dakota	38	19	19	50	411,662
Tennessee	179	34	145	81	3,141,628
Texas	557	80	477	86	10,334,873
Utah	52	23	29	56	628,326
Vermont	N/A	N/A	N/A	N/A	N/A
Virgina	124	22	102	82	2,209,973
Washington	488	81	407	83	8,818,225
West Virginia	N/A	N/A	N/A	N/A	N/A
Wisconsin	749	34	715	95	15,491,476
Wyoming	N/A	N/A	N/A	N/A	N/A
Nationwide	17,307	3,076	14,231	82	308,334,538

PREPARED STATEMENT OF THOMAS H. COREY, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Mr. Chairman and other distinguished Members of this Committee, on behalf of the membership of Vietnam Veterans of America (VVA), I am pleased to submit our views with respect to the President's budget proposal for FY06 as it pertains to the funding of programs of relevance and concern to veterans and their families. VVA thanks you for the opportunity to provide this statement, and for considering our thoughts in this important matter.

This Administration has trumpeted the increases in funding for the operations of the Department of Veterans Affairs in the past four years. It is true that in President Bush's first term, appropriations for veterans' affairs have increased by more than 40 percent. Some of those increases were in mandatory funding, some were in increased collections from veterans and third-party payments. But there have been substantial increases in funds for medical care. Yet these increases have failed to keep pace not only with medical inflation, but also with the increased demand for services by veterans statutorily eligible for care and treatment by the VA. The per capita funding for a veteran at VA has lagged far behind even the increases provided to Medicare recipients, which is so inadequate that providers continue to drop out of that system.

In fairness to the President, he inherited an inadequate budget base, due to the flatline funding of veterans' health care during his predecessor's second term. It appears that another few years of flatline medical budget proposals are in our future yet again.

Certainly Undersecretary of Defense David Chu's public statement portends this attitude, especially in light of the fact that neither the President nor anyone else in the Administration moved to neither rebuke Mr. Chu for his remarks nor to distance themselves from his remarks demeaning and slandering those who have served our Nation honorably and well in military service. It appears that this unfortunate and disgraceful pattern of second-term neglect and irresponsibility is about to repeat itself.

We see the writing on the wall in the President's budget proposal for FY 2006.

The "enhanced restraint" touted by the Office of Management and Budget (OMB) bodes ill for veterans. This restraint eliminates, on paper, more than one million veterans from the VA health care system. Men and women who are

categorized as Priority 7 and 8 veterans, who have no service-connected disabilities, but whose, economic fortunes are tottering or who do have service-connected disabilities, but are rated as 0 percent compensable at the present time.

It is an affront to term these men and women "higher income" veterans. Most make less than $40,000 per year; most have no health insurance. Otherwise they would likely not seek help from the VA health care system. VVA points out that these are also the men and women who account for some 40 percent of the third-party reimbursement to VA coffers. The marginal cost of including these veterans in the system actually may produce more income than they cost the system, as they tend to be less sick when they seek help from VA. Most importantly, they are men

and women who have served our country honorably and are statutorily eligible for care and treatment. Yet they are being denied that earned entitlement by the conscious starving of the system for resources.

This "enhanced restraint" also will make it difficult if not impossible to well serve all disabled veterans who depend on the VA system as their primary health care provider.

Let it be clearly said: "enhanced restraint" means budget cuts.

We have seen this coming for a while, in VA's long-term strategic planning documents and, most recently in, a February 7th press release from the Department of Veterans Affairs that attempted to put a rosy spin on the $70.8 billion budget request for that agency's operations. No fewer than five times is it noted that the department "will be able to care for those veterans who count on VA the most." This makes a presumption that the veterans who will be pushed out of the system have other options for health care.

Many do not. Therefore, they will do without medical care until they get so sick that they lose their jobs, and become destitute and therefore eligible for care. For those who are service-connected disabled, but excluded for the moment, they will be denied medical care until such time as their service-connected condition worsens to the point that they become service-disabled compensable. This does a distinct disservice to veterans. It also means that when, after much delay and worsening of their medical condition, these veterans are granted medical care from VA to which they were statutorily eligible, their need for clinical resources will likely be greater and therefore' more expensive than it would have been if they had been granted access to VA health care at an earlier point.

This is not only wrong, but it is fiscally foolish in the medium and long run. It is also a blatant attempt to circumvent the law and the will of the American people to care for veterans.

We challenge the new Secretary of Veterans Affairs, the bureaucrats at the Office of Management and Budget (OMB) who are in large measure responsible for this document, and all concerned to cite anywhere in statute where it says that the VA will only serve a "core constituency" of "veterans who count on VA the most." Indeed, if it is the will of the people to narrow the parameters of eligibility for VA services, then one would hope you will be open, honest, and forthright in this matter and move to amend the law. But do not penalize veterans in a backdoor machination.

VVA has said this before and we'll say it again: The cost of caring for those who have borne the battle, and their widow and their orphans—this quote adorns the side of the VA headquarters on Vermont Avenue—is part of the cost of the national defense. It is up to you, the members of Congress who must agree on what programs and services are to take precedence in funding, to consider this—and honor this—as you deliberate the Administration's budget proposal. Caring for veterans is not a Democratic cause. It is not a Republican effort. It is an American issue, one that cuts across all party affiliations.

VVA has in the past, and does today, Mr. Chairman, call for action for much greater accountability from all elements of the VA. From Veterans Health Administration (VHA) there must be much greater accountability for clinical outcomes, overall management of resources, and securing the best possible use of the taxpayer dollars to secure the best possible health care for our Nation's veterans. That means greater scrutiny of all contracts, of part time physicians, of so-called "enhanced use" lease deals that may be, in fact, be "sweetheart" deals, a hard look at bonuses at every level, and comprehensive and close scrutiny of high ranking doctors, nurses, and other clinicians who see few or no patients at the same time that it is difficult to secure enough coverage for inpatient wards.

We hope that you will work with us on this vital issue of accountability, as well as the effort to ensure that VHA moves more quickly toward truly becoming a "veterans health care system" and not one that is all too often general health care that happens to be for veterans. To VVA, that means that a complete military history must be taken and used for each veteran in the VHA system, to get the most complete diagnosis and medical treatment plan possible.

VVA also hope to work closely with you to achieve more proper observance of veterans preference in hiring by all parts of VA, and ensuring that VA exceeds the goal set in law, and re-emphasized by President Bush in Executive Order 13–360 to exceed securing at least 3 percent of all goods and services from service-disabled veteran-owned businesses. Part of real accountability is holding VA managers strictly accountable in regard to these two Federal laws, which affect the economic well being of veterans.

VVA has certain very specific concerns about the budget request for FY06. We outline them for you now.

• Our main concern revolves around the effects of this flat-line budget. The effect on a system already operating on the margin of safety in medical and acute care units will now be strained all the more by the "hard freeze" on hiring already implemented at most VA medical centers. Specialized services, such as prosthetics, spinal cord injury, and mental health will be strained to the point of delays or denials of service.

• If passed, this budget will eventuate in a decrease of 1,110,416 veterans from the VA health care system. It says so on page 2–16 of the medical programs budget submission. This is not right. This usurps the covenant between the American people and those who in uniform defended the Constitution.

• The $250 "user fee," if passed, will force the exodus of veterans who cannot afford this fee. The VA estimates that some 213,000 currently enrolled veterans will opt not to pay this fee to the detriment of their health nor will they opt not to pay the increased drug co-payment of $15 as proposed by the Administration. Congress rejected these misguided proposals last year. We hope you will do the same this time around.

• The budget cites an anticipated savings of some $590 million in unnamed "management efficiencies." Does this mean laying off half of the staff at VA's headquarters? Deferring yet more needed preventive maintenance and capital improvements? More important, what exactly will this mean as it trickles down to individual VA medical centers? We fear that this will lead to longer waits to be seen by primary care physicians and by specialists, and a general degradation of the system.

• At the same time, the proposed budget does not take into account long-term care. Nor does it consider the shortterm or long-term needs of a new generation fighting today in hotspots around the globe. Many of these men and women are returning to our shores with grievous, maiming injuries that will take years of treatment and rehabilitation.

• With regard to long-term care facilities, an increasing need will be met by decreasing resources. The $312 million slash in funding for nursing homes (including care for veterans in State extended care facilities) will result, according to top VA officials, in some 5,000 fewer beds in the VA system. This will impact the States, and on the families of veterans who urgently need this care. What will they do?

• There are no additional resources provided for the VA Readjustment Counseling Service, or vet center program. This is the most studied program of the VA, and every study, by GAO and others, have found that this is the most cost-effective, cost-efficient program operated by the VA. An investment of $17 million in the vet centers would by one full-time family counselor skilled in grief counseling and PTSD counseling in each of the 206 centers, as well as an additional 40 staff to augment the staff at centers near clusters of the returning veteran population to be able to meet their needs. Vet Centers help keep veterans employed, and help keep their families together. This $17 million would disappear into the rest of VHA without a trace, whereas by setting aside this amount for an increase in the vet centers budget will have an immediate, measurable, and very visible impact.

• The budget proposal flat-lines funding for medical research, which we believe is a mistake. The National Institutes for Health received a significant increase yet once again, despite the fact that it does not fund even one veteran-specific grant. Are veterans less worthy, or their health care needs not worth studying? It is only through research that we gain knowledge that we then turn into practical applications of immediate benefit to improve care for veterans, especially as to conditions that may have originated in military service. Of course, these discoveries not only accrue to veterans, but to all of us. The VA can be justifiably proud of the fruits of its research over the past half-century; one researcher was awarded a Nobel Prize for her research. This cannot continue without proper funding.

• When the endorsement of the CARES program by former Secretary Principi was announced, we were assured, in a presentation at the Longworth House Office Building, that this initiative would be funded to the tune of $1 billion a year over the next five years. This was guaranteed. Now we see funding of $750 million. This might be the silver lining in an otherwise grim budget: The VA is forced to rework what we see as a flawed formula on which the CARES model is based. Most veterans are not middle class. They present at VAMCs with far greater frequency than do most middle-class health consumers, a salient fact not taken into account by CARES. Currently CARES still does not take into account long term care, nor does it take into account returning veterans who are disabled, wounded, and ill from the war raging in Iraq, Afghanistan, and elsewhere in the world.

Mr. Chairman, as you are aware there are more than 250,000 homeless veterans sleeping on the streets or in shelters every night. While we appreciate the slight increase in the VA FY06 budget for homeless programs, VVA believes that the VA

Health Care for Homeless Veterans funds, which includes the Homeless Grant and Per Diem Program, needs to be a separate line item in the budget. For these veterans, who once served our Nation with pride, we simply must do more and we must do better.

In regard to the Veterans Benefits Administration, (VBA), VVA is concerned that the structural shortfall of resources in funding is not addressed in this budget. As you are aware, $125 million had to transferred from medical care services this year just to keep a minimum number of staff, particularly compensation and pension adjudicators, on the job and working in order not to fall even further behind in the time it takes to get a fair and accurate decision on a veteran's claim. We are also concerned that there does not appear to be any significant enhancement in the number of veteran benefits counselors to assist returning OIF/OEF veterans who may need their assistance, nor does there appear to be any major outreach campaign to reach returning veterans, as well as returning members of the National Guard and Reserves.

Many Members of this committee are familiar with a quote from the Father of Our Country, George Washington: "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their Nation." As you discuss and debate this budget, think about this, and those in uniform in Iraq and Afghanistan.

Mr. Chairman, Vietnam Veterans of America thanks you and your distinguished colleagues for considering our views on this issue of vital importance to veterans of every generation.