

THE

A Comprehensive Budget & Policy Document Created by Veterans for Veterans

INDEPENDENT

for the Department of Veterans Affairs

BUDGET

CRITICAL ISSUES



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The Independent Budget Critical Issues Report for Fiscal Year 2012

As the United States closes out a decade of sending service members into harm's way as part of the war on terrorism, and with service members continuing to deploy on a regular basis to Iraq, Afghanistan, and other foreign theaters, the Department of Veterans Affairs (VA) faces growing pressure to address their needs for health care, compensation for injuries, and other earned benefits, while meeting the needs of the men and women who served in prior conflicts. Since the beginning of Operation Enduring Freedom and Operation Iraqi Freedom, and now continuing with Operation New Dawn, more than 2 million service members have been deployed to combat theaters. Despite recent troop drawdowns in Iraq, thousands more personnel are still being sent into hostile environments. The physical and psychological traumas they face are immense. The sacrifices these brave soldiers, sailors, airmen, marines, and coastguardsmen have made will leave many of them dealing with a lifetime of physical and psychological wounds. It is for these men and women and the millions who came before them that we set out each year to assess the state of the one federal department whose sole task it is to care for them and their families: the Department of Veterans Affairs.

The Independent Budget is based on a systematic methodology that accounts for changes in the size and age of the veteran population, federal employee staffing, and wages; medical care inflation; the need for cost-of-living adjustments; construction and infrastructure needs; trends in health-care utilization; benefit needs; efficient and effective means of benefits delivery; education and employment needs; and estimates of the number of veterans and their spouses who will be laid to rest in our nation's veterans cemeteries.

The Independent Budget will be released in February 2011 concurrent with the release of the President's proposed budget for VA, but this Critical Issues Report is designed to alert the Administration, Congress, VA, and the public to the issues concerning VA health care, benefits, and benefits delivery that we believe deserve early scrutiny and attention. *The Independent Budget* veterans service organizations are releasing this report now as a guide to

policymakers so that they can enact an adequate health-care budget for fiscal year (FY) 2011 and make necessary adjustments to the advance appropriation for the Medical Care accounts of VA for FY 2012. Likewise, in February 2011, *The Independent Budget* will present a detailed funding analysis and recommendations for FY 2012. Through these efforts we believe VA will be better positioned to successfully meet the challenges of the future. We also hope this document will provide direction and guidance for the Administration and Congress.

As the war on terrorism continues with no end date certain, this country's obligation to the men and women who have served and sacrificed continues to grow. Additionally, we must be cognizant of current fiscal realities in a time of turbulent and rapidly fluctuating economic conditions that may compel veterans of past service to seek VA care and benefits for the first time. In fact, this occurrence has already begun to manifest, as VA Secretary Eric Shinseki outlined in a letter to Congress July 30, 2010. He explained that the advance appropriations levels provided for FY 2011, which virtually match the Administration's request and the appropriations levels provided in the FY 2011 Military Construction and Veterans Affairs Appropriations bills, may not be sufficient to meet the health-care demand the Department of Veterans Affairs will face this fiscal year. Secretary Shinseki also emphasized that the passage of P.L. 111-163, the "Caregivers and Veterans Omnibus Health Services Act," and P.L. 111-148, the "Patient Protection and Affordable Care Act," will increase the workload for VA, thereby requiring supplemental funding.

Additionally, this nation faces a harsh reality when it comes to our fiscal future. Rapid growth in federal spending, coupled with an economic downturn that has had a secondary impact on federal revenues, has set us on a course that needs to be corrected. Yet continued investment in the critical programs administered by VA is imperative. The ongoing cost of caring for the men and women who have honorably served this nation does not diminish simply because financial times become challenging.

With this new reality ever present in our minds, we must do everything we can to ensure that VA has all the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve on the frontiers of freedom need to know that they come home to a nation that respects and honors them for their service. Part of this obligation must provide for the best possible medical care to make them whole, the best vocational rehabilitation to help them overcome the employment challenges created by injury, and the best claims-processing system to deliver accurate compensation, education, and survivors' benefits—to anyone harmed in service to our nation and to all who earn benefits by serving.

We are proud that this marks a historic 25th year for *The Independent Budget*. We are equally proud of the respect and influence that it has gained during that time. The coauthors—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States—endeavor each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are founded on facts, rigorous analysis, and sound reasoning.

We hope that each reader approaches this Critical Issues Report with an open mind and a clear understanding that America's veterans should not be treated as the refuse of war, but as patriots.

CRITICAL ISSUE 1

Reforming the Benefits Claims-Processing System

The Veterans Benefits Administration is at a critical junction in its efforts to reform an outdated, inefficient, and overwhelmed claims-processing system, and strong leadership is required by both Congress and the Department of Veterans Affairs to ensure that this system is finally and truly reformed.

After struggling for decades to provide timely and accurate decisions on claims for veterans benefits, the Veterans Benefits Administration (VBA) over the past year has started down a path that could finally lead to essential transformation and modernization, but only if it is ready, willing, able, and provided incentives to complete this journey.

At the beginning of the year, VA Secretary Eric Shinseki set an ambitious long-term goal of zero claims pending longer than 125 days and all claims completed to a 98 percent accuracy standard—a far cry from today’s falling quality levels and growing backlog of pending claims. He and his leadership team have forcefully and repeatedly made clear their intention to “break the back of the backlog” this year. While this goal is laudable and ambitious, eliminating the backlog is not necessarily the same objective as reforming the claims-processing system, nor does it guarantee that veterans will be better served.

In fact, the backlog is not the problem, nor even the cause of the problem; rather, it is only one symptom. We believe the true problem is that VA decisions on benefits claims are too often inaccurate.

Although recent increases in staffing and funding were necessary to keep pace with a growing workload, it will take fundamental change to reform the claims-processing system. To achieve real and lasting success, the VBA must undergo a cultural shift so that rather than focusing its efforts on reducing the backlog by increasing production and reducing cycle times, it concentrates on improving accuracy and quality. Rather than defining success as the

elimination of the backlog, VA must realize that, for veterans, success is having their claims “done right the first time.”

Over the next year, it will be imperative that Congress provide strong oversight and leadership to help guide the VBA toward real and lasting reform. *The Independent Budget* veterans service organizations (IBVSOs) have supported and promoted many of the dozens of new initiatives under way by the VBA, including the Fully Developed Claim program, the expanded use of private medical evidence, and the increased use of interim ratings. While the VBA is to be applauded for moving forward with these initiatives, we have doubts about whether it will ultimately be successful in evaluating and synthesizing the data and results of this experimentation into a more efficient and accurate claims-processing system. Given the enormous pressure to reduce the backlog, the IBVSOs are concerned that there could be a bias toward process improvements that result only in greater numbers of completed claims rather than improvements that lead to higher quality and accuracy.

Unquestionably, the most important new initiative under way at the VBA is the development and deployment of the Veterans Benefits Management System (VBMS), which is scheduled for a pilot test in November 2010 at the Providence, Rhode Island, VA Regional Office. The IBVSOs have concerns about the VBA’s plans and commitment to maximizing rules-based decision support as a core and essential feature of the VBMS. We are also concerned about how the VBA will handle legacy paper-based claims. While the VBA is committed to moving forward with a paperless system for new claims, it has not stated how new claims with previously established paper files will be integrated into the VBMS environment. The choices, whether to convert existing paper files to electronic media or continue a paper-bound claims system parallel to the VBMS for the next several decades, or some variant thereof, are critical, in our view, to the design of a new claims-processing system. Consequently, because of the highly technical nature of information technology development, an independent, expert review of the VBMS system—while it is still early

enough in the development phase to make course corrections—could help to ensure that the VBA builds this new IT system “right the first time.”

Veterans service organizations (VSOs) and our local and national service officers represent almost half of all claims before VA and have vast expertise in the process. Yet in spite of some recent outreach efforts, the VBA is not regularly soliciting nor integrating VSO input during the planning, development, or evaluation of the VBMS or the ongoing pilot programs. Working with VSOs during the earliest planning stages of new initiatives, as well as throughout the ongoing IT developmental phase, could significantly help the VBA achieve more effective and efficient solutions for veterans.

At the core of the VBA’s reform efforts must be a renewed commitment to strengthen and integrate training and quality control programs so that they are an interrelated part of a continuous improvement program, both for employees and for the claims process itself. Quality control programs should identify subjects that require new or additional training for VBA’s employees. Better training programs for employees and managers should improve the overall quality of the VBA’s work. To achieve success, training must be a shared responsibility of both VBA employees and managers, and the VBA must provide accountability and incentives for successfully completing training. Finally, the results of all employee testing, coaches’ reviews, quality assurance, and quality control programs should be aggregated and regularly analyzed using the new capabilities of the VBMS to help determine problem areas that need new training curricula and identify possible claims process improvements.

Recommendations:

The Veterans Benefits Administration (VBA) should develop regular and ongoing roles for veterans service organizations’ participation in future Veterans Benefit Management System (VBMS) development as well as the planning, implementation, evaluation, and integration of other claims-processing pilots and initiatives.

Congress must ensure that sufficient funding is provided to the VBA's information technology modernization program and must aggressively oversee the ongoing development and deployment of the VBMS, including third-party independent reviews of its progress, to ensure that quality control is built in at every step of the process.

The VBA must maximize the development of rules-based decision support in the VBMS and minimize the length of time it takes to transition all active files to the new paperless system.

Congress must provide sufficient oversight of the VBA's myriad ongoing pilots and initiatives to ensure that best practices are adopted and integrated into a cohesive new claims process and that each pilot or initiative is judged first and foremost on its ability to help VA get claims "done right the first time."

The VBA should significantly increase the total annual hour requirement for continuing training of all employees, and all VBA employees, coaches, and managers should undergo regular testing to measure job skills and knowledge as well as the effectiveness of the training itself.

CRITICAL ISSUE 2

Sufficient, Timely, and Predictable Funding for VA Health Care

The Department of Veterans Affairs must receive sufficient funding for veterans health care, and Congress must fully and faithfully implement the advance appropriations process to ensure sufficient, timely, and predictable VA health-care funding.

With the 111th Congress virtually completed, it is important to once again review and assess its efforts to provide sufficient, timely, and predictable funding for the Department of Veterans Affairs, particularly the VA health-care system. The first session of the 111th Congress laid the groundwork for a historic year in 2010. In 2009 the President signed Public Law 111-81, the “Veterans Health Care Budget Reform and Transparency Act,” which required the President’s budget submission to include estimates of appropriations for the Medical Care accounts for fiscal year (FY) 2012 and thereafter (advance appropriations) and the VA Secretary to provide detailed estimates of the funds necessary for these accounts in budget documents submitted to Congress. Consistent with advocacy by *The Independent Budget*, the law also required a thorough analysis and public report by the Government Accountability Office (GAO) of the Administration’s advance appropriations projections to determine whether that information is sound and accurately reflects expected demand and costs to be incurred in FY 2012 and subsequent years.

The Independent Budget veterans service organizations (IBVSOs) were pleased to see that in February 2010 the Administration released a detailed estimate of its FY 2011 funding needs as well as a blueprint for the advance funding needed for the Medical Care accounts of VA for FY 2012. It is important to note that this is the first year the budget documents have included advance appropriations estimates. Due to differences in interpretation of the language of Public Law 111-81, the GAO did not provide an examination of the budget submission to analyze its consistency with VA’s Enrollee Health Care Projection Model. The IBVSOs were informed that the GAO was not obligated to report on the advance

appropriations projections of VA until at least 2011. We look forward to working with Congress to ensure that the GAO fulfills its responsibility in the coming year.

For FY 2011, Congress provided historic funding levels for VA in the House and Senate versions of the Military Construction and Veterans Affairs Appropriations bill that matched, and in some cases exceeded, the recommendations of *The Independent Budget*.

Unfortunately, as has become the disappointing and recurring process, the Military Construction and Veterans Affairs Appropriations bill had not been completed even as the new fiscal year began October 1, 2010. Although the House passed the bill in the summer, the Senate failed to enact this bill in a timely manner. This fact serves as a continuing reminder that, despite excellent funding levels provided over the past few years, the larger appropriations process continues to break down over matters unrelated to VA's budget due to partisan political gridlock.

Fortunately, this year the enactment of advance appropriations has temporarily shielded the VA health-care system from such political wrangling and legislative deadlock. However, the larger VA system is still negatively affected by the incomplete appropriations work. VA still faces the daunting task of meeting ever-increasing health-care demand as well as demand for benefits and other services.

In February 2010, the President released a preliminary budget submission for VA for FY 2011. The Administration recommended an overall funding authority of \$60.3 billion for VA, approximately \$4.3 billion above the FY 2010 appropriated level but approximately \$1.2 billion less than *The Independent Budget* recommended. The Administration's recommendation included approximately \$51.5 billion in total medical care funding for FY 2011. This amount included \$48.1 billion in appropriated funding and nearly \$3.4 billion in medical care collections. The budget also included \$590 million in funding for Medical and Prosthetic Research, an increase of \$9 million over the FY 2010 appropriated level.

For FY 2011, *The Independent Budget* recommended that the Administration and Congress provide \$61.5 billion to VA, \$5.5 billion more than the FY 2010 operating budget, to adequately meet veterans' health-care and benefits needs. Our recommendations included \$52 billion for health care and \$700 million for medical and prosthetic research.

The Administration also included an initial estimate for the VA health-care accounts for FY 2012. Specifically, the budget request calls for \$54.3 billion in total budget authority, with \$50.6 billion in discretionary funding and approximately \$3.7 billion for medical care collections. Unfortunately, because work on the FY 2011 appropriations bill was not completed, advance appropriations funding for FY 2012 remains in limbo.

Moreover, recent actions by VA suggest that the FY 2011 advance appropriations funding levels (which were affirmed in the President's budget request) may not be sufficient to support the health-care programs managed by VA. In a letter sent to Congress July 30, 2010, VA Secretary Eric Shinseki explained that he believes the advance appropriations levels provided for FY 2011—that virtually match the Administration's request and the House Committee on Appropriations funding levels for FY 2011—will be insufficient to meet the health-care demand that VA will face this year. He also emphasized that the passage of Public Law 111-163, the "Caregivers and Veterans Omnibus Health Services Act," and Public Law 111-148, the "Patient Protection and Affordable Care Act," will increase workloads for VA. Unfortunately, the House version of the FY 2011 Military Construction and Veterans Affairs Appropriations bill does not fully address this projected current year demand. Likewise, the Senate version of the appropriations bill is apparently insufficient to meet the new demand the Secretary projects.

While we appreciate the funding levels that are provided by the appropriations bills, we believe that the Secretary's letter sends a clear message that, absent some unclear "management action" by VA, more funding will be needed for FY 2011 for VA Medical Care accounts. We hope that, as the House and Senate move the final version of the Military

Construction and Veterans' Affairs Appropriations bill forward, proper consideration is given to this concern.

Recommendations:

Congress must complete work on the FY 2011 Military Construction and Veterans Affairs Appropriations bill as soon as practicable to ensure that VA is not hampered further in providing services and making reforms and to ensure that advance appropriations for FY 2012 are provided for VA Medical Care accounts, in accordance with Public Law 111-81.

Congress must ensure that supplemental funding is included in FY 2011 and in subsequent years to meet new demand projected as a result of the "Caregivers and Veterans Omnibus Health Services Act" and the "Patient Protection and Affordable Care Act."

The Administration, Congress, and the Government Accountability Office must fully and faithfully implement all provisions of Public Law 111-81, the "Veterans Health Care Budget Reform and Transparency Act," in order to ensure sufficient, timely, and predictable funding for VA health care.

The Administration and Congress must provide sufficient funding for VA health care to ensure that all eligible veterans are able to receive VA medical services without undue delays or restrictions.

CRITICAL ISSUE 3

The Continuing Challenge of Caring for War Veterans and Assisting Them in Their Transitions to Civilian Life

The Departments of Defense and Veterans Affairs face challenges in meeting the needs of a new generation of war veterans and those of their families while sustaining effective care for all military beneficiaries and veterans and working together to ensure that injured and ill service members gain a seamless transition from military to civilian life.

As service members return from war and separate from military service, the Department of Defense and the Department of Veterans Affairs must provide them with a seamless transition of services and benefits to ensure their successful reintegration into civilian life. More than 2 million U.S. service members have deployed to Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) since October 2001, with many individuals serving several tours of duty, thus increasing their exposure to multiple blasts and other threats that result in a variety of “invisible” wounds. *The Independent Budget* veterans service organizations (IBVSOs) believe particular attention must be paid to this vulnerable patient population, including women veterans, and to the families of severely injured veterans.

Advancements in military medicine have resulted in a 90 percent survival rate among those physically wounded, but within DOD and VA health-care systems, gaps remain in the recognition, diagnosis, treatment, and rehabilitation of the less-visible injuries of mild-to-moderate traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD).

Emerging literature strongly suggests that even mild TBI can leave patients with long-term mental and physical health consequences. According to DOD and VA experts, mild TBI can produce behavioral manifestations that mimic PTSD or other mental health conditions. Additionally, TBI and PTSD can be coexisting conditions. However, much is still unknown about the long-term effects of these injuries and the best treatment models to address mild-

to-moderate TBI. The IBVSOs believe VA should conduct more research into the long-term consequences of brain injury and continue to develop best practices in its treatment. We are encouraged by the DOD's recent findings in studying a small number of post-combat personnel for TBI. The preliminary results of that study indicate that mild brain injury may be detected with a specialized blood analysis. We look forward to additional research on TBI by both the DOD and VA.

What is clear is that without proper screening, diagnosis, and treatment, postdeployment mental health problems could eventually lead some distressed individuals to thoughts of suicide. The IBVSOs are encouraged that VA has developed a comprehensive strategy to address suicide prevention in veterans, but we urge Congress to provide oversight to ensure ready access to robust primary mental health and substance abuse treatment programs, emphasizing early intervention and routine screening. The DOD and VA need to work together to improve their response to these at-risk combat veterans.

Responding to the unique health-care needs of women veterans is a growing challenge for VA. The number of women now serving in our military is unprecedented in U.S. history, and women have played extraordinary roles in OEF/OIF deployments. The current rate of enrollment of women veterans in VA health care constitutes the most dramatic growth of any subset of veterans. Since 2002, 49.7 percent of women deployed in OEF/OIF have discharged from the military and enrolled in VA health care. We encourage VA to continue to enhance and expand treatment programs aimed at women veterans, with accompanying research initiatives to improve women's health.

In addition to treatment and rehabilitation, the IBVSOs are concerned about the coordination of services for severely injured veterans and their families. The Office of Health Care Inspections of VA's Office of the Inspector General (OIG) conducted follow-up interviews designed to determine changes that had occurred since a 2006 OIG report that focused on the health status of and services for OEF/OIF veterans after TBI rehabilitation. The OIG

concluded that three years after completion of initial inpatient rehabilitation, many veterans with TBI continue to have significant disabilities, and although case management has improved, it is not uniformly provided to these patients.

The IBVSOs believe that veterans should not need to wade through bureaucratic delays to obtain the benefits and health care that they have earned and deserve. Along with our concerns that VA has not fully addressed the long-term emotional and behavioral problems associated with TBI and their devastating impact on veterans, we are equally concerned about the families of these severely injured veterans.

Family members often serve as lifelong caregivers to critically injured veterans. Until recently this role has received little acknowledgment from Congress or the government. The IBVSOs were pleased that the President signed Public Law 111-163, the “Caregivers and Veterans Omnibus Health Services Act,” on May 5, 2010. This law authorizes VA to create an array of supportive services for family caregivers of disabled veterans. We urge VA to quickly publish regulations and policy implementing this law so that family caregivers can obtain some relief from their duties. However, we remain concerned for caregivers of disabled veterans who are not eligible for some of the benefits of the act, and believe that the services provided to caregivers of veterans serving on or after September 11, 2001, should apply to all service-disabled veterans on the basis of medical and financial need. We also remain concerned about the law’s implementation and believe clear, decisive rules are needed to carefully define a severely wounded veteran; explain who qualifies for the new benefits and services afforded by the act and how they can gain access to them; and provide information on other elements of the new law.

To support injured veterans and their families, the IBVSOs believe that strong case management is necessary as these veterans transfer from DOD to VA care.

In October 2007, the DOD and VA partnered to create the Federal Recovery Coordination Program (FRCP) to coordinate clinical and nonclinical care for severely injured and ill

service members. The IBVSOs remain concerned about the gaps that exist in the FRCP and the accompanying social work case management essential to coordinating complex components of care, particularly for polytrauma patients and their families. The gaps that need to be addressed include better communication, education, promotion of the program for increased visibility, and streamlining of the referral process. These needs were highlighted by disabled veterans and their caregivers in Congressional hearings in 2009 and 2010 and warrant continued oversight and evaluation by Congress, VA, and the DOD.

The IBVSOs continue to stress increased collaboration between the DOD and VA for the transfer of military service records and health-care information. We acknowledge that progress has been made in this area by VA and the DOD; however, the military service branches and VA are not sharing electronic health information on a broad scale, and this shortfall is a major deterrent to achieving seamless transition to veteran status for injured and ill military service personnel.

The IBVSOs are pleased with the establishment of two Virtual Lifetime Electronic Record pilot programs among VA, the DOD, and civilian providers in the Richmond-Tidewater area of Virginia, following on a similar agreement with the Kaiser Permanente health plan in Southern California. In light of these initiatives, the IBVSOs remain firm that the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and that allows for two-way, real-time electronic exchange of health information and occupational and environmental exposure data for transitioning veterans.

Effective record exchange could increase health-care sharing between agencies and providers, laboratories, pharmacies, and patients; help patients transition between health-care settings; reduce duplicative and unnecessary testing; improve patient safety by reducing medical errors; and increase our understanding of the clinical, safety, quality, financial, and organizational value of health information technology. Electronic health information should also include an easily transferable electronic Department of Defense Form DD-214 discharge

record to allow VA to expedite claims and give service members faster access to their earned benefits.

Unfortunately, the DOD-VA information interoperability plan mandated by the National Defense Authorization Act for Fiscal Year 2008 (NDAA) has not been fully achieved, but according to a Government Accountability Office review, social history data are now being shared by the DOD to provide VA with clinical information on patients; physical examination data are also being shared by the DOD to allow VA to view medical data that support the Physical Evaluation Board process for individuals separating from the military; and five secured network gateways have been established to support health information sharing between the departments. The remaining NDAA benchmarks remain incomplete.

Recommendations:

Congress must conduct rigorous oversight to ensure that the DOD and VA provide service members a seamless transition from military to civilian life and that the DOD and VA continue to support the development of electronic medical and military service records that are interoperable and bidirectional.

The DOD and VA must develop clear plans of sustained rehabilitation for severely injured service members and veterans and must receive the necessary resources to accomplish their goals.

VA and the DOD should establish a program of early intervention services for treatment of war-related health problems, with a priority on mental health and substance-use disorders.

The DOD and VA must invest in traumatic brain injury and postdeployment mental health research to close gaps in care and develop best practices in screening, diagnosis, and treatment of brain injuries.

VA should initiate surveys and other research to assess and reduce barriers to VA care for veterans of Operations Enduring and Iraqi Freedom (OEF/OIF), with an emphasis on reservists and guardsmen returning to veteran status after deployments, veterans who live in rural areas, and women veterans.

The DOD and VA must increase the number of providers who are trained and certified to deliver evidence-based care for post-traumatic stress disorder and major depression and should encourage service members and veterans to seek care without fear of stigma, including having an “open door” policy for active duty service members to be counseled in VA’s Vet Centers.

VA should continue its promotion and expansion of programs for the treatment of the unique needs of women veterans with a focus on those who served in OEF/OIF.

Congress should authorize and VA should provide a full range of medical, psychological, financial, and social support services to family caregivers of veterans, especially veterans with brain and severe physical injuries.

Congress should monitor VA to ensure that it faithfully implements Public Law 111-163 with respect to caregiver support and programs for women veterans.

Congress should ensure that the DOD and VA will improve the use of federal recovery coordinators (FRCs) in military treatment and VA facilities caring for severely injured service members and veterans, while tracking workload, geographic distribution, and the complexity and acuity of the injuries of these individuals.

VA should periodically survey family members of veterans assigned to FRCs to determine where improvements might be necessary to the services they provide these families.

Congress, the President, the DOD, and VA must ensure that pertinent programs are sufficiently funded and *adapted* to meet the needs of our OEF/OIF generation of veterans while the DOD and VA continue to address the health needs of earlier generations of war veterans.

Critical Issue 4

Transformation of the Department of Veterans Affairs Health-Care Delivery Model— Patient-Centered Medical Home or Patient Aligned Care Teams

The Veterans Health Administration (VHA) is undergoing a change in the way it plans to deliver health care to the veterans it serves. As the VHA implements a patient-centered medical home (PCMH) model, Department of Veterans Affairs leaders must ensure the unique health-care needs of the veteran population are met while sustaining quality and satisfaction.

Over the past 15 years, the Department of Veterans Affairs has been transformed into a nationally recognized, first-rate, and comprehensive health-care system. To maintain its high standards of quality care, VA recently announced its intention to transition into a patient-centered medical home model, referred to as the Patient Aligned Care Team (PACT) approach. *The Independent Budget* veterans service organizations (IBVSOs) believe that such a change has the potential to enhance the delivery of health services for veterans; however, to ensure that the expected positive outcomes are achieved, VA must include three critical factors as fundamental components of the medical home model: 1) the patient centered care must meet the unique needs of disabled veterans; 2) PACTs must provide consistent communication with veterans and their advocates; and 3) the VHA's infrastructure needs must be aligned with the medical home model delivery of care.

VA research teams are studying the effectiveness of the model in a variety of settings. While this research proceeds, VA policymakers have projected that 80 percent of all its outpatient clinics will be participating in the medical home adaptation initiative by 2012, with all VA health-care sites functioning as PACTs by 2015. Although medical home carries no single and universal, definition, a set of accepted principles is common to the concept:

- team-based care that emphasizes continuity of care over the lifespan of the veteran-patient;

- a larger role for nurses, nurse practitioners, and physician assistants in coordinating care;
- use of email, secure messaging, and other alternative forms of communication and telemetry with patients to monitor care;
- greater attention on behavioral and mental health issues; and
- increased focus on what patients *want* while increasing patient and practitioner satisfaction.

The IBVSOs believe flexibility will be important to foster creation of best practices for the wide variety of health-care options in VA's unique population and geographic diversity—yet it is vital that VA ensures consistency throughout the system. Over the years, VA has established specialized systems of care and primary care teams with specialty-trained practitioners for veterans who have incurred spinal cord injury or disease, blindness, amputations, polytraumatic injuries, and chronic mental health challenges. These specialized systems of care serve as excellent models for patient-centered care. The IBVSOs strongly encourage VA to maintain and enhance these specialized areas of care tailored to the unique needs of these veterans. Particularly, VA must make certain that the specialized systems of care are not replaced or diluted by the advent of PACTs that focus on the basic outpatient model of care and are not trained to adequately meet unique health care needs of these veteran populations.

Further, because chronic medical issues require interdisciplinary approaches, VA must put in place policies and guidelines that create a structure for a care model that will not penalize clinicians for aggressively consulting specialists for coordination of treatment plans. For this reason we believe the numerous emerging versions of the model must be carefully studied, and that consideration must be given to the sensitivities of VA health-care personnel who will actually be making the changes envisioned.

As such studies are conducted, a comprehensive educational component should be created and shared with veterans and their advocates, including the IBVSOs, during the early stages of PACT implementation. VA must help veterans, family members, and caregivers

understand the purpose and goals of this new culture in order for them and their families to become true collaborators in the health-care decisions and care plans formulated to maintain veterans' health. As PACTs are established in VA medical centers, the IBVSOs recommend that VA schedule frequent meetings to reach out to veterans and their advocates for input and feedback, as well as identify tools to monitor quality performance using measurable indicators to ensure that the intended health-care outcomes are achieved.

The IBVSOs are also interested in the planned methods for implementing this model. Thus far, two large VHA conferences have been conducted that focused on the VHA's intention to transform its health-care system into a PCMH/PACT model; however, we have not seen any specific details about how the VHA intends to train health-care personnel to ensure consistent, safe, and high-quality care. Also, the results of VA's ongoing research efforts have yet to emerge, and these could be important in guiding implementation.

As PACT implementation moves forward, we are concerned that the changes inherent in this cultural shift in health-care delivery be taken into account in VA's infrastructure and capital investment policies. In Critical Issue 6, "Maintaining VA's Critical Infrastructure," the IBVSOs express concerns about VA's adoption of the "Strategic Capital Investment Plan," or SCIP, a new VA policy that seems designed to rely heavily on a health-care facility lease, or "build-to-suit" strategy, with reliance on community providers or academic affiliates for inpatient services rather than VA construction of its own comprehensive facilities. With the advent of PACT, VA would no longer simply be replacing worn-out medical centers and clinics with like, but modernized, facilities; VA's evolution to PACT in all likelihood will result in the need for VA to redesign its thinking for how a 21st-century VA health-care system, based on the new PACT model of care, should be configured. Historic academic VA missions in training new generations of American physicians, nurses, and other health care professionals, plus VA's world-class biomedical research programs, need to be taken into account as the new PACT culture takes hold.

The medical home concept has evolved over several decades, but only recently gained more general acceptance. More than 100 demonstration projects have tested the effectiveness of the PCMH model in the private sector, most with positive results. Currently, VA health-service researchers are conducting a study of selected VA medical home pilot programs in five diverse regions. The teams are collecting data to address a complex array of questions to determine how the national medical home model should be structured and governed to ensure it meets the needs of VA's unique enrolled patient population. The analysis is focused on determining which features of the concept work best for veterans in the VA system; if the program is economically viable and sustainable; if a system with more than 1,400 sites of care can make this shift in care while maintaining continuity of care for patients; and, finally, if the medical home model increases satisfaction for patients, families, and VA providers. In addition to the goal of better health outcomes and management of chronic diseases, the value of long-term, one-to-one relationships that are established and nurtured between patient and practitioner and the emphasis on enhanced access to care, quality, safety, and coordination of care are also important and beneficial to the results desired.

Today VA benefits from the great advantages of having a number of current VA programs in place, such as anticoagulation, hypertension, and diabetes clinics where nurses and pharmacists lead in providing and monitoring patients' health; the availability of an indispensable electronic health record to promote accuracy, safety, and quality of care; the use of performance measurements to determine management and clinical effectiveness; reliance on evidence-based treatments; and use of telemedicine and telemetry to manage the system, reach, and treat certain patient populations. Having these programs and policies prepositioned and working enables VA to move beyond the essential building blocks and structural elements of the PCMH model to focus far more on transforming the in-place culture of primary care within the system.

Recommendations:

VA must ensure that the specialized systems of care are not replaced or diluted by standard patient-aligned care teams (PACTs) that are not trained to adequately meet unique health-care needs of these veteran populations.

Because chronic medical issues require interdisciplinary approaches, VA must create new policies to outline a structure for a care model that will not penalize clinicians for aggressively consulting specialists for coordination of treatment plans.

VA must implement policies to provide continuity of care throughout the Veterans Health Administration to ensure safe delivery of quality health care.

VA must use the data collected from its research efforts to bring all of the pieces of the patient-centered medical home (PCMH)/Patient Aligned Care Team (PACT) puzzle into a cohesive and integrated whole.

VA must communicate clearly with all affected employees the change that is being made with movement to the PACT approach and gain broad “buy-in” by them in making the change.

VA must create and implement a comprehensive educational component for veterans and their advocates during the early stages of PACT implementation to increase the likelihood VA users understand how the new model serves them in an improved way.

The Independent Budget veterans service organizations must be an integral part of the transformational process and must be kept informed and involved in the changes to come in order to help serve and educate their memberships and the veterans VA serves.

VA capital investment planning, and its academic missions, must be accommodated as VA shifts its culture to that of PCMH/PACT.

CRITICAL ISSUE 5

VA Must Strengthen Its Human Resources Management Programs

The Department of Veterans Affairs must update existing personnel programs and develop innovative employment strategies to help human resources staffs, facility program leaders, and executives to recruit, train, and retain a qualified VA workforce.

The Department of Veterans Affairs must improve its human resources management policies and procedures in order to remain a leader in health-care delivery and ensure that America's veterans receive the benefits and services they have earned. Specifically, VA must revamp its hiring system to make the hiring process timely and efficient, update salary and compensation scales to levels that are competitive in the current employment market, and ensure that adequate training and continuing education opportunities are offered and made available to all employees for career progression. Both Congress and VA must continue to work to strengthen and energize VA human resources management programs and give human resources staffs, facility program leaders, and executives new tools to recruit, train, and retain highly qualified VA employees.

As service members return home from the conflicts in Afghanistan and Iraq, and veterans from previous and future wars seek VA services, VA must make certain that it is adequately staffed with a well-trained workforce committed to providing veterans with high-quality care and services. VA's ability to sustain a full complement of skilled and motivated personnel requires assertive and competitive hiring strategies that enable VA to successfully compete in the local and national labor markets. To be successful, human resources management programs of both the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA), as well as a multiplicity of other VA offices, require attention by the highest levels of VA leadership, the use of effective tools and strategies with measurable outcomes, and strong oversight by an engaged Congress.

Timely and Efficient Hiring

To ensure that VA is able to hire and retain the most qualified applicants, it must strengthen its employee recruitment and retention programs and increase the timeliness of its hiring processes. *The Independent Budget* veterans service organizations (IBVSOs) have received recurring reports indicating that appointment of a new employee within the VHA can consume up to 90 days or more. In some professional occupations (especially in cases of physicians and nurses), months can pass from the date a position vacancy is announced by VA to the date a newly VA-credentialed and privileged professional caregiver is on board, receiving pay, and providing clinical care to veterans. The seeming lack of ability to make employment offers and confirm them in a timely manner unquestionably affects VA's success in hiring highly qualified employees and has the potential to diminish the quality of VA health care and the Department's ability to deliver benefits and services.

In addition to hiring and recruiting new employees as a method for maintaining adequate staff, VA must also set in place programs for future succession. In the VHA alone, between fiscal years 2002 and 2006, 108,620 new hires (21,724 per year) were needed to maintain the VA health-care workforce. Between fiscal years 2007 and 2017, 163,308 new hires will be needed to maintain that workforce (an average of 23,330 new hires per year). VA has recognized that the employment market is extremely competitive for some positions and is working to provide more professional development opportunities and programs to attract the new employees it will need to care for veterans; however, because a large percentage of its workforce is eligible for or nearing retirement, VA must begin to put more effort into creating succession plans.

In addition to implementing new recruitment incentives to help improve the efficiency of VA human resources, VA must work to ensure that human resources staffs are held accountable for filling vacancies in a timely manner. When vacancies are not filled in a timely manner, departments are forced to spread thin available employees across many areas of service delivery in VA programs. As a result, both efficiency in the workplace and the quality of

services provided to veterans can be compromised. Meeting VA hiring and recruitment goals is essential to the delivery of quality services in a timely manner.

Competitive Compensation

Adequate compensation for VA employees is a tool for both recruitment and retention. VA must provide its employees with salaries that are competitive with the private sector if it is to become and remain an employer of choice. VA must combine competitive compensation packages with new employee incentives, such as signing bonuses, retention incentives, education scholarships, loan repayment, and other attractive benefits.

Congress and VA must work together to ensure that sufficient resources are available to VA management to offer competitive salary and employment packages to new employees. For instance, in 2004, Congress passed Public Law 108-445, the “Department of Veterans Affairs Health Care Personnel Enhancement Act.” The act is partially intended to aid VA in recruitment and retention of VA physicians, including scarce subspecialty practitioners, by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. VA has implemented the act, but the IBVSOs believe the act did not provide VA the optimum tools needed to ensure that veterans will have available the variety and number of physicians needed in the VA health-care system. We urge Congress to provide further oversight and to determine whether VA has adequately implemented the law as intended or if VA needs additional tools to ensure full employment for qualified physicians as it addresses future staffing needs. Additionally, in an effort to recruit and retain medical subspecialists who provide care in VA’s specialized medical programs (spinal cord injury, blind rehabilitation, surgical specialties, pulmonary and cardiac rehabilitation, etc.), Congress should implement an additional title 38 specialty pay provision.

Another human resource challenge that is increasing in importance is pay disparity between top executives at medical centers and Veterans Integrated Service Networks (VISNs) and the people they supervise. With reforms in nurse executive and physician pay resulting from

previous laws, medical center and VISN chief executives now find themselves in a compensation system that pays them significantly less than some of the senior personnel they supervise. Under current law, pay rules and annual caps in the Senior Executive Service are limited by title 5, United States Code. This pay inequality also contributes to a dampening of interest among these executives to relocate to more challenging, complex facilities in the VHA—because essentially there is no pay incentive to encourage mobility among these senior health executives.

As a result of these pay disparities, many VA executives are encouraged to retire at a young age in order to accept higher-paying positions in the private health industry. The loss of this experience in the VHA is coming at a crucial time, with the passage of health insurance reform likely causing significant expansion of private health care. This is of concern to our organizations. Increasing VA compensation for these individuals now may offset some of these losses to the VA system by dissuading executives from leaving VA service. If increasing pay can slow the drain of talent from the VA system, it would be a well-justified investment.

The IBVSOs believe the physician pay reform authorized by Public Law 108-445, previously described, could be an effective model of reform for senior health executive compensation in the VHA. Congress and VA should explore this strategic issue with oversight and further investigation and develop an appropriate statutory response to achieve pay equity and retention incentives for VHA's senior health executive leadership.

Personnel Training and Education

Maintaining a high-caliber professional staff is critical to the successful delivery of quality VA services. VA must make continuing education and training programs and incentives available to all qualified employees. VA leadership must make certain that existing staff and potential employees are aware of these opportunities and benefits for career development within VA.

Last year VA increased the maximum award amount for its Employee Incentive Scholarship Program from \$35,900 to \$37,494. This increase will help many existing VA employees who wish to further their education and will, it is hoped, serve as a retention tool to keep valuable employees within VA; however, other incentive programs, such as the VA Education Debt Reduction Program (EDRP) are in need of award increases since educational costs continue to rise. An increased EDRP award would also serve as an effective recruitment tool to attract recent graduates and students in all degree programs of VA-affiliated institutions to VA employment. The immediate benefits of the EDRP program should be coordinated with VA's need to better time its recruitment efforts with new health profession graduates.

To improve personnel performance and efficiency, VA leadership must make certain that employees are made aware of professional development opportunities and benefits offered through VA. While continuing education is necessary for all VA employees, adequate training is particularly critical to VA's claims-processing and adjudication staffs because the VBA has hired a record number of new claims adjudication employees. Unfortunately, as a result of senior VBA officials retiring in the interim, an increase in disability claims received, rising complexity of such claims, and the time required for new employees to become proficient in processing accurate claims, VA has achieved no noticeable improvement in its claims work. The VBA has a major challenge under way in completing the complex training required to gain full productivity of several thousand new staff.

Such is the size of the claims backlog that it would be naive to expect an immediate reduction in the VBA workload or for backlogs to fall dramatically simply because of increased staffing. Such an expectation would be defeated merely by the time required for new employees to gain necessary experience and the drain on experienced employees who currently provide much of the training for them. In order to make the best use of its new human resources, the VBA must focus on improving training and accountability while simplifying the claims process itself. This year the IBVSOs offer a number of

recommendations in Critical Issue 1, “Reforming the Benefits Claims-Processing System” on the urgent need for reform. Nevertheless, the VBA human resources system needs similar reforms and new incentives to keep VBA employment high, to improve workplace morale, and to help VBA properly recruit and retain the employees VBA needs to adjudicate veterans’ claims for disability, education, insurance, and other benefits.

Human resource management policies and procedures serve as the foundation of initial employment for all VA employees, and provide the pathway for overall career direction. VA must strive to provide satisfying work environments that encourage scholarship, professional development and growth, and career advancement. VA human resources should set the standard of excellence when it comes to providing services for America’s veterans.

Recommendations:

VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment.

VA must implement an energized succession plan in VA medical and regional office facilities and other VA offices that utilize the experience and expertise of current employees. It must also improve existing human resources policies and procedures that promote succession of the next generation of VA leadership.

VA must ensure that human resources staffs are held accountable for filling vacancies in a timely manner.

VA facilities must fully utilize recruitment and retention tools, such as hiring, relocation, and retention bonuses; locality pay for VA nurses; physician compensation improvements; and educational scholarship and educational loan payment programs, as employment incentives, in both the Veterans Health Administration and Veterans Benefits Administration.

Congress should implement an additional specialty pay supplement in title 38, United States Code, for medical professionals who provide care in VA's specialized services areas, such as spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury programs.

VA must develop more assertive recruitment strategy and tactics that provide employment incentives to attract and encourage affiliated health professions students, as well as new graduates in all relevant degree programs of affiliated institutions, to commit to VA careers.

CRITICAL ISSUE 6

Maintaining VA's Critical Infrastructure

The Department of Veterans Affairs must receive sufficient funding to reduce the growing infrastructure and maintenance backlog in its medical facilities and improve efforts to spend the resources it is given.

The Department of Veterans Affairs health-care infrastructure is at a crossroads. The system is facing many challenges, including the average age of buildings (60 years) and the need for significant funding for routine maintenance, upgrades, modernization, and construction.

Aging facilities create an increased burden on VA's overall maintenance requirements. In order to keep up with rapidly deteriorating building systems—electrical, plumbing, and capital equipment—VA must aggressively plan for repairs. Buildings must be kept up to date and repaired in order to provide safe environments to deliver health care to veterans.

VA is beginning a patient-centered reformation and transformation of the way it delivers care and new ways of managing its infrastructure plan based on the needs of sick and disabled veterans in the 21st century. Regardless of what the VA health-care system of the future may look like, our focus must remain on ensuring a lasting, accessible, and modernized system that is dedicated to the unique needs of veterans while also providing unparalleled and timely care when and where veterans need it.

The Capital Asset Realignment for Enhanced Services (CARES) process, VA's data-based assessment of current and future construction needs, gave VA a long-term roadmap and has helped guide its capital planning process over the past 10 years. CARES showed a large number of significant construction priorities that would be necessary for VA to fulfill its obligation to this nation's veterans. Over the past several years, the Administration and Congress have made significant inroads in funding these priorities. Since fiscal year (FY)

2004, \$5.9 billion has been allocated for these projects. *The Independent Budget* veterans service organizations (IBVSOs) believe that it has been a necessary undertaking and that VA has made slow but steady progress on many of these critical projects.

In the post-CARES era, many necessary projects are still waiting to be initiated or completed, and we firmly believe that Congress cannot allow the construction needs that led to the CARES blueprint to be disregarded. Both strong oversight and sufficient funding are critical in this ongoing task of ensuring the best care for our veterans.

VA acknowledges three main challenges with its capital infrastructure projects. First, they are costly: over the next five years VA needs \$2 billion per year for its capital budget. Second, there is a large backlog of partially funded construction projects. VA claimed that the difference between the major construction requests it proposed to the Office of Management and Budget and what it actually received was \$8.6 billion from FY 2003 through FY 2009. Additionally, there is a \$2 billion funding backlog for projects that are partially, but not completely, funded. Third, VA is concerned about the timeliness of construction projects, noting that it can take the better part of a decade from the time VA initially proposes a project until the doors actually open for veterans' care.

Given these challenges, VA has proposed a new program, Strategic Capital Investment Planning (SCIP), to address some of the infrastructure issues that have been noted by the IBVSOs. SCIP is VA's newest approach to reevaluating its aging and underutilized infrastructure as well as the lack of infrastructure in various locations around the country.

The intent of SCIP, according to VA, is to scrutinize all property so that VA can best address gaps in delivery of care and services to veterans. Unlike CARES, SCIP will cover all of VA, not only Veterans Health Administration facilities; however, similar to CARES, SCIP is designed to evaluate the condition of VA's infrastructure to build a 10-year integrated capital plan. The goal is to improve quality of and access to VA services by modernizing facilities

based on current and future needs. VA plans to begin this process with the FY 2012 budget cycle.

VA has advised that SCIP is intended to address the funding shortfall of \$24.3 billion to deal with major construction and facility condition assessment backlogs, inefficient use of resources and higher maintenance costs, and an existing commitment of more than \$5.4 billion in partially funded projects.

Because SCIP is a new initiative, the IBVSOs encourage VA to provide transparency during the process. It is our understanding that the program will be a 10-year plan in which VA will review and assess all current and future needs focused at the VISN level, with review by a VA board. The goal of this new initiative must be a comprehensive plan that will improve quality by providing equitable access to services for all veterans across the VA system of care and services.

Another recent initiative by VA is the Health Care Center Facility (HCCF) leasing concept. Under the HCCF, VA would begin leasing large outpatient clinics in lieu of major construction. These large clinics would provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

Initially, *The Independent Budget* veterans service organizations were supportive of the goals of this program. Leasing has the advantage of being able to be completed quickly, as well as being adaptable, especially when compared to the existing major construction process. Leasing has been particularly valuable for VA as evidenced by the success of the community-based outpatient clinic and Vet Center leasing policies.

As the process has unfolded, however, concerns have arisen about VA's plan for inpatient services. VA suggests it will contract for these essential services with affiliates or

community hospitals. This program would privatize many services the IBVSOs believe VA should continue to provide. An example would be the VA facility located in Grand Island, Nebraska. In 1997, the Grand Island VA Medical Center closed its inpatient facilities, contracting with a local hospital (St. Francis Medical Center) for those services. The contract between St. Francis and VA was subsequently cancelled, meaning veterans in that area could no longer receive inpatient services locally, but would have to travel great distances to other VA facilities, such as the Omaha VA Medical Center. In some cases in which the Omaha VA is unable to provide specialized care, VA is flying patients at its expense to faraway VA medical centers, including those in St. Louis and Minneapolis.

Furthermore, with the cancellation of the contract, St. Francis no longer provides the same level of emergency services that a full VA medical center would provide. Given VA's restrictions on paying for emergency services in non-VA facilities, especially for those who may have some form of private insurance, this amounts to a cut in essential VA services to veterans. Given the expenses of air travel and medevac services, the current situation in Grand Island likely has not resulted in any cost savings for VA. Ferrying sick and disabled veterans great distances for inpatient VA care also raises legitimate patient safety and quality concerns.

CARES provided a sound, data-based assessment of VA's infrastructure needs, but VA seems to be backing away from it toward a model that emphasizes more privatization of care. The IBVSOs will be monitoring the process carefully and will insist that VA act in a transparent manner by providing specific information and reasons for any changes in plans that deviate from the CARES blueprint.

For years the IBVSOs have highlighted the need for increased funding for the Nonrecurring Maintenance (NRM) account. NRM consists of small projects that are essential to the proper maintenance and preservation of VA's facilities. These NRM projects are one-time repairs, such as maintenance and replacement of roofs, repair and replacement of windows and

flooring, or minor upgrades to the mechanical or electrical systems. Such basic maintenance is necessary for any facility.

These projects are essential because if such problems are left unrepaired, they can take a toll on a facility, leading to more costly repairs in the future and heightening the potential for increases in funding for VA's minor construction project accounts. Beyond the fiscal aspects, facilities that fall into disrepair can create access difficulties and impair the health and safety of both patients and staff. If these issues develop into a larger construction requirement because basic maintenance was ignored over time, it will create an even larger inconvenience for veterans and staff while needlessly increasing long-term costs.

The industry standard for medical facilities is for managers to spend from 2 percent to 4 percent of plant replacement value (PRV) on upkeep and maintenance. The 1998 PricewaterhouseCoopers study of VA's facilities management practices argued for this level of funding, and previous versions of VA's own Asset Management Plan also have supported it.

The most recent estimate of VA's PRV is from the FY 2008 Asset Management Plan. Using the standards of the federal government's Federal Real Property Council (FRPC), VA's PRV is just over \$85 billion. To fully maintain its facilities, VA needs an NRM budget of at least \$1.7 billion. This level would represent a doubling of VA's budget request and would be a significant increase over what it has received in recent years. Yet the IBVSOs believe it is in line with the total NRM budget when factoring in the increases Congress has provided, including the targeted funding attached to the American Recovery and Reinvestment Act.

Increased funding is required not only to fill current maintenance needs and levels, but also to reduce the extensive backlog of maintenance requirements VA has acknowledged. VA monitors the condition of its structures and systems through the Facility Condition Assessment (FCA) reports. VA surveys each medical center periodically, giving each

building a thorough assessment of all essential systems. Systems are assigned a letter grade based upon their age and condition, and VA gives each component a cost for repair or replacement. The bulk of these repairs and replacements is conducted through the NRM program, although the large increases in minor construction over the past few years have helped VA to address some of these deficiencies.

VA's Five-Year Capital Plan discusses FCA reports and acknowledges the significant backlog and the number of high priority deficiencies—those with ratings of *D* or *F* and replacement and repair costs of more than \$9.4 billion. VA estimates that 52 percent of NRM dollars are obligated toward these costs. VA uses the FCA reports as part of its FRPC metrics. The department calculates a facility condition index, which is the ratio of the cost of FCA repairs to the cost of replacement. According to the FY 2008 Asset Management Plan, this ratio has decreased from 82 percent in 2006 to 68 percent in 2008. VA's strategic goal is 87 percent. For that goal to be reached, a sizeable investment in NRM and minor construction would be needed.

Given the low level of funding the NRM account has historically received, the IBVSOs are not surprised at the metrics or the dollar cost of the FCA deficiencies. The 2007 "National Roll Up of Environment of Care Report," which was triggered after the shameful maintenance deficiencies at Walter Reed Army Medical Center were reported, further proves the need for increased spending in this account. Maintenance has been neglected for far too long, and for VA to provide safe, high-quality health care in its aging facilities, it is essential that more money be allocated for this account.

The IBVSOs also have concerns with how NRM funding is actually apportioned. Since it falls under the Medical Care appropriations account, NRM funding has traditionally been apportioned using the Veterans Equitable Resource Allocation formula. This model is designed and used to target funds to those areas with the greatest demand for health care. When dealing with maintenance needs, however, this same formula may actually intensify

the problem by moving resources away from older facilities, such as those in the Northeast, to newer facilities where patient demand is greater, even if the maintenance needs are not as critical.

Additionally, a May 2007 Government Accountability Office (GAO) report found that the bulk of NRM funding is not actually apportioned until September, the final month of the fiscal year. In September 2006, the GAO found that VA had allocated 60 percent of that year's NRM funding in the final month of the fiscal year. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and with NRM funding being year to year, this policy can lead to wasteful or unnecessary spending as medical center managers rush to spend their apportionment so as not to forfeit it. We cannot expect VA to perform a year's worth of maintenance in a month. It is clearly an ill-suited policy that is not in the best interest of veterans. The IBVSOs believe that Congress should consider allowing some NRM funding to be carried over from one fiscal year to another. While we would hope that this would not result in medical center administrators hoarding funds, we believe it could promote more efficient spending and better planning, rather than medical center managers sometimes spending a large portion of maintenance funding in less beneficial ways under the current "use it or lose it" paradigm.

Recommendations:

Congress must dramatically increase funding for Nonrecurring Maintenance (NRM) in line with the 2 percent to 4 percent total that is the industry standard so as to maintain clean, safe, and efficient facilities. VA also should receive additional maintenance funding to allow the department to begin addressing the substantial maintenance backlog of Facility Condition Assessment-identified projects.

VA should allocate portions of the NRM account outside of the Veterans Equitable Resource Allocation formula so that funding is allocated to the facilities that actually have the greatest maintenance needs.

VA must not implement a broad-based Health Care Center Facility leasing program until fully addressing the concerns of *The Independent Budget* veterans service organizations, and it must explain how the program would meet the needs of veterans, particularly with respect to the baseline established by the Capital Asset Realignment for Enhanced Services process.

Congress and the Administration must ensure that funds are adequate for VA's capital budget so that VA can properly invest in its physical assets to protect their value and to ensure that the Department can continue to provide health care in safe and functional facilities long into the future.

VA's new capital plan, Strategic Capital Investment Planning, must be explained fully, including addressing the current backlog, identifying the gaps in care, and determining how funding will be dispersed and prioritized, and explaining the plan's relationship to the HCCF initiative.

CRITICAL ISSUE 7

Education, Employment, and Training

Positive transition from military service to civilian life hinges on veterans' ability to be competitive in the workforce; therefore, it is imperative that Congress fund education, employment, and training programs to meet increasing needs.

Education

Education benefits have been the single greatest recruitment tool for the Department of Defense since the military became an all-volunteer force. Over the years, veterans' education benefits have evolved from the "Servicemen's Readjustment Act of 1944" to the peace-time Montgomery GI Bill (MGIB) and now to the Post-9/11 GI Bill. Historically, service members were not eligible for multiple types of education benefits as they are today. Now new service members must make tough choices between the different benefits without fully understanding the scope of their available options. Until the seven different types of veterans education benefits are consolidated into a total force GI Bill, veterans will have to continue navigating this bureaucratic maze at their peril, and incoming service members will still be taxed \$1,200 during their first year in the military to qualify for the MGIB.

The Independent Budget veterans service organizations (IBVSOs) praise the passage of the Post-9/11 GI Bill. Even though this benefit represents the largest increase in educational assistance since World War II, there are several issues that still need to be addressed to provide parity for veterans. Under the current provisions, certain veterans will receive reduced value with the new Post-9/11 GI Bill. The issues include disproportionate levels of payment under the Yellow Ribbon Program because of large disparities in tuition and fee caps between the states, denial of living stipends for veterans who attend college solely online, absence of benefits under title 32 in regard to Active Guard Reserve and Guard members who are called to active duty by their states, and exclusion of vocational, on-the-job training, apprenticeships, and certification programs from the benefit.

VA's current method for determining tuition and fee caps for each state causes confusion, unpredictability, and inequities for student veterans using the new Post-9/11 GI Bill. For example, due to the complexity of determining the various state caps, this year VA was a month late publishing the list of benefits. Many students who had already started school in August did not know what their new Post-9/11 GI Bill benefits would cover.

For Minnesota students, for example, the rates unexpectedly dropped 40 percent, and they were left to pay the bill. This is the second time the tuition rates have dropped unexpectedly in a state, and there is no way for a student veteran to predict year to year what their new Post-9/11 GI Bill benefit will be. Even during the year, every time a state changes its public school tuition rates, VA is required to change the state caps to match, requiring the Department to recertify tens of thousands of Post-9/11 GI Bill claims under the new rates each time.

Often veterans decide to attend online universities to achieve their educational goals. Online education has become enormously popular and has strong employer support. This option is not solely used for convenience; it is used as a necessity. Many veterans have families and work obligations that prevent them from attending college in a traditional manner. However, veterans who opt for a degree track strictly through online courses are denied a living stipend. Education benefits for student veterans should not be reduced or denied if they pursue nontraditional forms of higher education.

By virtue of their status, National Guard members and certain members of the reserve who have volunteered to wear the uniform and to serve their states or work within their community do not qualify for any benefits under the new Post-9/11 GI Bill. This affects nearly 45,000 National Guard and reserve members who have been called to serve in disaster relief, in domestic national security roles, or who volunteer to have their Guard or reserve status as active duty.

The original GI Bill provided benefits for more than 8 million World War II veterans, but just over 2 million of those went to a four-year, degree-seeking institution. The other 6 million sought training through apprenticeships, on-the-job training, and vocational training. Today's veterans are not provided the same benefits. The Post-9/11 GI Bill is denied to veterans who attend a vocational training school. Veterans seeking these nondegree careers are being penalized by being forced to pay into the old MGIB system only to later receive a lesser benefit. Veterans, regardless of their postmilitary occupational desires, should have access to Post-9/11 GI Bill benefits.

In addition, the IBVSOs are concerned that veterans who are eligible for both the Post-9/11 GI Bill and traditional VA Vocational Rehabilitation (Chapter 31) as a result of service-connected disability will choose to receive Post-9/11 benefits because the living allowance is significantly higher than the monthly benefit under Chapter 31. As a result, disabled veterans, in order to provide for their families, will forgo receipt of the comprehensive rehabilitative assistance available to them through the Vocational Rehabilitation and Education (VR&E) Service. This option is not the best one for the veteran's rehabilitation because Chapter 31 participants are entitled to a wider range of services through the VR&E Service, including counseling, skills assessments, and job placement assistance. Congress should act to authorize subsistence allowances for veterans participating in Chapter 31 at the same rates as those eligible for the Post-9/11 GI Bill benefits.

Employment and Training

Employment policy is vital to veterans and veterans with disabilities in today's environment in which work is critical to independence and self-sufficiency. People with disabilities, including disabled veterans, often encounter barriers to their entry or reentry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties, in turn, contribute to low labor force participation rates and high levels of reliance on public benefits.

The Department of Defense indicates that each year approximately 25,000 active duty service members are found “not fit for duty” due to medical conditions that may qualify for VA disability ratings and eligibility for VR&E services.

The VA VR&E program is authorized by Congress under title 38, United States Code, and is better known as Chapter 31 benefits. The program provides services and counseling necessary to enable service-disabled veterans to overcome employment barriers and allow them to prepare for, find, and maintain gainful employment in their communities. The program also provides independent living services to veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their reentry into to private life. The program further offers educational and vocational counseling to service-disabled veterans recently separated from active duty and helps to expedite their reentry into the labor force. These services are also available to dependents of veterans who meet certain eligibility requirements.

In FY 2007 the Office of Management and Budget (OMB) estimated the average cost of placing a service-connected veteran in employment at \$8,856, calculated by dividing VR&E program obligations by the number of veterans rehabilitated. However, the OMB calculations do not include a provision for inflation, increased student tuition costs, and the numbers of veterans who drop out of the VR&E program or choose to interrupt their rehabilitation plans. Comparisons to other vocational programs are not appropriate because nonfederal dollars are excluded when calculating the cost to place an individual in employment status.

Performance reporting for the VR&E Chapter 31 benefits program that is used by VA and Congress to authorize funding and staffing needs must be improved. For example, in FY 2009, in its Performance and Accountability Report and Budget Submission, VA reported 11,022 participants placed in employment, with a rehabilitation rate of 74.4 percent.

However, VA excluded 5,002 veterans who discontinued participating in the program even though these veterans represent a significant portion of veterans served by the program. Recalculating the rehabilitation rate for 2009 by including all participants finds the VR&E success rate to be 45 percent, not 74.4 percent. As a result of this lack of clarity in analysis and reporting, decision makers and Congress are not totally aware of the overall performance rate when making decisions on needed resources.

The number of veterans in various phases of VR&E programs is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. In fact, participation has increased by 9.4 percent, from 97,100 participants in FY 2008 to 106,200 in FY 2009, according to the FY 2009 Performance and Accountability Report. Even though the focus of the VR&E program has drastically changed to career development and employment, it is not clear whether VA is able to meet the current and future demand for employment services. Because the data demonstrate that only 11,022 veterans out of 90,000 active cases were placed in employment, it would be inaccurate to conclude that the program's focus is on employment.

The period of eligibility for VR&E benefits is 12 years from the date of separation from the military or the date the veteran was first notified by VA of a service-connected disability rating. Unfortunately, many veterans are not informed of their eligibility for VR&E services or do not understand the benefits of the program. In addition, veterans who later in life may become so disabled that their disabilities create an employment barrier would benefit from VR&E services well beyond the 12-year delimiting date.

Many veterans with significant disabilities are turning to state vocational rehabilitation and workforce development systems because of these and other impediments to accessing VR&E. Almost all state vocational rehabilitation agencies have entered into memoranda of understanding with VA to serve veterans. Disabled Veterans Outreach Program and Local Veterans' Employment Representative Program personnel are often housed in state One-Stop

Career Centers, and these positions are often praised as a model that should be emulated by the broader workforce system. However, all of these vocational programs are under considerable resource distress and their ability to serve veterans who are unserved by VR&E is hindered by their own personnel and budgetary limitations.

Veteran entrepreneurship programs allow veterans to use their training and skills to establish small businesses. Veterans need assurances that support for their businesses will be available. That is why federal agencies must be held accountable to meeting the federal procurement goals outlined by Executive Order 13360 and sections 15(g) and 36 of the Small Business Act. As more and more service-disabled military members begin to transition into civilian life, they are choosing to start their new lives as entrepreneurs. Recent studies of our newly returning and current veteran population show a 33 percent increase in the formation of new business entities over the past five years. Currently there are more than 18,000 service-disabled veteran-owned small businesses (SDVOSBs) registered in the Central Contractor Registration (CCR) database. This number does not accurately reflect the true number of SDVOSBs and veteran-owned small businesses (VOSBs) that may not yet be registered or have their statuses verified nor the number of veterans who may not be familiar with how to register for inclusion in federal procurement databases.

Veteran-owned businesses face many obstacles to success. For this reason VA established the Center for Veterans Enterprise (CVE) program with the passage of the “Veterans Entrepreneurship and Small Business Development Act of 1999.” As VOSBs and SDVOSBs continue to grow, it is vital that the CVE be ready and able to meet the increasing demand for its services.

The CVE, a subdivision of the Office of Small and Disadvantaged Business Utilization, extends entrepreneur services to veterans who own or who want to start a VOSB. It also helps federal contracting offices to identify VOSBs in response to Executive Order 133600, which calls for federal contracting and subcontracting opportunities for SDVOSBs. In

addition, the CVE works with the Small Business Administration's Veterans Business Development Centers nationwide regarding veteran business financing, management, and bonding and provides technical support for veteran entrepreneurs with the goal of increasing the number of VOSBs and SDVOSBs. Unfortunately, the funding for this program is insufficient to meet the ever increasing needs of our nation's veterans.

At present, vendors desiring to do business with the federal government must register in the CCR database, and those who indicate they are veterans or service-disabled veterans must self-certify their status without verification. Public Law 109-461 required VA to establish a Vendor Information Page database to accurately identify businesses that are 51 percent or more owned by veterans or service-disabled veterans. This database was supposed to give all federal agencies a single source in the identification of possible SDVOSBs and VOSBs for consideration during their procurement processes. However, because of a lack of oversight in this area, the database has failed to fulfill its purpose.

Employment Issues Affecting Veterans on Pension

Many veterans discharged in good health later acquire significant disabilities. Low-income disabled veterans qualify for VA pension benefits under title 38, United States Code, Chapter 15. VA pension is often likened to Supplemental Security Income (SSI) under Social Security. However, unlike SSI that program, VA pensioners face a "cash cliff," in which benefits may be terminated when an individual's earnings pass certain limits, which is similar to what occurs with Social Security Disability Insurance (SSDI) benefits. Because of a modest work record, many of these veterans or their surviving spouses may receive a small SSDI benefit that supplements their VA pension. If these individuals attempt to return to the workforce, not only is their SSDI benefit terminated, but their VA pension benefits are reduced dollar for dollar by their earnings as well.

In the mid-1980s, under Public Law 98-543, Congress authorized VA to undertake a four-year pilot program of vocational training for veterans awarded VA pension. Modeled on the

Social Security Administration's trial work period, veterans in the pilot were allowed to retain eligibility for pension up to 12 months after obtaining employment. In addition, they remained eligible for VA health care up to three years after their pension terminated because of employment. Running from 1985 to 1989, this pilot program achieved some modest success. However, it was discontinued because, prior to VA eligibility reform, most catastrophically disabled veterans were reluctant to risk their access to VA health care by working.

The VA Office of Policy, Planning and Preparedness examined VA's pension program in 2002, and, although a small number, 7 percent of unemployed veterans on pension and 9 percent of veteran spouses on pension cited the dollar-for-dollar reduction in VA pension benefits as a disincentive to work. Now that veterans with catastrophic nonservice-connected disabilities retain access to VA health care, work incentives for VA's pension program should be reexamined and policies toward earnings should be changed to parallel those in the SSI program.

Establishment of a Veterans Economic Opportunity Administration

Statistics prove that veterans struggle with transitioning from military service to civilian life. Young veterans, ages 18 to 24, are at times twice as likely to be unemployed as their civilian counterparts, and on any given night 107,000 veterans are homeless. Education benefits have been greatly improved, but veteran retention on college campuses continues to be dismal. Employment rehabilitation rates for our wounded and injured veterans continue to be unacceptably low. Entrepreneurial programs continue to be underfunded so quality support for veterans seeking to start their own business is lacking.

The IBVSOs believe that these programs, along with other benefits that affect veterans' economic status, could be consolidated under a single and separate administration within VA. Therefore, we recommend that Congress consider the viability of establishing within the Department of Veterans Affairs a Veterans Economic Opportunity Administration, headed

by an under secretary for Veterans Economic Opportunity who would administer all VA programs of economic opportunity assistance to veterans and their dependents and survivors. This new administration would be responsible for vocational rehabilitation and employment, educational assistance, veterans' entrepreneurship, home loans, and homeless veterans programs. If established, this new administration would be the single point of interagency exchange regarding programs that are administered for veterans outside of VA.

Recommendations:

Congress must appropriate and VA must fully cover tuition and fees at all public undergraduate schools, while setting a national standard for private and graduate schools.

Congress must include title 32 service for Active Guard Reserve and National Guard members who are called to active duty by their states as acceptable service under the Post-9/11 GI Bill.

VA must grant Post-9/11 GI Bill benefits to veterans who enroll in apprenticeships, on-the-job training, and vocational programs and living stipends that are equal to the stipends for traditional students based on the zip codes in which these veterans reside.

Congress must provide the funding level to meet the increasing veteran demand for VA Vocational Rehabilitation & Employment (VR&E) program services.

VA should provide placement follow-up with employers equal to the length of an employer's probationary employment period.

The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.

The VR&E Service must place higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

The VR&E Service should initiate a nationwide study to reveal the reasons why veterans discontinue participation in the VR&E program, including veterans who discontinue participating in the program without implementing a written rehabilitation plan and use the information to design interventions to reduce the probability of veterans dropping out of the program.

The VR&E service must report the true number of veterans participating in the program by including veterans who discontinue participation in the program without implementing a written rehabilitation plan. This would ensure more accurate performance data for budgetary and other resource decisions.

Congress should change the eligibility delimiting date for VR&E services by eliminating the 12-year eligibility period for Chapter 31 benefits and allow all veterans with employment impediments or problems with independent living to qualify for VR&E services.

Congress must ensure that all vocational systems to which veterans with significant disabilities must turn have adequate resources to serve them until changes are made in the law to broaden access to VR&E.

Congress must authorize subsistence allowance rates under VA Vocational Rehabilitation (Chapter 31) benefits identical to those available under the Post-9/11 GI Bill to preclude veterans from having to choose the lesser of two benefits out of economic necessity as opposed to employment placement needs.

Congress should investigate the viability of establishing a Veterans Economic Opportunity Administration within VA, to be headed by an under secretary, which would administer all

VA programs of economic opportunity assistance to veterans, dependents, and survivors. This new administration would have responsibility for education programs, Vocational Rehabilitation and Employment, small business programs, and similar programs. Congress should also consider the implications that creation of a new Economic Opportunity Administration would have on overall VA funding.

Congress must also ensure that adequate funding is provided for the Center for Veterans Enterprise to adequately meet increasing veteran demand for entrepreneurial services. These additional funds should also be appropriated for the employment of more staff at CVE to meet the growing veteran entrepreneur population.

Congress must work with VA, the Small Business Administration, and other federal agencies to help eliminate the barriers that veterans face in regard to the formation and development of their business ventures.

Congress and the Administration must require all federal agencies to certify veteran status and ownership through the VA's Veterans Information Portal program before awarding contracts to companies claiming to be veteran-owned or service-disabled veteran-owned small businesses.

Congress should reexamine work incentives in the VA pension program and give consideration to changes that would reduce benefits as earned income rises, as occurs with recipients of Supplemental Security Income.

Congress must extend eligibility for the Post-9/11 GI Bill to all members of the National Guard and certain members of the reserve who have volunteered to wear the uniform and to serve their states or work within their communities.

Congress must extend eligibility for the Post-9/11 GI Bill to those training through apprenticeships, on-the-job training, and vocational training.