Fiscal Year 2007

A Comprehensive Budget & Policy Document Created by Veterans for Veterans

THE INDEPENDENT BUDGET

for the Department of Veterans Affairs

20th Anniversary
1987 ★ 2007

Prologue

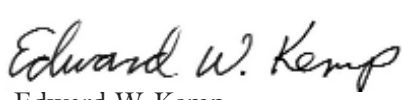
This is the 20th year *The Independent Budget (IB)* has been developed by four veterans service organizations: AMVETS, Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States. This document is the collaborative effort of a united veteran and health advocacy community that presents policy and budget recommendations on programs administered by the Department of Veterans Affairs (VA) and the Department of Labor.

The *IB* is built on a systematic methodology that takes into account changes in the size and age structure of the veteran population, federal employee wage increases, medical care inflation, cost-of-living adjustments, construction needs, trends in health-care utilization, benefit needs, efficient and effective means of benefits delivery, and estimates of the number of veterans to be laid to rest in our national and state veterans cemeteries.

Midway through 2005, the Administration admitted it had severely underestimated the budgetary needs of the VA health-care system for both FY 2005 and FY 2006 by hundreds of millions of dollars. Correcting the massive shortfalls, many Congressional leaders admitted that the *IB* estimates for both years had more adequately hit the target for the true health-care needs of VA and veterans.

As in years past, the budget and appropriations for veterans programs for fiscal year 2007 will line up as discretionary spending in tortured competition with all other domestic discretionary programs funded by the federal government. The *IB* veterans service organizations have become increasingly alarmed that this annual battle for funding is failing to meet the true needs of the veteran population. Dollar amounts are never adequate in the push and pull of the Congressional process. Furthermore, judging from the experiences of the past four years alone, Congress has failed to even pass a VA appropriations bill until months into the new fiscal year, leaving VA hospitals limping along on wholly inadequate continuing resolutions. The system does not suffer in this process, veterans do, veterans waiting months for a doctor's appointment or hours for a nurse to answer a call button.

This year, as in the past, we call on Congress to find a better way to fund veterans health-care spending by removing the veterans budget from the battle over annual discretionary spending. We call on Congress to establish a formula to provide VA health-care funding from the mandatory side of the federal budget, assuring an adequate and timely flow of dollars to meet the needs of sick and disabled veterans.



Edward W. Kemp
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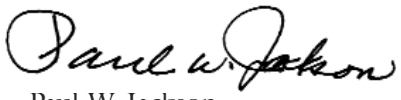

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FY 2007 *INDEPENDENT BUDGET* SUPPORTERS

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African American Post Traumatic Stress Disorder
Air Force Association
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American Coalition for Filipino Veterans
American Ex-Prisoners of War
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Korea Defense Veterans of America
Korea Veterans of America
Military Officers Association of America
Military Order of the Purple Heart of the USA, Inc.
National Alliance on Mental Illness

continued on next page

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National Association for Uniformed Services
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
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United States Navy Cruiser Sailors Association
Veterans Affairs Physician Assistant Association
Veterans Assistance Foundation, Inc.
Veterans of the Battle of the Bulge
Veterans of the Vietnam War, Inc.
Vietnam Veterans of America

Guiding Principles

- Veterans must not have to wait for benefits to which they are entitled.
- Veterans must be ensured access to high-quality medical care.
- Veterans must be guaranteed timely access to the full continuum of health-care services, including long-term care.
- Veterans must be assured burial in state or national cemeteries in every state.
- Specialized care must remain the focus of the Department of Veterans Affairs (VA).
- VA's mission to support the military medical system in time of war or national emergency is essential to the nation's security.
- VA's mission to conduct medical and prosthetic research in areas of veterans' special needs is critical to the integrity of the veterans health-care system and to the advancement of American medicine.
- VA's mission to support health professional education is vital to the health of all Americans.

ACKNOWLEDGEMENTS

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Introduction

A primary and paramount responsibility of any national government is to provide for the common defense. Thus it follows that one of the most essential and fundamental obligations of government is to provide for and guarantee the care of those who defend and preserve it against its enemies. The men and women who are willing to risk life and limb for their country and fellow citizens must be assured that their government will fulfill its reciprocal duty to care for them. All citizens who enjoy the benefits of our nation's democracy and national security individually bear a responsibility for the common defense. Mindful of those principles and genuinely grateful for the contributions and sacrifices of those who serve in the armed forces, our citizens, through our government, have provided for our country's military veterans since our nation was born.

Each new generation is the inheritor of the great republic that thousands of men and women of our armed forces have fought and died for, and we have a continuing solemn obligation to preserve this republic with a strong national defense. Proper treatment of our veterans is an integral and indispensable element of this obligation. The future strength of our nation depends on the willingness of men and women to serve in our military, and their willingness depends in part on our government's ability to meet its obligation to them as veterans. The social contract must be honored; the promise must be kept.

Despite these undeniable truths, the ever-increasing competition for funding of federal programs has made the role of a strong and united voice of advocacy on behalf of veterans all the more critical to ensuring that our government's promise to our veterans is kept. Faced with recurring administration budgets that have requested inadequate resources for veterans' programs and recognizing that responding reactively to these budget recommendations was not effective, four major veterans service organizations (VSOs) perceived a heightened need for a more proactive approach to the annual budget process.

The VSOs joined forces to develop and present a more realistic assessment of the resource requirements for veterans' programs. They committed themselves to follow an objective and responsible approach producing a budget for veterans' programs that was "independent" of the political motivation and influences that too often shortchanged veterans. Over the years since that first independent budget, many public interest groups involved in veterans' issues have joined to support the recommendations. This year the four organizations—AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States—for the 20th consecutive year present the comprehensive independent budget and policy document for veterans' programs, known as *The Independent Budget*.

Department of Veterans Affairs
(Discretionary Budget Authority)
(Dollars in Thousands)

	FY 2006 APPROPRIATION	FY 2007 ADMINISTRATION REQUEST	FY 2007 IB RECOMMENDED APPROPRIATION
Medical Services	22,547,141	24,716,000*	25,990,463
Medical Administration	2,858,442	3,177,000	2,939,403
Medical Facilities	3,297,669	3,569,000	3,461,348
Total, Medical Care	**28,703,252**	**31,462,000**	**32,391,214**
Medical and Prosthetic Research	412,000	399,000	460,000
Subtotal, Veterans Health Administration	*29,115,252*	*31,861,000*	*32,851,214*
Veterans Benefits Administration	1,053,938	1,167,859	1,410,728
General Administration	356,582	312,905	416,017
Total, General Operating Expenses (GOE)	**1,410,520**	**1,480,764**	**1,826,745**
Information Technology	1,213,820	1,257,000	1,252,119
National Cemetery Administration	156,447	160,733	213,982
Office of Inspector General	70,174	69,499	72,778
Subtotal, Dept. Admin. and Misc. Programs	*1,440,441*	*1,487,232*	*1,538,879*
Construction, Major	607,100	399,000	1,447,000
Construction, Minor	198,937	198,000	505,000
Grants for State Extended Care Facilities	85,000	85,000	150,000
Grants for Construction of State Veterans Cemeteries	32,000	32,000	37,000
Subtotal, Construction Programs	*923,037*	*714,000*	*2,139,000*
Other Discretionary	154,513	154,158	158,747
Subtotal, Discretionary	**33,043,763**	**35,697,154**	**38,514,585**
Cost for Priority 8 Veterans Denied Enrollment			**684,443**
Total Discretionary with Priority 8 Veterans			**39,199,028**

**This figure is the result of the Administration's request for $795 million in additional copayment increases and user fees to achieve an overall funding level for Medical Services of $25.5 billion.*

Benefits Programs

Through the Department of Veterans Affairs (VA), our citizens provide various benefits to veterans. Included are disability compensation and dependency and indemnity compensation (DIC), pensions, vocational rehabilitation and employment, education benefits, housing loans, ancillary benefits for service-connected disabled veterans, life insurance, and burial benefits.

Disability compensation payments fulfill our primary obligation to make up for the economic and other losses veterans suffer due to the effects of service-connected diseases and injuries. When veterans' lives are cut short due to service-connected causes or following a substantial period of total service-connected disability, eligible family members receive DIC. Veterans' pensions provide a measure of financial relief for needy veterans of wartime service who are totally disabled by nonservice-connected causes or who have attained age 65. Death pensions are paid to needy eligible survivors of wartime veterans. Burial benefits assist families in meeting the costs of veterans' funerals and burials and provide for burial flags and grave markers. Miscellaneous assistance includes other special allowances for smaller select groups of veterans and dependents and attorney fee awards under the Equal Access to Justice Act. Because of an apparent correlation between veterans' service in Vietnam and spina bifida and other birth defects in the children of these veterans, Congress authorized special programs to provide a monthly monetary allowance, medical treatment, and vocation rehabilitation to these children.

In recognition of the disadvantages that result from interruption of civilian life to perform military service, Congress has authorized various benefits to aid veterans in their readjustment to civilian life. These readjustment benefits provide monetary assistance to veterans undertaking education or vocational rehabilitation programs and to seriously disabled veterans in acquiring specially adapted housing and automobiles. Educational benefits are also available for children and spouses of veterans who are permanently and totally disabled or die as a result of service-connected disability. Qualifying students pursuing VA education or rehabilitation programs may receive work-study allowances. For temporary financial assistance to veterans undergoing vocational rehabilitation, loans are available from the vocational rehabilitation revolving fund.

Under its home loan program, VA guarantees home loans for veterans, certain surviving spouses of veterans, certain service members, and eligible reservists and National Guard personnel. VA also makes direct loans to supplement specially adapted housing grants. VA makes direct housing loans to Native Americans living on trust lands.

Under several different plans, VA offers life insurance to eligible veterans, disabled veterans, and members of the Retired Reserves. A group plan also covers service members and members of the Ready Reserves and their family members. Mortgage life insurance protects veterans who have received specially adapted housing grants.

Through collaborative efforts of Congress, VA, and veterans organizations, these benefit programs have been carefully crafted. Experience has proven that they generally serve their intended purposes and taxpayers very well. Over time, however, we learn of areas in which adjustments are needed to make the programs better serve veterans or to meet changing circumstances. Unfortunately, failure to regularly adjust the benefit rates for increases in the cost of living and failure to make other needed changes threatens the effectiveness of some veterans' benefits.

Veterans' programs must remain a national priority. Additionally, they must be maintained, protected, and improved as necessary. To maintain or increase their effectiveness, we offer the following recommendations.

Benefits Issues

COMPENSATION AND PENSIONS
Compensation

Annual Cost-of-Living Adjustment:

Congress should provide a cost-of-living adjustment (COLA) for compensation benefits.

Veterans whose earning power is limited or completely lost due to service-connected disabilities must rely on compensation for the necessities of life. Similarly, surviving spouses of veterans who died of service-connected disabilities often have little or no income other than dependency and indemnity compensation (DIC). Compensation and DIC rates are modest, and any erosion due to inflation has a direct detrimental impact on recipients with fixed incomes. Therefore, these benefits must be adjusted periodically to keep pace with increases in the cost of living. Observant of this principle, Congress has traditionally adjusted compensation and DIC rates annually.

Recommendation:

Congress should enact a COLA for all compensation benefits sufficient to offset the rise in the cost of living.

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Full Cost-of-Living Adjustment for Compensation:

To maintain the effectiveness of compensation for offsetting the economic loss resulting from service-connected disability and death, Congress must provide cost-of-living adjustments equal to the annual increase in the cost of living.

Disability and dependency and indemnity compensation rates have historically been increased each year to keep these benefits even with the cost of living. However, as a temporary measure to reduce the federal budget deficit, Congress enacted legislation to require monthly payments, after adjustment for increases in the cost of living, to be rounded down to the nearest whole dollar amount. Finding this a convenient way to meet budget reconciliation targets and fund spending for other purposes, Congress seemingly has become unable to break the habit of extending this round-down provision and has extended it even in the face of budget surpluses. Inexplicably, VA budgets have recommended that Congress make the round-down requirement a permanent part of the law. While rounding down compensation rates for one or two years may not seriously degrade its effectiveness, the cumulative effect over several years will substantially erode the value of compensation. Moreover, extended—and certainly permanent—rounding down is entirely unjustified. It robs monies from the benefits of some of our most deserving veterans and dependents, who must rely on their modest compensation for the necessities of life.

Recommendation:

Congress should reject any recommendations to permanently extend provisions for rounding down compensation cost-of-living adjustments and allow the temporary round-down provisions to expire on their statutory sunset date.

Standard for Service Connection:

Service-connected benefits should be provided for all disabilities incurred or aggravated in the line of duty.

The core veterans' benefits are those provided to make up for the effects of "service-connected" disabilities and deaths. When disability or death results from an injury or disease incurred or aggravated in the "line of duty," the disability or death is service-connected for purposes of entitlement to these benefits for veterans and their eligible dependents and survivors. A disability or death from injury or disease is in the line of duty if incurred or aggravated "during" active military, naval, or air service, unless due to misconduct or other disqualifying circumstances. Accordingly, a disability or death from an injury or disease that occurs or increases during service meets the current requirements of law for service connection.

These principles are expressly and clearly set forth in current law. Under the law, the term "service-connected" means, with respect to disability or death, "that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in the line of duty in the active military, naval, or air service." The term "active military, naval, or air service" contemplates, principally, "active duty," although duty for training qualifies when a disability is incurred during such period. The term "active duty" means "full-time" duty in the armed forces.

A member on active duty in the armed forces is at the disposal of military authority and, in effect, on duty 24 hours a day, 7 days a week. Under many circumstances, such member may be directly engaged in performing tasks involved in his or her military vocation for far more extended periods than a typical eight-hour civilian workday and may be on call or standing by for the remainder of the hours in a day. Under other typical circumstances, a service member may live on or near the workstation 24 hours a day, such as duty on submarine, ship, or remote outpost. Even when a military member is not actively or directly engaged in performing functions of his or her military occupation, the member is indirectly on duty or involved in general military duties and ongoing responsibilities. In the military service, there is no distinction between on duty and off duty for purposes of legal status, and there is often no clear practical demarcation between being on and being off duty. Moreover, in the overall military environment, there are rigors, physical and mental stresses, and known and unknown risks and hazards unlike and far beyond those seen in civilian occupations and daily life. Military members stationed in foreign countries are often exposed to increased risks of injury and disease, both on and off military facilities.

For these reasons, current law requires only that an injury or disease be incurred or aggravated "coincident with" military service; there is no requirement that the veteran prove a causal connection between military service and a disability for which service-connected status is sought. For these same reasons, a requirement to prove service causation would be unworkable as long as it is the purpose of the law to equitably dispose of questions of service connection and provide benefits when benefits are rightfully due those who lay their health and lives on the line to bear the extraordinary burdens of defending our national interests. Of course, if it were to become the object of our government to limit as much as possible its responsibility for veterans' disabilities rather than to have a fair and practical legal framework for justice, requiring proof of service causation would accomplish that object quite effectively by making it impossible to prove many meritorious claims.

Surprisingly, during deliberations on the annual defense authorization bill for fiscal year 2004, key members of the leadership of the United States House of Representatives developed a scheme to accomplish that very purpose by replacing the "line of duty" standard with a strict "performance of duty" standard, under which service connection would not generally be in order unless a veteran could prove that a disability was caused by actually performing military duties per se. Although this scheme was not enacted into law, the defense authorization bill did provide for the establishment of a commission to study the foundations of disability benefit programs for veterans, presumably with the same ultimate goal in mind. This action is consistent with current systematic efforts to reduce spending on military personnel and veterans to devote more resources to military hardware and the other costs of war.

It is self-evident that current standards governing service-connected status for veterans' disabilities and deaths are equitable, practical, sound, and time-tested. *The Independent Budget* veterans service organizations urge Congress to reject any revision of this standard for the purpose of permitting the government to coldly and expediently avoid its responsibilities for the human costs of war and national defense.

Recommendation:

Congress should reject any suggestion to change the terms for service connection of disabilities and deaths.

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Concurrent Receipt of Compensation and Military Retired Pay:

All military retirees should be permitted to receive military retired pay and Department of Veterans Affairs (VA) disability compensation concurrently.

Some former service members who are retired from the armed forces on the basis of length of service must forfeit a portion of the retired pay they earned through faithful performance of military service to receive compensation for service-connected disabilities. This is inequitable because military retired pay is earned by virtue of a veteran's long service on behalf of the country.

Entitlement to compensation, on the other hand, is for an entirely separate reason—because of service-related disability. Many nondisabled military retirees pursue second careers after service to supplement their income, thereby justly enjoying the full reward for completion of a military career along with the added reward of full pay for the civilian employment. In contrast, military retirees with service-connected disabilities do not enjoy the same full earning potential. Their earning potential is reduced commensurate with the degree of service-connected disability. To put them on equal footing with nondisabled retirees, they should receive full military retired pay and compensation to substitute for diminution of earning capacity.

To the extent that military retired pay and disability compensation now offset each other, the disabled retiree is treated less fairly than the nondisabled military retiree. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after his or her enlistment expires can receive full compensation and full civilian retired pay. A veteran who has served this country for 20 years or more should have that same right. The veteran should not be penalized for choosing military service as a career rather than a civilian career, especially where in all likelihood a civilian career would have involved fewer sacrifices and greater rewards. Compensation should not be offset against military longevity retired pay. If a veteran must forfeit a dollar of retired pay for every dollar of compensation the veteran receives, our government is in effect paying the veteran nothing for the service-connected disability he or she suffers. *The Independent Budget* veterans service organizations urge Congress to correct this serious inequity.

Recommendation:

Congress should enact legislation to totally repeal the inequitable requirement that veterans' military retired pay based on longevity be offset by an amount equal to their VA disability compensation.

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Continuation of Monthly Payments for all Compensable Service-Connected Disabilities:

Lump-sum settlements of disability compensation should not be used as a way to decrease the government's obligation to disabled veterans and save the government money.

Under current law, the government pays disability compensation monthly to eligible veterans on account of and at a rate commensurate with diminished earning capacity resulting form the effects of service-connected diseases and injuries. By design, compensation continues to provide relief from the service-connected disability for as long as the veteran continues to suffer its effects at a compensable level. By law, the level of disability determines the rate of compensation, thereby requiring reevaluation of the disability upon change in its degree. Lump-sum payments have been recommended as a way for the government to avoid the administrative costs of reevaluating service-connected disabilities and as a way to avoid future liabilities to service-connected disabled veterans when their disabilities worsen or cause secondary disabilities. Under such a scheme, the Department of Veterans Affairs would use the immediate availability of a lump-sum settlement to entice veterans to bargain away their future entitlement. Such lump-sum payments would not, on the whole, be in the best interests of disabled veterans, but rather would be for government savings and convenience. *The Independent Budget* veterans service organizations strongly oppose any change in law to provide for lump-sum payments of compensation.

Recommendation:

Congress should reject any recommendation that it change the law to permit VA to discharge its future obligation to compensate service-connected disabilities through payment of lump-sum settlements to veterans.

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More Equitable Rules for Service Connection of Hearing Loss and Tinnitus:

For combat veterans and those who had military occupations that typically involved noise exposure sufficient to cause hearing loss or tinnitus, service connection should be presumed.

Many combat veterans and veterans that had military duties involving high levels of noise exposure who now suffer from hearing loss or tinnitus likely related to noise exposure or acoustic trauma during service are unable to prove service connection because of inadequate testing procedures, lax examination practices, or poor recordkeeping.

In its September 2005 report, *Noise and Military Service: Implications for Hearing Loss and Tinnitus*, the Institute of Medicine found: "Patterns of hearing loss consistent with noise exposure can be seen in cross-sectional studies of military personnel…Because large numbers of people have served in the military since World War II, the total number who experienced noise-induced hearing loss by the time their military service ended may be substantial, but the available data provide no basis for a valid estimate of the number."

Hearing loss and tinnitus are common among combat veterans. The reason is simple: Combat veterans are typically exposed to prolonged and frequent loud noises from such things as gunfire and jet and other loud aircraft engines, just to name a few. Combat veterans are likely to have suffered acoustic trauma from explosions. Exposure to loud noises and acoustic trauma are both known causes of high frequency hearing loss and tinnitus. Yet many combat veterans are unable to establish that their hearing loss or tinnitus is due to military service. World War II veterans are particularly at a disadvantage because testing by

spoken voice and whispered voice were insufficient to detect hearing loss in many instances.

Other veterans serve in military occupations that typically involve noise exposure sufficient to cause hearing loss. Today, ear protection is mandatory in these military occupations, but many performed the same jobs without protection in earlier periods.

With some regularity, audiometric testing or records of testing are insufficient or lacking for a variety of reasons. Congress has made special provisions for other deserving groups of veterans whose claims are unusually difficult to establish because of circumstances beyond their control. It should do the same for combat veterans and veterans whose military duties are known to have involved noise exposure sufficient to cause hearing loss and tinnitus. When these veterans suffer from tinnitus or the type of hearing loss that can result from noise exposure and when their medical records are insufficient to prove absence of service-related hearing loss or tinnitus during service, service connection should be presumed as long as no evidence of post-service causation exists.

Recommendation:

Congress should enact a presumption of service connection for combat veterans and veterans that had military duties typically involving high levels of noise exposure who suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma, to apply when the record does not affirmatively prove such condition or conditions are unrelated to service.

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Compensable Disability Rating for Hearing Loss Necessitating Hearing Aid:

The Department of Veterans Affairs (VA) disability rating schedule should provide a minimum 10 percent disability rating for hearing loss that requires use of a hearing aid.

The VA *Schedule for Rating Disabilities* does not provide a compensable evaluation for hearing loss at certain levels severe enough to require hearing aids. The minimum rating for any hearing loss warranting use of hearing aids should be 10 percent, however.

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment and the disadvantages of artificial restoration of hearing, hearing aids negatively affect the wearer's physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of disability compensation that ratings are not offset by the function artificially restored by prosthesis. For example, a veteran receives full compensation for amputation of a lower extremity though he or she may ambulate with a prosthetic limb. Providing a compensable rating would be consistent with minimum ratings provided elsewhere when a disability does not meet the rating formula requirements but requires continuous medication.

Recommendation:

VA should amend its *Schedule for Rating Disabilities* to provide a minimum 10 percent disability evaluation for any hearing loss for which a hearing aid is medically indicated.

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Temporary Total Compensation Awards:

Temporary awards of total disability compensation should be exempted from delayed payment dates.

An inequity exists in current law controlling the beginning date for payment of increased compensation based on periods of incapacity due to hospitalization or convalescence.

Hospitalization in excess of 21 days for a service-connected disability entitles the veteran to a temporary total disability rating. This rating is effective the first day of hospitalization and continues to the last day of the month of hospital discharge. Similarly, where surgery for a service-connected disability necessitates at least one month's convalescence or causes complications, or where immobilization of a major joint by cast is necessary, a temporary total rating is awarded effective the date of hospital admission or outpatient visit.

Though the effective date of the temporary total disability rating corresponds to the beginning date of hospitalization or treatment, the provisions of 38 U.S.C. § 5111 delay the effective date for payment purposes until the first day of the month following the effective date of the increased rating.

This provision deprives veterans of any increase in compensation to offset the total disability during the first month in which temporary total disability occurs. This deprivation and consequent delay in the payment of increased compensation often jeopardizes disabled veterans' financial security and unfairly causes them hardships.

Therefore, *The Independent Budget* veterans service organizations urge Congress to enact legislation exempting these temporary total ratings, under 38 C.F.R. §§ 4.29, 4.30, from the provisions of 38 U.S.C. § 5111.

Recommendation:

Congress should amend the law to authorize increased compensation on the basis of a temporary total rating for hospitalization or convalescence to be effective, for payment purposes, on the date of admission to the hospital or the date of treatment, surgery, or other circumstances necessitating convalescence.

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Dependency and Indemnity Compensation

Repeal of Offset Against Survivor Benefit Plan:

The current requirement that the amount of an annuity under the Survivor Benefit Plan (SBP) be reduced on account of and by an amount equal to dependency and indemnity compensation (DIC) is inequitable.

A veteran disabled in service in our armed forces is compensated for the effects of the service-connected disability. When a veteran dies of service-connected causes, or following a substantial period of total disability from service-connected causes, eligible survivors receive DIC from the Department of Veterans Affairs. This benefit indemnifies survivors for the losses associated with the veteran's death from service-connected causes or after a period of time when the veteran was unable, because of total disability, to accumulate an estate for inheritance by survivors.

Career members of the armed forces earn entitlement to retired pay after 20 or more years' service. Unlike many retirement plans in the private sector, survivors have no entitlement to any portion of the member's retired pay after his or her death. Under the SBP, deductions are made from the member's retired pay to

purchase a survivors' annuity. This is not a gratuitous benefit. Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died of other than service-connected causes or was not totally disabled by service-connected causes for the required time preceding his or her death, beneficiaries receive full SBP payments. However, if the veteran's death was due to service-connected causes or followed from the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. Where the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose all entitlement to the SBP annuity.

This offset is inequitable because no duplication of benefits is involved. The offset penalizes survivors of military retired veterans whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay.

Recommendation:

Congress should repeal the offset between dependency and indemnity compensation and the Survivor Benefit Plan.

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READJUSTMENT BENEFITS

Montgomery GI Bill

Expansion of Montgomery GI Bill Eligibility:

Service members who in every respect are at least equally entitled to participate in the Montgomery GI Bill as service members who first entered military service after June 30, 1985, are ineligible if they entered or had military service before that date.

Under current law, an active duty service member must have first become a member of the armed forces after June 30, 1985, to be eligible to participate in the Montgomery GI Bill. An active duty service member who entered the armed forces before that date and continues to serve cannot participate—unless he or she was enrolled in the prior educational assistance program and elected to convert to the Montgomery GI Bill. In this situation, service members who have served longer and are arguably more deserving of educational benefits are treated less favorably than members who have served in the armed forces for shorter periods.

Any person who was serving in the armed forces on June 30, 1985, or any person who reentered service in the armed forces on or after that date, if otherwise eligible, should be allowed to participate in the Montgomery GI Bill under the same conditions as members who first entered military service after that date.

Recommendation:

Congress should amend the law to remove the restriction on eligibility to the Montgomery GI Bill to those who first entered military service after June 30, 1985.

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Refund of Montgomery GI Bill Contributions for Ineligible Veterans:

The government should refund the contributions of individuals who become ineligible for the Montgomery GI Bill because of general discharges or discharges "under honorable conditions."

The Montgomery GI Bill–Active Duty program provides educational assistance to veterans who first entered active duty (including full-time National Guard duty) after June 30, 1985. To be eligible, service members must have elected to participate in the program and made monthly contributions from their military pay. These contributions are not refundable.

Eligibility is also subject to an honorable discharge. Discharges characterized as "under honorable conditions" or "general" do not qualify. *The Independent Budget* veterans service organizations believe that in the case of a discharge that involves a minor infraction or deficiency in the performance of duty the individual should at least be entitled to a refund of his or her contributions to the program.

Recommendation:

Congress should change the law to permit refund of an individual's Montgomery GI Bill contributions when his or her discharge was characterized as "general" or "under honorable conditions" because of minor infractions or inefficiency.

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Matching Education Benefits to Service Performed— A 21st Century Montgomery GI Bill:

The nation's active duty, National Guard, and Reserve forces are operationally integrated under the Total Force policy. But educational benefits do not reflect the policy nor match benefits to service commitment.

Congress reestablished the GI Bill in 1984. The Montgomery GI Bill (MGIB) was designed to stimulate all-volunteer force recruitment and retention and to help veterans readjust to civilian life. Active duty veterans have up to 10 years post-service to use the MGIB. But Reservists who earn certain MGIB benefits during mobilization get no post-service use of those benefits. In the 1980s, policymakers and Congress never envisioned the routine use of Guard and Reserve forces for every operational mission, nor did many people perceive a need for a post-service readjustment benefit for Reserve participants. The Reserve MGIB worked well for the first 15 years of the MGIBs existence. Slippage of Reserve benefits in relationship to the active duty MGIB started at about the time that large and sustained callups of the Guard and Reserve began after the September 11, 2001, attacks. Congress attempted to respond to this benefit gap by authorizing a second Reserve Title 10 MGIB program—"Chapter 1607"—for reservists who were mobilized for more than 90 days for a contingency operation. However, the complexity of "Chapter 1607" program funding challenges, and the difficulty of correlating it with both the original Reserve MGIB—"Chapter 1606"—and the active duty program, have delayed its implementation, perhaps indefinitely.

The nation's total armed forces need a MGIB that supports recruitment and retention, readjustment to civilian life, proportionality of benefits for service rendered, and ease of administration.

The Total Force MGIB has two broad concepts. First, all active duty and reserve MGIB programs would be organized under title 38. (The responsibility for enlistment incentives, MGIB "kickers," and other incentives would remain with the Department of Defense under title 10). Second, MGIB benefit levels should be simplified according to the military service performed.

To align benefits with service performed, National Guard and Reserve MGIB programs would be integrated with the active duty program. Second, benefit rates would be structured as follows:

1. Tier one—similar to the current Montgomery GI Bill-Active Duty three-year rate—would be provided to all who enlist in the active armed forces. Service entrants would receive 36 months of benefits at the active duty rate.
2. Tier two would be for non-prior service direct entry in the Selected Reserve (SELRES) for six years. Benefits would be proportional to the active duty rate. Historically, Selected Reserve Benefits have been 47 to 48 percent of active duty benefits.
3. Tier three would be for members of the Ready Reserves who are activated for at least 90 days. They would receive one month of benefits for each month of activation, up to a total of 36 months, at the active duty rate.

A service member would have up to 10 years to use remaining active duty or activated-service benefits—Tier One and Tier Three—from the date of separation. A Selected Reservist could use remaining Second Tier MGIB benefits as long as he/she were satisfactorily participating in the SELRES and for up to 10 years following separation from the reserves if a separation were for disability or qualification for a reserve retirement at age 60.

Recommendation:

Congress should combine all active duty and reserve MGIB programs and tier benefits according to the service performed.

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Housing Grants

Increase in Amount of Grants and Automatic Annual Adjustments for Inflation:

Housing grants and home adaptation grants for seriously disabled veterans need to be adjusted automatically each year to keep pace with the rise in the cost of living.

The Department of Veterans Affairs provides specially adapted housing grants of up to $50,000 to veterans with service-connected disabilities consisting of certain combinations of loss or loss of use of extremities and blindness or other organic diseases or injuries. Veterans with service-connected blindness alone or with loss or loss of use of both upper extremities, may receive a home adaptation grant of up to $10,000.

Increases in housing and home adaptation grants have been infrequent, although real estate and construction costs rise continually. Unless the amounts of the grants are periodically adjusted, inflation erodes the value and effectiveness of these benefits, which are payable to a select few but among the most seriously disabled service-connected veterans. Congress should increase the grants this year and amend the law to provide for automatic adjustment annually.

Recommendation:

Congress should increase the specially adapted housing grants and provide for future automatic annual adjustments indexed to the rise in the cost-of-living.

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Grant for Adaptation of Second Home:

Grants should be available for special adaptations to homes that veterans purchase or build to replace initial specially adapted homes.

Like those of other families today, veterans' housing needs tend to change with time and new circumstances. An initial home may become too small when the family grows or become too large when children leave home. Changes in the nature of a veteran's disability may necessitate a home configured differently and changes in the special adaptations. These things merit a second grant to cover the costs of adaptations to a new home.

Recommendation:

Congress should establish a grant to cover the costs of home adaptations for veterans who replace their specially adapted homes with new housing.

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Automobile Grants and Adaptive Equipment

Increase in Amount of Grant and Automatic Annual Adjustments for Increased Costs:

The automobile and adaptive equipment grants need to be increased and automatically adjusted annually to cover increases in costs.

The Department of Veterans Affairs provides certain severely disabled veterans and service members grants for the purchase of automobiles or other conveyances. This grant also provides for adaptive equipment necessary for safe operation of these vehicles. Veterans suffering from service-connected ankylosis of one or both knees or hips are eligible for only the adaptive equipment. This program also authorizes replacement or repair of adaptive equipment.

Congress initially fixed the amount of the automobile grant to cover the full cost of the automobile. With subsequent cost-of-living increases in the grant, Congress sought to provide 85 percent of the average cost of a new automobile, and later 80 percent. Until the 2001 increase to $9,000, the amount of the grant had not been adjusted since 1988, when it was set at $5,500.

Because of a lack of adjustments to keep pace with increased costs, the value of the automobile allowance has substantially eroded through the years. In 1946 the $1,600 allowance represented 85 percent of average retail cost and a sufficient amount to pay the full cost of automobiles in the "low-price field." By contrast, in 1997 the allowance was $5,500, and the average retail cost of new automobiles was $21,750, according the National Automobile Dealers Association. The 1997 average cost of an automobile was 1,155 percent of the 1946 cost, but the automobile allowance of $5,500 was only 343 percent of the 1946 award. Currently, the $11,000 automobile allowance represents only about 39 percent of the average cost of a new automobile, which is $28,105. To restore the comparability between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be $22,484.

Veterans eligible for the automobile allowance under 38 U.S.C. § 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the nature of their disabilities requires the larger and more

expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current $11,000 allowance is only a fraction of the cost of even the modest and smaller models, which are often not suited to these veterans' needs.

Accordingly, if this benefit is to accomplish its purpose, it must be adjusted to reflect the current cost of automobiles. The amount of the allowance should be increased to 80 percent of the average cost of a new automobile in 2004. And to avoid further erosion of this benefit, Congress should provide for automatic annual adjustments based on the rise in the cost of living.

Recommendation:

Congress should increase the automobile allowance to 80 percent of the average cost of a new automobile and provide for automatic annual adjustments in the future.

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Home Loans

No Increase in, and Eventual Repeal of, Funding Fees:

Funding fees are contrary to the principles underlying our benefit programs for veterans, and increased funding fees are negating the benefits and advantages of Department of Veterans Affairs home loans.

Congress initially imposed funding fees upon VA guaranteed home loans under budget reconciliation provisions as a temporary deficit-reduction measure. Now, loan fees are a regular feature of all VA home loans except those exempted. During its first session, the 108th Congress increased these loan fees. The purpose of the increases was to generate additional revenues to cover the costs of improvements and cost-of-living adjustments in other veterans' programs. In effect, this legislation requires one group of veterans, (and especially our young active duty military), those subject to loan fees, to pay for the benefits of another group of veterans, those benefiting from the programs improved or adjusted for increases in the cost of living.

First and foremost, it is the position of *The Independent Budget* that veterans' benefits, provided to veterans by a grateful nation in return for their contributions and sacrifices through service in the armed forces, should be entirely free. In addition, *The Independent Budget* finds it entirely indefensible that Congress can only make improvements or adjustments in veterans' programs for inflation by shifting the costs onto the backs of other veterans. The government, not veterans, should bear the costs of veterans' benefits. With these increased funding fees, the advantages of VA home loans for veterans are being negated. These fees are increasing the burdens upon veterans purchasing homes while the intent of VA's home loan program is to lessen the burdens.

Recommendation:

Congress should refrain from further increasing home loan funding fees and should, as soon as feasible, repeal these fees entirely.

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INSURANCE
Government Life Insurance

Value of Policies Excluded from Consideration as Income or Assets:

For purposes of other government programs, the cash value of veterans' life insurance policies should not be considered assets, and dividends and proceeds should not be considered income.

For nursing home care under Medicaid, the government forces veterans to surrender their government life insurance polices and apply the amount received from the surrender for cash value toward nursing home care as a condition for Medicaid coverage of the related expenses of needy veterans. It is unconscionable to require veterans to surrender their life insurance to receive nursing home care. Similarly, dividends and proceeds from veterans' life insurance should be exempt from countable income for purposes of other government programs.

Recommendation:

Congress should enact legislation to exempt the cash value of, and dividends and proceeds from, Department of Veterans Affairs life insurance policies from consideration in determining entitlement under other federal programs.

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Lower Premium Schedule for Service-Disabled Veterans' Insurance:

The Department of Veterans Affairs (VA) should be authorized to charge lower premiums for Service-Disabled Veterans' Insurance (SDVI) policies based on improved life expectancy under current mortality tables.

Because of service-connected disabilities, disabled veterans have difficulty getting or are charged higher premiums for life insurance on the commercial market. Congress therefore created the SDVI program to furnish disabled veterans life insurance at standard rates. When this program began in 1951, its rates, based on mortality tables then in use, were competitive with commercial insurance. Commercial rates have since been lowered to reflect improved life expectancy shown by current mortality tables. VA continues to base its rates on mortality tables from 1941 however. Consequently, SDVI premiums are no longer competitive with commercial insurance and therefore no longer provide the intended benefit for eligible veterans.

Recommendation:

Congress should enact legislation to authorize VA to revise its premium schedule for SDVI to reflect current mortality tables.

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Increase in Maximum Service-Disabled Veterans' Insurance Coverage:

The current $10,000 maximum for life insurance under Service-Disabled Veterans' Insurance does not provide adequately for the needs of survivors.

When life insurance for veterans had its beginnings in the War Risk Insurance program, first made available to members of the armed forces in October 1917, coverage was limited to $10,000. At that time, the law authorized an annual salary of $5,000 for the Director of the Bureau of War Risk Insurance. Obviously, the average annual wages of service members in 1917 was considerably less than $5,000. A $10,000 life insurance policy provided sufficiently for the loss of income from the death of an insured in 1917.

Today, more than 88 years later, maximum coverage under the base SDVI policy is still $10,000. Given that the annual cost of living is many times what it was in 1917, the same maximum coverage well over three quarters of a century later clearly does not provide meaningful income replacement for the survivors of service-disabled veterans.

In the May 2001 report from an SDVI program evaluation conducted for VA, it was recommended that basic SDVI coverage be increased to $50,000 maximum. The IBVSOs therefore recommend that the maximum protection available under SDVI be increased to at least $50,000.

Recommendation:

Congress should enact legislation to increase the maximum protection under base SDVI policies to at least $50,000.

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Veterans' Mortgage Life Insurance

Increase in VMLI Maximum Coverage:

The maximum amount of mortgage protection under veterans mortgage life insurance (VMLI) needs to be increased.

The maximum VMLI coverage was last increased in 1992. Since then, housing costs have risen substantially. Because of the great geographic differentials in the costs associated with accessible housing, many veterans have mortgages that exceed the maximum face value of VMLI. Thus, the current maximum coverage amount does not cover many catastrophically disabled veterans' outstanding mortgages. Moreover, severely disabled veterans may not have the option of purchasing extra life insurance coverage from commercial insurers at affordable premiums.

Recommendation:

Congress should increase the maximum coverage under VMLI from $90,000 to $150,000.

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OTHER SUGGESTED BENEFIT IMPROVEMENTS

Protection of Veterans' Benefits Against Claims of Third Parties

Restoration of Exemption from Court-Ordered Awards to Former Spouses:

Through interpretation of the law to suit their own ends, the courts have nullified plain statutory provisions protecting veterans' benefits against claims of former spouses in divorce actions.

Congress has enacted laws to ensure veterans' benefits serve their intended purposes by prohibiting their diversion to third parties. To shield these benefits from the clutch of others who might try to obtain them by a wide variety of devices or legal processes, Congress fashioned broad and sweeping statutory language. Pursuant to 38 U.S.C. § 5301(a), "[p]ayments of benefits due or to become due under any law administered by the Secretary shall not be assignable except to the extent specifically authorized by law, and such payments made to, or on account of, a beneficiary shall be exempt from taxation, shall be exempt from the claim of creditors, and shall not be liable to attachment, levy, or seizure by or under any legal or equitable process whatever, either before or after receipt by the beneficiary."

Thus, while as a general rule an individual's income and assets should rightfully be subject to legal claims of others, the special purposes and special status of veterans' benefits trump the rights of all others except liabilities to the United States Government. Veterans cannot voluntarily or involuntarily alienate their rights to veterans' benefits. The justification for this principle in public policy is one that can never obsolesce with the passage of time or changes in societal circumstances.

However, unappreciative of the special character and superior status of veterans' rights and benefits, the courts have supplanted the will and plain language of Congress with their own expedient views of what the public policy should be and their own convenient interpretations of the law. The courts have chiseled away at the protections in § 5301 until this plain and forceful language has, in essence, become meaningless.

Various courts have shown no hesitation to force disabled veterans to surrender their disability compensation and sole source of sustenance to able-bodied former spouses as alimony awards, although divorced spouses are entitled to no veterans' benefits under veterans laws. The welfare of ex-spouses has never been a purpose for dispensing veterans' benefits.

We should never lose sight of the fact that it is the veteran who, in addition to a loss in earning power, suffers the pain, limitations in the routine activities of daily life, and the other social and lifestyle constraints that result from disability. The needs and well-being of the veteran should always be the primary, foremost, and overriding concern when considering claims against a veteran's disability compensation. Disability compensation is a personal entitlement of the veteran, without whom there could never be any secondary entitlement to compensation by dependent family members. Therefore, federal law should place strict limits on access to veterans' benefits by third parties to ensure compensation goes mainly to support veterans disabled in the service of their country. Congress should enact legislation to override judicial interpretation and leave no doubt about the exempt status of veterans' benefits.

Recommendation:

Congress should amend 38 U.S.C. § 5301(a) to make its exemption of veterans' benefits from the claims of others applicable "notwithstanding any other provision of law" and to clarify that veterans' benefits shall not be liable to attachment, levy, or seizure by or under any legal or equitable process whatever "for any purpose."

General Operating Expenses

From its central office in Washington, D.C., and through a nationwide system of field offices, the Department of Veterans Affairs (VA) administers its veterans' benefits programs. Responsibility for the various benefit programs is divided among five different services within the Veterans Benefits Administration (VBA): Compensation and Pension (C&P), Vocational Rehabilitation and Employment (VR&E), Education, Loan Guaranty, and Insurance. Under the direction and control of the Under Secretary for Benefits and various deputies, the program directors set policy and oversee their programs from VA's Central Office. The field offices receive benefit applications, determine entitlement, and authorize benefit payments and awards.

The Office of the Secretary of Veterans Affairs and the assistant secretaries provide departmental management and administrative support. These offices along with the Office of General Counsel and the Board of Veterans' Appeals are the major activities under the General Administration portion of the General Operating Expenses (GOE) appropriation. The GOE appropriation funds the benefits delivery system—VBA and its constituent line, staff, and support functions—and the functions under General Administration.

The best-designed benefit programs achieve their intended purposes only if the benefits are delivered to entitled beneficiaries in a timely manner and in the correct amounts. *The Independent Budget* veterans service organizations make the following recommendations to maintain VA's benefits delivery infrastructure and to improve VA performance and service to veterans.

General Operating Expense Issues

VETERANS BENEFITS ADMINISTRATION

Veterans Benefits Administration Management

Line Authority over Field Offices:

Department of Veterans Affairs' (VA) program directors should have line authority over benefits administration in the field offices.

The Veterans Benefits Administration (VBA) has introduced several new initiatives to improve its claims processes. Besides fundamental reorganization of claims processing methods to achieve increased efficiencies, the initiatives include several measures to improve quality in claims decisions. Among these measures are better quality assurance and accountability for technically correct decisions.

The VBA's current management structure presents a serious obstacle to enforcement of accountability, however, because program directors lack line authority over those who make claims decisions. Of VBA management, program directors have the most hands-on experience with and intimate knowledge of their benefit lines and have the most direct involvement in day-to-day monitoring of field office compliance. Program directors are therefore in the best position to enforce quality standards and program policies within their respective benefit programs. While higher level VBA managers are properly positioned to direct operational aspects of field offices, they are indirectly involved in the substantive elements of the benefit programs. To enforce accountability for technical accuracy and to ensure uniformity in claims decisions, program directors logically should have authority over the decision-making process and should be able to order remedial measures when variances are identified.

In its August 1997 report to Congress, the National Academy of Public Administration (NAPA) attributed much of the VBA's problems to unclear lines of accountability. NAPA found that a sense of powerlessness to act permeates the VBA. In turn, field personnel perceived VBA's central office staff as incapable of taking firm action. NAPA said that a number of executives interviewed by its study team indicated VBA executives have difficulty giving each other bad news or disciplining one another. NAPA concluded that until the VBA is willing to deal with this conflict and modify its decentralized management style it will not be able to effectively analyze the variations in performance and operations existing among its regional offices. Neither will it be able to achieve a more uniform level of performance. Regarding the Compensation and Pension Service (C&P) especially, NAPA concluded that the C&P director's lack of influence or authority over its field office employees would greatly hamper any efforts to implement reforms and real accountability. NAPA recommended that the Under Secretary for Benefits strengthen C&P influence over field operations and close the gaps in accountability.

In its March 2004 "Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veteran," the VA Vocational Rehabilitation and Employment Task Force recommended that the director of the Vocational Rehabilitation and Employment Service be given "some line-of-sight authority for the field administration of the program."

Recommendation:

To make the management structure in the VBA more effective for purposes of enforcing program standards and accountability for quality, VA's Under Secretary for Benefits should give VBA's program directors line authority over VA field office directors.

Veterans Benefits Administration Initiatives

Investment in Veterans Benefits Administration Initiatives:

To maintain and improve efficiency and services, the Veterans Benefits Administration (VBA) must continue to upgrade its technology and training.

To meet ever-increasing demands and maintain efficiency, any benefits system must continually modernize its tools. With the continually changing environment in claims processing and benefits administration, the VBA must continue to upgrade its information technology infrastructure and revise its training to stay abreast of program changes and modern business practices.

Despite these undeniable needs, Congress has steadily and drastically reduced funding for VBA initiatives over the past five fiscal years. In FY 2001, Congress provided $82 million for VBA initiatives. In FY 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and in 2006, $23 million. Funding for FY 2006 is only 28 percent of FY 2001 funding, without regard to the added loss of buying power due to inflation.

With restored investments in initiatives, the VBA could complement staffing adjustments for increased workloads with a support infrastructure designed to increase operations effectiveness. The VBA could resume an adequate pace in its development and deployment of information technology solutions, as well as upgrading and enhancement of training systems, to improve operations and service delivery.

Some initiative priorities for funding are:

- Replacement of the antiquated and inadequate Benefits Delivery Network (BDN) with VETSNET for Compensation and Pensions Service, the Education Expert System (TEES) for Education Service, and Corporate WINRS (CWINRS) for Vocational Rehabilitation and Employment service.

  VETSNET serves to integrate several subsystems into one nationwide information system for claims development and adjudication and payment administration. TEES serves to provide for electronic transmission of applications and enrollment documentation along with automated expert processing. CWINRS is a case-management and information system allowing for more efficient award processing and sharing of information nationwide.

- Continued development and enhancement of data-centric benefits integration with "Virtual VA" and modification of The imaging Management System (TIMS), which serve to replace paper-based records with electronic files for acquiring, storing, and processing of claims data.

  Virtual VA supports pension maintenance activities at three pension maintenance centers. Further enhancement would allow for the entire claims and award process to be accomplished electronically. TIMS is the Education Service's system for electronic education claims files, storage of imaged documents, and workflow management. This initiative is to modify and enhance TIMS to make it fully interactive to allow for fully automated claims and award processing by the Education Service and VR&E nationwide.

- Upgrading and enhancement of training systems.

  VA's Training and Performance Support Systems (TPSS) is a multimedia, multimethod training tool that applies Instructional Systems Development methodology to train and support employee performance. These TPSS applications require technical updating to incorporate changes in laws, regulations, procedures, and benefit programs. In addition to regular software upgrades, a help desk for users is needed to make TPSS work effectively.

  The VBA initiated its "Skills Certification" instrument in 2004. This tool helps the VBA assess the knowledge base of veterans service representatives. The VBA intends to develop additional skills certification modules to test rating veterans service representatives, decision review officers, field examiners, pension maintenance center employees, and education veterans claims examiners.

- Accelerated implementation of Virtual Information Centers (VICs).

  By providing veterans regionalized telephone contact access from multiple offices within specified geographic locations, the Department of Veterans Affairs achieves greater efficiency and improved customer service. Accelerated deployment of VICs will more timely accomplish this beneficial effect.

With the effects of inflation, the growth in veterans' programs, and the imperative to invest more in advanced information technology, *The Independent Budget* veterans service organizations believe that a conservative increase of at least 5 percent annually in VBA initiatives is warranted. Had Congress increased the FY 2001 funding of $82 million by 5 percent each year since then, the amount for FY 2007 would be $109.9 million.

Recommendation:

Congress should provide $109.9 million for Veterans Benefits Administration initiatives to improve its information systems.

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Compensation and Pension Service

Improvements in Claims Processing Accuracy:

To overcome the persistent and longstanding problem of large claims backlogs and consequent protracted delays in the delivery of crucial disability benefits to veterans and their families, the Administration must invest adequate resources in a long-term strategy to improve quality, proficiency, and efficiency within the Veterans Benefits Administration (VBA).

A core mission of the Department of Veterans Affairs (VA) is the provision of benefits to relieve the economic effects of disability upon veterans and their families. For those benefits to effectively fulfill their intended purpose, VA must promptly deliver them to veterans. The ability of disabled veterans to feed, clothe, and provide shelter for themselves and their families often depends on these benefits. The need for benefits among disabled veterans is urgent. While awaiting action by VA, they and their families suffer hardships; protracted delays can lead to deprivation and bankruptcies. Disability benefits are critical, and providing for disabled veterans should always be a top priority of the government.

VA can promptly deliver benefits to entitled veterans only if it can process and adjudicate claims in a timely and accurate fashion. Given the critical importance of disability benefits, VA has a paramount responsibility to maintain an effective delivery system, taking decisive and appropriate action to correct any deficiencies as soon as they become evident. However, VA has neither maintained the necessary capacity to match and meet its claims workload nor corrected systemic deficiencies that compound the problem of inadequate capacity. Rather than making headway and overcoming the chronic claims backlog and consequent protracted delays in claims disposition, VA has lost ground to the problem, with the backlog of pending claims growing substantially larger.

Historically, many underlying causes acted in concert to bring on this now intractable problem. These include mismanagement, misdirected goals, the wrong focus on mere cosmetic fixes, poor planning and execution, and denial and excuses rather than real strategic remedial measures. These dynamics have been thoroughly detailed in several studies into the problem. While the problem has been exacerbated by lack of appropriate and decisive action, most of the causes can be directly or indirectly associated with inadequate resources. The problem was primarily triggered and is now perpetuated by insufficient resources.

Insufficient resources are the result of misplaced priorities, those that seek to reduce spending on veterans' programs despite the need for greater resources to meet a growing wartime workload and to overcome the deficiencies and failures of the past. Instead of requesting the additional resources needed, the President has sought and Congress has provided fewer resources. Recent budgets have sought reductions in full-time employees for the VBA. Such reductions in staffing are clearly at odds with the realities of VA's workload and its failure to improve quality and make gains against the claims backlog. During Congressional hearings, VA is forced to defend a budget that it knows is inadequate.

The priorities and goals of the immediate political strategy are at odds with VA's ability to fulfill its mission and the nation's moral obligation to provide for disabled veterans in an effective manner. VA must have a long-term strategy focused principally on attaining quality and not merely meeting arbitrary production numbers. VA must have adequate resources, and it must invest them in that long-term strategy rather than reactively targeting them to short-term, temporary, and superficial gains. Only then can the claims backlog really be overcome. Only then will the system serve disabled veterans in a satisfactory fashion, in which their needs are addressed timely with the effects of disability alleviated by prompt delivery of benefits. Veterans who suffer disability from military service should not also have to needlessly suffer economic deprivation because of the inefficiency and indifference of their government.

To end this long series of repeated failures from inadequate resources and misplaced priorities, *The Independent Budget* will recommend funding levels for fiscal year 2007 adequate to meet the real staffing (see "Sufficient Staffing Levels" discussion) and other needs of the VBA.

Recommendations:

Congress and the Administration must provide adequate funding to ensure that the Veterans Benefits Administration can process claims in an accurate and timely manner.

VA must develop a long-term strategy focused on improving quality, proficiency, and efficiency and not merely on achieving production numbers.

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Sufficient Staffing Levels:

To overcome its claims backlog and meet an increasing workload, the Department of Veterans Affairs (VA) must be authorized to increase its staffing for the Compensation and Pension Service (C&P).

Despite ongoing efforts to reduce the unacceptably large claims backlog, C&P has been unable to gain ground on its pending claims. This problem persists primarily because the lack of resources has been compounded by higher claims volumes.

During FY 2004 and FY 2005, the total number of compensation, pension, and burial claims received in C&P increased by 9 percent, from 735,275 at the beginning of FY 2003 to 801,960 at the end of FY 2005. This represents an average annual growth rate in claims of 4.5 percent. During this same period, the number of pending claims requiring rating decisions increased by more than 33 percent. (As the Under Secretary for Benefits has stated, "[c]laims that require a disability rating determination are the primary workload component because they are the most difficult, time consuming, and resource intensive.") With an aging veterans' population and ongoing hostilities in Iraq and Afghanistan, there is no reason to believe the growth rate will decline during FY 2006 or FY 2007. With a 9 percent increase in the number of claims in FY 2005, VA can expect 874,136 claims for C&P in FY 2007. Without adequate resources, no

reason exists to believe VA will be able to hold its pending claims backlog to existing levels, much less reduce it.

Moreover, legislation requiring VA to invite veterans in six states to request review of past claims decisions and ratings in their cases and to invite new claims from other veterans in these states will add substantially to the expected increased workload. It is projected that of the approximately 325,000 veterans receiving disability compensation and the additional estimated 50,000 who will be invited to file new claims, 15 percent will seek new or increased benefits, resulting in an estimated 56,000 additional claims. Given past claims processing times, much of this workload will carry over into FY 2007, making the new total more than 930,000 claims in FY 2007.

In its budget submission for FY 2006, VA projected production based an output of 109 claims per direct program full-time employee (FTE). *The Independent Budget* veterans service organizations (IBVSOs) have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, thus resulting in compromised quality, higher error and appeal rates, and even greater system overload. In addition to recommending staffing levels more commensurate with the workload, the IBVSOs have maintained that VA should invest more in training adjudicators and that it should hold them accountable for higher standards of accuracy.

In response to a survey from VA's Office of Inspector General, nearly half of the adjudicators responding admitted that many claims are decided without adequate record development. They recognized the incongruity between their objectives of making legally correct and factually substantiated decisions and management objectives of maximizing decision output to meet production standards and reduce backlogs. Nearly half reported that it is generally or very difficult to meet production standards without sacrificing quality. Fifty-seven percent reported difficulty meeting production standards if they make sure they have sufficient evidence for rating each case and thoroughly review the evidence. Most attributed VA's inability to make timely and high quality decisions to insufficient staff. They indicated that adjudicator training had not been a high priority in VA.

To allow for more time to be invested in training, the IBVSOs believe it prudent to recommend staffing levels based on an output of 100 cases per year for each direct program full-time employee (FTE). With an estimated 930,000 claims in FY 2007, that would require 9,300 direct program FTEs. With the FY 2006 level of 1,520 support FTEs added, this would require C&P to be authorized 10,820 total FTEs for FY 2007.

Recommendation:

Congress should authorize 10,820 total FTEs for the C&P Service for FY 2007.

Vocational Rehabilitation and Employment

Adequate Staffing Levels:

To meet its ongoing workload demands and to implement new initiatives recommended by the Secretary's Vocational Rehabilitation and Employment (VR&E) Task Force, VR&E needs to increase its staffing.

Given its increased reliance on contract services, VR&E needs approximately 50 additional full-time employees (FTE) dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA Vocational Rehabilitation and Employment Task Force recommended in its March 2004 report creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

To implement reforms to improve the effectiveness and efficiency of its programs, the Task Force recommended VA add approximately 200 new FTEs positions to the VR&E workforce. The FY 2006 total of 1,125 FTEs for VR&E should be increased by 250, to 1,375 total FTEs.

Recommendation:

Congress should authorize 1,375 total FTEs for VR&E for FY 2007.

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Education Service

Adequate Staffing:

To meet its increasing workload demands, the Education Service needs to increase direct program full-time employees (FTEs).

As it has with its other benefit programs, the Department of Veterans Affairs has been striving to provide more timely and efficient service to its claimants for education benefits. Though the workload (number of applications and recurring certifications, etc.) increased by 11 percent during FY 2004 and FY 2005, direct program FTEs were reduced from 708 at the end of FY 2003 to 675 at the end of FY 2005. Based on experience during FY 2004 and FY 2005, it is very conservatively estimated that the workload will increase by 5.5 percent in FY 2007. VA must increase staffing to meet the existing and added workload or service to veterans seeking educational benefits will decline. Based on the number of direct program FTEs at the end of FY 2003 in relation to the workload at that time, the Veterans Benefits Administration must increase direct program staffing in its Education Service in FY 2007 to 873 FTEs, 149 more direct program FTEs than authorized for FY 2006. With the addition of the 160 support FTEs as currently authorized, the Education Service should be provided 1,033 total FTEs for FY 2007.

Recommendation:

Congress should authorize 1,033 total FTEs for VA's Education Service.

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Judicial Review in Veterans' Benefits

In 1988, Congress recognized the need to change the procedures that had existed throughout the modern history of veterans' programs, in which claims decisions of the Department of Veterans Affairs (VA) were immune to judicial review. Congress enacted legislation to authorize judicial review and created what is now the United States Court of Appeals for Veterans Claims (CAVC or the court) to hear appeals from VA's Board of Veterans' Appeals (BVA).

Now, VA's administrative decisions on claims are subject to judicial review in much the same way as a trial court's decisions are subject to review on appeal. This provides a course for an individual to seek a remedy for an erroneous decision and a means by which to settle questions of law for application in other similar cases. When Congress established the court, it added another beneficial element to appellate review. It created oversight of VA decision making by an independent, impartial tribunal from a different branch of government. Veterans are no longer without a remedy for erroneous BVA decisions.

For the most part, judicial review of the claims decisions of VA has lived up to positive expectations of its proponents. To some extent it has also brought about some of the adverse consequences foreseen by its opponents. Based on past recommendations of *The Independent Budget,* Congress made important adjustments to correct some of the unintended effects of the judicial review process. Despite the CAVC's initial decisions construing some of these changes, we have not seen the effect intended by Congress to ensure that veterans have meaningful judicial review in all aspects of their appeals. More precise adjustments are still needed to conform CAVC review to Congressional intent.

In addition, most of VA's rulemaking is subject to judicial review, either in connection with a case before the CAVC or upon direct challenge to the United States Court of Appeals for the Federal Circuit. Here again, changes are needed to bring the positive effects of judicial review to all VA rulemaking.

Accordingly, *The Independent Budget* veterans service organizations make the following recommendations to improve the processes of judicial review in veterans' benefits matters.

Judicial Review Issues

THE COURT OF APPEALS FOR VETERANS CLAIMS

Scope of Review

Standard for Reversal of Erroneous Findings of Fact:

To achieve its intent that the court enforce the benefit-of-the-doubt rule on appellate review, Congress must enact more precise and effective amendments to the statute setting forth the Court of Appeals for Veterans Claims (CAVC) scope of review.

The CAVC upholds Department of Veterans Affairs (VA) factual findings unless they are clearly erroneous. Clearly erroneous is the standard for appellate court reversal of a district court's findings. When there is a "plausible basis" for a factual finding, it is not clearly erroneous under the case law from other courts, which the CAVC has applied to the Board of Veterans' Appeals (BVA) findings.

Under the statutory "benefit-of-the-doubt" standard, the BVA is required to find in the veteran's favor when the veteran's evidence is at least of equal weight as that against him or her, or, stated differently, when there is not a preponderance of the evidence against the veteran. Yet the court has been affirming any BVA finding of fact when the record contains the minimal evidence necessary to show a plausible basis for such finding. This renders the statutory benefit-of-the-doubt rule meaningless because veterans' claims can be denied and the denial upheld when supported by far less than a preponderance of evidence against the veteran.

To correct this situation, Congress amended the law to expressly require the CAVC to consider, in its clearly erroneous analysis, whether a finding of fact is consistent with the benefit-of-the-doubt rule. With this statutory requirement, the CAVC can no longer properly uphold a BVA finding of fact solely because it has a plausible basis, inasmuch as that would clearly contradict the requirement that the CAVC's decision must take into account whether the factual finding adheres to the benefit-of-the-doubt rule. The court can no longer end its inquiry after merely searching for and finding a plausible basis for a factual determination. Congress intended for the CAVC to afford a meaningful review of both factual and legal determinations presented in an appeal before the court. Congress also amended the law to specify that the CAVC should, as a general rule, reverse erroneous factual findings rather than set them aside and allow the BVA to decide the question anew on remand.

While Congress chose not to replace the clearly erroneous standard of review, it did foreclose the application of this standard in ways inconsistent with the benefit-of-the-doubt rule. Also, Congress made it clear that the CAVC is not to routinely remand cases for new BVA fact-finding when the findings of fact before the court did not have sufficient support in the record and the current record supports a conclusion opposite of that reached by the BVA. However, the CAVC has construed these amendments, intended to require a more searching appellate review of BVA fact-finding and to enforce the benefit-of-the-doubt rule, as making no substantive change. The CAVC precedent decisions now make it clear that it will continue to defer to and uphold BVA fact-finding without regard to whether it is consistent with the statutory benefit-of-the-doubt rule as long as the court's scope of review retains the clearly erroneous standard. To ensure the CAVC enforces the benefit-of-the doubt rule, Congress should replace the clearly erroneous standard with a requirement that the CAVC will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

Recommendation:

Congress should amend section 38 U.S.C. § 7261 to provide that the CAVC will hold unlawful and set aside any finding of material fact that is not reasonably supported by a preponderance of the evidence.

Court Facilities

Courthouse and Adjunct Offices:

The Court of Appeals for Veterans Claims (CAVC) should be housed in its own dedicated building, designed and constructed to its specific needs and befitting its authority, status, and function as an appellate court of the United States.

During the nearly 16 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse. This court for veterans should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Rather than being a tenant in a commercial office building, the CAVC should have its own dedicated building that meets its specific functional and security needs, projects the proper image, and concurrently allows the consolidation of VA General Counsel staff, CAVC practicing attorneys, and veterans service organization representatives to the CAVC in one place. The CAVC should have its own home, located in a dignified setting, with distinctive architecture that communicates its judicial authority and stature as a judicial institution of the United States.

Construction of a courthouse and justice center requires an appropriate site, authorizing legislation, and funding.

Recommendation:

Congress should enact legislation and provide the funding necessary to construct a courthouse and justice center for the CAVC.

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COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Review of Challenges to VA Rulemaking

Authority to Review Changes to the VA Schedule for Rating Disabilities:

The exemption from judicial review of Department of Veterans Affairs (VA) changes to the rating schedule leaves no remedy for arbitrary and capricious rating criteria.

Under 38 U.S.C. § 502, the Court of Appeals for the Federal Circuit (CAFC) may review directly challenges to VA's rulemaking. Section 502 exempts from judicial review actions relating to the adoption or revision of the VA *Schedule for Rating Disabilities*, however.

Formulation of criteria for evaluating reductions in earning capacity from various injuries and diseases requires expertise not generally available in Congress. Similarly, unlike other matters of law, this is an area outside the expertise of the courts. Unfortunately, without any constraints or oversight whatsoever, VA is free to promulgate rules for rating disabilities that do not have as their basis reduction in earning capacity. The authors of *The Independent Budget* are alarmed by the arbitrary nature of recent proposals to adopt or revise criteria for evaluating disabilities. If it so desired, VA could issue a rule that a totally paralyzed veteran, for example, would be compensated only as 10 percent disabled. VA should not be empowered to issue rules that are clearly arbitrary and capricious. Therefore, the CAFC should have jurisdiction to review and set aside VA changes or additions to the rating schedule when they are shown to be arbitrary and capricious or clearly violate basic statutory provisions.

Recommendation:

Congress should amend 38 U.S.C. § 502 to authorize the CAFC to review and set aside changes to the *Schedule for Rating Disabilities* found to be arbitrary and capricious or clearly in violation of statutory provisions.

Medical Care

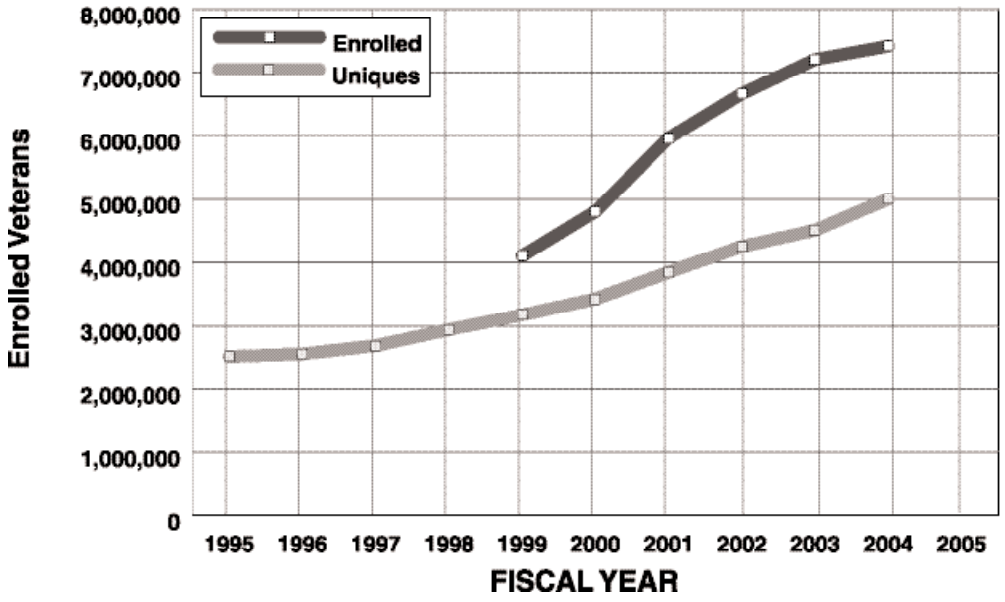
Medical Programs

The Veterans Health Administration (VHA) is the largest direct provider of health-care services in the nation. The VHA provides the most extensive training environment for health professionals and is the nation's most clinically focused setting for medical and prosthetics research. Additionally the VHA is the nation's primary backup to the Department of Defense in times of war or domestic emergency.

Of the 7.5 million veterans enrolled in fiscal year 2005, the VHA provided health care to more than 5.5 million of them. The quality of VHA care is equivalent to, or better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any other system in the United States or worldwide. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors.

CHART 1. UNIQUE VHA PATIENTS & ENROLLED VETERANS

This graph shows the trend toward increasing the number of patients treated in VHA facilities and the increase of veterans enrolled for care.



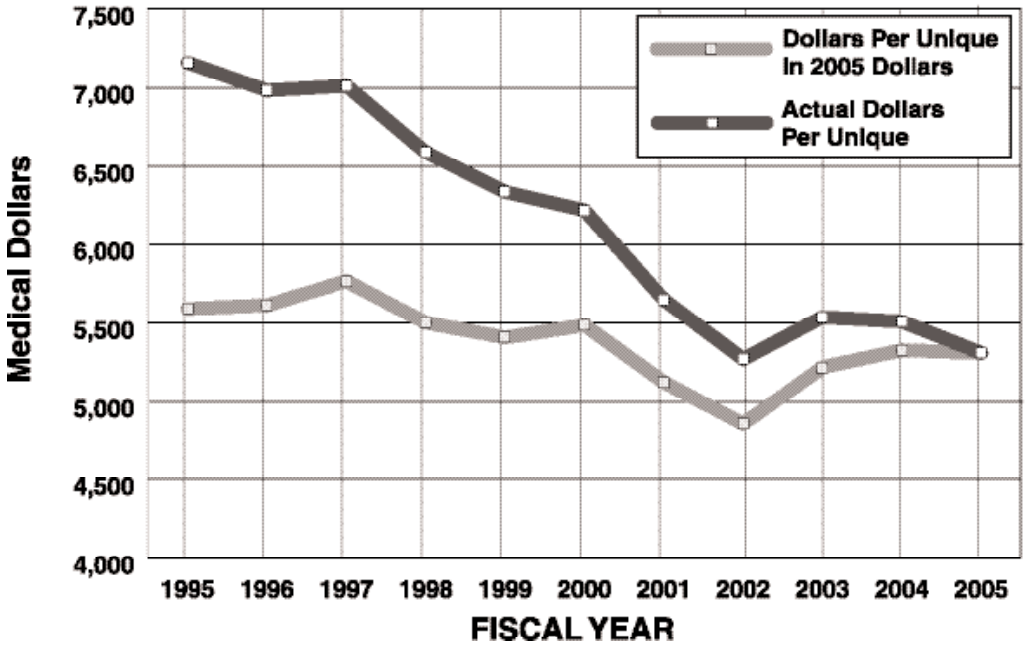
Although the VHA makes no profit, buys no advertising, pays no insurance premiums, and compensates its physicians and clinical staff significantly less than private-sector health-care systems, it is the most efficient and cost-effective health-care system in the nation. The VHA sets the standards for quality and efficiency, and it does so at or below Medicare rates, while serving a population of veterans that is older, sicker, and has a higher prevalence of mental and related health problems.

Year after year the Department of Veterans Affairs (VA) faces inadequate appropriations and is forced to ration care by lengthening waiting times. Although the backlog of veterans waiting more than 60 days for their first appointment has been significantly reduced during the past couple of years, *The Independent Budget* veterans service organizations are concerned that the methodology used in producing the statistics that indicate this reduction in the backlog may be skewed.

The annual shortfall in the VA Medical Care budget translates directly into higher national health-care expenditures. When veterans cannot get needed health-care services from VA, they go elsewhere, and the cost of care is shifted to Medicare or safety net hospitals, often at higher per patient costs. In any case, society pays more while the veteran suffers. A method must be put in place to ensure VA receives adequate funding annually to continue providing timely, quality health care to all enrolled veterans.

In the past five budget cycles, FY 2002 through FY 2006, the Administration's request for the VA Health Care budget has increased from $20.98 billion to $27.81 billion, which represents approximately a 32.6 percent increase. In each of these five budget cycles, Congress has rejected the Administration's request and increased the VA health-care appropriation—from $21.33 billion in FY 2002 to $29.9 billion in FY 2006. This represents an increase of approximately 40.25 percent. During this same time period, the number of enrolled veterans receiving care has increased from 3.9 million unique patients in FY 2001 to 5.5 million in FY 2005, a 40 percent increase.

CHART 2. APPROPRIATED DOLLARS PER UNIQUE PATIENTS AND EFFECTS OF INFLATION ON BUYING POWER



This graph shows the declining value of appropriated dollars per VHA patient in 2005 dollars as compared to actual dollars appropriated. The amounts of appropriation, number of unique users, and inflation are considered.

Medical Care Issues

FINANCING ISSUES

Adequate Funding for VA Health-Care Needed:

The Department of Veterans Affairs (VA) must receive adequate funds to meet the ever-increasing demands of veterans seeking health care.

Last year (2005) proved to be perhaps the most unique year ever in the debate over the VA budget. VA admitted that it did not have the resources necessary to meet the demands being placed on its health-care system. Congress was forced to react quickly and decisively to address this situation. These events served to validate the recommendations made every year by *The Independent Budget (IB)*, coauthored by AMVETS, Disabled American Veterans, the Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States.

Unfortunately, despite these actions, VA still faces the real possibility that it will receive inadequate resources in future budgets and the resources received will be provided after the start of the new fiscal year. These factors continue to place enormous stress on the system and will leave VA struggling to provide the care that veterans have earned and deserve.

For FY 2006 the Administration requested $27.8 billion for veterans' health care, a mere $110 million more than funding for FY 2005. This request represented an increase of only 0.4 percent despite that VA has regularly testified that it requires 13 percent to 14 percent just to meet the demands of inflation and mandatory salary increases.

Once again the President's recommendation attempted to use budget gimmicks, major cuts in long-term care programs, and higher out-of-pocket costs for veterans to cover for its lack of appropriated dollars. The budget request sought to require veterans in categories 7 and 8 to pay a $250 enrollment fee in order to access the health-care system each year. The request also included a recommendation to more than double prescription drug copayments from $7 to $15 for a 30-day supply. VA originally estimated that these fees could result in the disenrollment of more than 213,000 veterans. In fact, more than a million veterans in categories 7 and 8 would have been affected by these proposals.

Faced with growing federal budget deficits, these proposals were part of a concerted effort to save money and reduce discretionary spending in all federal programs, including VA health care. Early in 2005, Congress considered budget control legislation that would have placed spending caps on all discretionary programs. These caps would have meant significant cuts in funding. Such cuts would likely force VA to further restrict enrollment of new veterans seeking access to the system, and could mean staffing reductions, which would result in longer waiting times for veterans.

However, in June 2005, VA acknowledged a budget shortfall of approximately $1 billion for veterans' health-care funding for FY 2005. During a hearing conducted by the House Committee on Veterans' Affairs in June to examine models used to forecast funding needed to provide health care, the VA Under Secretary for Health, Dr. Jonathan Perlin, testified that because of flaws in its health-care model, VA would be transferring approximately $1 billion from other health-care accounts in order to meet demand. During subsequent hearings, the Secretary of Veterans Affairs, James Nicholson, explained that VA was forced to transfer approximately $600 million from operations and nonrecurring maintenance and approximately $400 million in funds that were originally made available for transfer for FY 2006 funding to meet current demand.

During a hearing conducted by the Senate Committee on Veterans' Affairs, a major focus was on the fact that this problem could have been avoided earlier in the year. During debate on the Senate floor on H.R. 1268, "Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief for 2005," an amendment was offered that would have provided an additional $1.9 billion to VA for health care for FY 2005.

That amendment was defeated when Secretary Nicholson informed Senate leaders—in writing—that VA had sufficient funds to meet the demand on the system.

In part, the shortfall was the result of the VA's underestimate of the growth rate of demand on the system. The VA had assumed a growth rate of approximately 2.3 percent when actually the growth rate was closer to 5.2 percent. *The Independent Budget for Fiscal Year 2006* projected a growth rate of approximately 5 percent. Furthermore, VA assumed that only about 23,500 veterans of the global war on terrorism would access the VA for health-care services, when in fact the total number is now estimated to be some 103,000 veterans.

To address this shortfall, the Senate approved an amendment to the FY 2006 Interior Appropriations bill that provided an additional $1.5 billion for veterans' health care. The House Committee on Veterans' Affairs refused to approve an equal amount and instead unanimously passed H.R. 3130, "Veterans Health Care Supplemental Appropriations Act," which provided $975 million, the amount VA had testified was needed to overcome the shortfall. After much debate, both the House and Senate agreed to include the $1.5 billion emergency supplemental for VA in the Interior Appropriations bill, PL 109-54.

One of the most important developments of these proceedings was validation of the recommendations made by *The Independent Budget* veterans service organizations (IBVSOs). During a press conference held by Rep. Steve Buyer (R-IN), chairman of the House Committee on Veterans' Affairs; James Walsh (R-NY), chairman of the House Appropriations Subcommittee on Military Quality of Life and Veterans' Affairs; and Secretary Nicholson, Chairman Buyer stated that, balanced against other health-care models, the *IB's* "best guess was as accurate as I've seen."

For FY 2007, *The Independent Budget* recommends $32.4 billion for VA health care, an increase of $3.7 billion more than the FY 2006 appropriation. Unfortunately, the FY 2006 "Military Quality of Life and Veterans' Affairs" appropriations bill was not approved until November 18, 2005. The bill provided approximately $28.7 billion for VA medical care. Although the appropriation provided a significant increase over the President's budget request, it still fell short of the actual resources needed to continue providing quality, timely care to veterans. When VA does not receive its funding in a timely manner, it is forced to ration health care. Furthermore, VA is unable to plan for the needs of veterans who will be seeking care by hiring much needed medical staff. Waiting times will also continue to increase and the quality of care will decrease as VA will be forced to cut staff.

The medical care appropriation includes three separate accounts—Medical Services, Medical Administration, and Medical Facilities—which comprise the total VA health-care funding level. For FY 2007 the *IB* recommends approximately $26 billion for Medical Services. The *IB's* recommendation includes the following:

Current Services Estimate	$23,350,760,000
Increase in Patient Workload	$ 1,470,817,000
Increase in Full-Time Employees	$ 118,886,000
Policy Initiatives	$ 1,050,000,000
Total FY 2007 Medical Services	**$25,990,463,000**

Our increase in patient workload is based on a projected 6.3 percent increase in workload. The policy initiatives include $500 million for improvement of mental health services, $250 million for funding the fourth mission, and $300 million to support centralized prosthetics funding.

For Medical Administration, the *IB* recommends approximately $2.9 billion. The FY 2006 appropriations bill separated $1.2 billion from this account to create a new Information Technology (IT) account. The new IT account is established as part of General Operating Expenses (GOE). Our recommendation reflects this money still being included in the Medical Administration account as well. We do recommend approximately $1.3 billion to be included in the GOE account for IT for FY 2007. If the IT funds are added back into the *IB*'s recommendation, the Medical Administration recommendation would then be approximately $4.2 billion, and the total Medical Care recommendation would be $33.6 billion. Finally, for Medical Facilities the *IB* recommends approximately $3.5 billion.

The *IB's* recommendation does not include additional money to provide for the health-care needs of category 8 veterans being denied enrollment into the system. Despite the clear desire of the IBVSOs to have the VA health-care system open to these veterans, Congress and the Administration have shown little

desire to overturn this policy decision. VA estimates that more than 1 million Category 8 veterans will have been denied enrollment into the VA health-care system by FY 2007. Assuming a utilization rate of 20 percent, the IBVSOs believe that it would take approximately $684 million to meet the health-care needs of these veterans, if the system were reopened. The IBVSOs believe that the system should be reopened to these veterans and this money appropriated on top of our Medical Care recommendation for this purpose.

In order to address the problem of adequate resources provided in a timely manner, *The Independent Budget* has proposed that funding for veterans' health care be removed from the discretionary budget process and made mandatory. This would not create a new entitlement; rather, it would change the manner of health-care funding, removing VA from the vagaries of the appropriations process. Until this proposal becomes law, however, Congress and the Administration must ensure that VA is fully funded through the current process.

Recommendation:

Congress and the Administration must provide adequate funding for veterans' health care to ensure that VA can provide the necessary services to all veterans seeking care.

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Accountability:

Department of Veterans Affairs (VA) managers must be held individually responsible for achieving needed enhancements to operations efficiency and effectiveness in their areas of operation.

The Independent Budget (IB) veterans service organizations firmly believe that sufficient funding in and of itself is not enough to achieve greater efficiency of processes and people within the Department and increased effectiveness of results that will further its mission. Enforcing accountability within VA will directly contribute to enhanced benefits and services to veterans within the context of finite budgetary resources.

To make management structure and function more effective, individual managers—from those in the Office of the Secretary and Under Secretaries to VA employees at all levels—must be held responsible for their areas of operation. The *IB* insists upon much greater focus and, ultimately, meaningful improvement through enforceable accountability in such areas as waiting times for medical appointments; supervision of part-time physicians; contract care, particularly specialty care from academic affiliates; fee-basis care; formulation of valid and reliable program reporting and workload data; timeliness of claims processing; and quality in claims adjudication.

- **Waiting times for medical appointments:**

  As of third quarter 2005, VA reports substantial reductions in the number of veterans on wait lists to 52,000 from 300,000 in July 2002. The Veterans Health Administration (VHA) also has reduced the number of new enrollees waiting for their first clinic appointment by 90 percent (17,875 from 176,000). However, the accuracy of reported veterans' waiting times and facility wait lists is undermined by variability in VA's compliance with outpatient scheduling procedures. In some cases, supervisors instructed schedulers to create appointments contrary to established scheduling procedures. In addition, VHA medical facilities do not have effective procedures in place nor comprehensive training available, resulting in substantial backlogs of consult referrals, which are not included on the electronic waiting lists, in addition to the fact that individual schedulers maintain informal waiting lists (a list other than the electronic list) of veterans needing appointments.

  VA embarked on a nationwide initiative to provide frontline personnel the ability to maximize resources to treat more patients in a timely manner. As part of this initiative, the electronic wait list is used to measure success. While the current electronic waiting list has undergone a number of revi-

sions since inception, reporting accuracy continues to be suspect and undermines the ability to produce effective and meaningful policy and procedures that would best capture what is considered a symptom of an inadequately funded health-care system.

- **Contract care, particularly specialty care provided by academic affiliates:**

  Many VA facilities award contracts with academic affiliates to provide needed medical care to sick and disabled veterans. However, some contracts contain no procedures for VA to monitor contract physician presence or level of performance to ensure that the services for which VA pays under the contract are actually provided. Furthermore, solicitation during the procurement process did not adequately compensate VA for any losses incurred as a result of noncompliance, nor did it require penalties for noncompliance with the terms and conditions of the contract.

  Furthermore, procurement processes, such as planning, the statement of work and other terms and conditions in the solicitation, and contract administration, are important because they affect the price reasonableness determination and have an impact on whether the contract is in the best interest of the government. VA physicians receiving compensation from the affiliate or its practice group are involved in the contracting process in violation of federal ethics laws and regulations.

- **Fee-basis care:**

  To ensure a full continuum of health-care services, VA should integrate clinical and claims information for veterans authorized to receive medical care from private community-based providers at VA expense. While required to receive minimal treatment records from a veteran's private physician as part of authorization to receive non-VA care, there is no requirement to ensure VA receives the complete medical record of the veteran to be made part of his or her electronic VA health record.

Meaningful accountability of the provision of enhanced benefits and services to veterans requires management be provided all the requisite guidance and tools to enforce performance standards among personnel under their direction. Management must be able to create an environment that promotes superior service, discourages mediocrity, and precludes substandard performance. Correspondingly, performance appraisals and senior executive contracts must accurately reflect execution in achieving specific outcomes. Success should be fittingly rewarded and failure appropriately sanctioned to enforce accountability and to promote a more efficient and effective provision of benefits and services to veterans.

VA faces many challenges to use its limited resources efficiently, to ensure reasonable access to high quality health care, and to manage its disability programs effectively. Thus, VA executives must be effective leaders, not just competent managers, particularly when making difficult decisions and taking decisive actions in a resource constrained environment.

Recommendations:

VA management must be provided with the requisite tools to enforce performance standards among the personnel under their direction.

VA must enforce meaningful performance standards, and VA should then reward individuals who exceed the standards and properly sanction those whose performance is substandard or unacceptable.

Guaranteed Funding:

Current methods of budget formulation for Department of Veterans Affairs health care, and the manner in which Congress addresses these needs in the discretionary budget and appropriations acts, are deeply flawed and cry out for basic reforms.

The formulation of an adequate budget for veterans' health care continues to confound Congress and the Administration. While leaders in both government branches continue to boast about the "record-setting" increases they have made compared to their predecessors, VA sources and our veterans seeking health care tell a different story of circumstances in the daily operating environment of the VA health-care system.

Early in 2005, VA facilities began to restrict services provided to veterans, institute local and regional freelance policies to restrict eligibility, and impose a variety of questionable—and potentially dangerous—cost-cutting measures just to make ends meet. VA medical facility directors reported that to stay financially afloat they had to resort to delaying critical building maintenance and repairs, the purchase of needed medical equipment, and the filling of clinical staff positions. When the degree of crisis became overwhelmingly obvious even to staunch defenders of the budget status quo, and only weeks before the end of the fiscal year, Congress provided an emergency supplement to VA's 2005 appropriation in the amount of $1.5 billion, while acknowledging that additional funding would be needed to restore the system to its proper level of functioning in 2006. In July the administration proposed a budget amendment for VA health care in 2006 of $1.977 billion, but VA witnesses have testified that even more funding may be necessary to keep VA financially sound. It is clear that VA remains in a state of operational and planning chaos and structural financial crisis as a result of the discretionary budget process.

Although welcomed by all, temporary funding supplements provided by Congress unfortunately do not solve the underlying problem. For this reason, *The Independent Budget* veterans service organizations (IBVSOs) propose a long-term solution in the form of mandatory or guaranteed funding or a combination of mandatory and discretionary funding for veterans' health care. A guaranteed system would make veterans' health-care funding more dependable and stable and eliminate the year-to-year uncertainty that has disrupted management of VA health care for more than a decade. Funding uncertainty has prevented VA from being able to adequately plan for and meet the needs of a rising enrolled veteran population, a large majority of whom are either service-disabled or poor. A guaranteed system of funding also would resolve the serious challenges created by late-arriving resources and stop the meddling on policy and politically motivated budget proposals by the Office of Management and Budget.

Budget reform is more important today than ever before. Because of the current conflicts in which our nation is engaged, VA is seeing increases in the number of veterans' suffering from traumatic amputations, head wounds, blindness, burns, spinal cord injuries, and post-traumatic stress disorder. These severely disabled veterans will need a lifetime of specialized health care. Veterans injured in Iraq and Afghanistan, as well as veterans wounded in previous conflicts, need assurance that VA is a stable and reliable provider that receives sufficient funding to provide the specialized services they need and have earned through their service.

The Administration must also consider other costs VA has incurred as it struggles to fulfill its core mission and mandates. Even with the stress of a chronic budget shortage, VA was an integral part of the national and regional response providing disaster relief to veterans and all residents affected by the recent storms in Louisiana, Mississippi, Alabama, Texas, and Florida. During these disasters, VA played an indispensable role, not only in continuing to serve sick and disabled veterans but also serving the Gulf Coast community in general with rescue, security and police, health care, transport, and other lifesaving services. Although necessary and admirable, VA is not funded adequately to carry out this type of mission without compromising or disrupting its ability to care for veterans in routine operations and thus must be provided adequate funds to compensate for such additional services at times of emergency.

Despite the fact that the FY 2006 VA Appropriations Bill was recently enacted, it appears VA may still face

across-the-board budget cuts to "offset" relief spending for the recent hurricane recovery efforts. If new cuts are imposed on VA health care to offset restoration efforts, veterans undoubtedly will be forced to fall back on Medicaid, Medicare, and other providers, and VA will return to financial chaos. *The IBVSOs firmly believe VA should not be punished for doing its job well.* VA's capacity to care for veterans should be enhanced with adequate and guaranteed funding. VA health care by many measures is not only the most cost-effective and secure (when adequately funded) system in the United States to care for America's sick and disabled veterans, but its existence also reduces the financial burden on other federal and state health-care systems.

During the 109th Congress, mandatory funding bills were introduced in both chambers. Unfortunately, the Administration and Congressional leadership remain opposed to this proposed change. To date, none of the measures introduced has been enacted. The Partnership for Veterans Health Care Budget Reform, made up of nine veterans service organizations, has urged the Administration and Congress to reform the method for funding veterans' health care to ensure more predictable and reliable funding. However, repeated requests for public hearings and open debate on this important issue have been denied or ignored by the House and Senate authorizing and appropriations committees.

Additionally, during the 109th Congress an alternative funding plan (combining mandatory and discretionary funding) was proposed to resolve VA's health-care funding crisis. Unfortunately, this proposal was defeated—even with full support of the Partnership for Veterans Health Care Budget Reform. In spite of an obvious need to reform the way VA health care is funded, the Administration and Congress have embraced other initiatives, such as permanent tax cuts and massive pork barrel spending, that take priority over ensuring guaranteed health-care funding for millions of older veterans dependent on VA care and tens of thousands of men and women returning sick and disabled as a result of military service to our country. Providing health care to our nation's sick and disabled veterans is a continuing cost of war and national security and should be a top priority of our government.

Without reform, all the advantages of VA health care, originating from a decade of internal improvements, are at risk. The manner in which the Administration and Congress provide funding for VA health care poses well-documented annual uncertainty that prevents VA managers from planning effectively to continue these vital services. When funding is eventually secured, it has proven time and again to be insufficient, causing VA practitioners to ration and delay care necessary to sick and disabled veterans who depend on VA and even forcing a former VA Secretary to restrict access to new enrollments.

Our government needs to take the politics, guesswork, and political gamesmanship out of VA health care and fully fund this transparent need. The Administration has a fundamental obligation to provide Congress an honest, accurate statement of the VA's financial needs. And Congress is obligated to fully fund VA health care in a timely manner. The best way to meet these obligations is to overhaul the budget and appropriations process and guarantee an adequate, predictable, reliable, and available funding stream to meet the health-care needs of America's sick and disabled veterans.

Recommendation:

The Administration and Congress must address the acknowledged shortfalls of the current approach and support legislation to reform funding for VA health care. This reform should move VA from its current status in domestic discretionary appropriations to full mandatory funding—or some combination of discretionary and direct funding—in order to ensure all eligible and enrolled veterans may gain and retain access to VA health-care programs and services.

Homeland Security/Funding for the Fourth Mission:

The Veterans Health Administration (VHA) is playing a major role in Homeland Security and bioterrorism prevention without additional funding to support this vital statutory fourth mission.

The Department of Veterans Affairs (VA) has four critical health-care missions. The primary mission is to provide health care to veterans. Its second mission is to educate and train health-care professionals. The third mission is to conduct medical research. The VA's fourth mission, as stated in a General Accounting Office Report of October 2001, is to "serve as a backup to the Department of Defense (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidents and other major disasters[.]"

The devastation created by Hurricanes Katrina and Rita in the Gulf Coast region in 2005 more than meets the criteria for the fourth mission. VA proved to be fully prepared to care for veterans affected by the hurricanes, and it did an outstanding job removing veterans from the threatened areas. Yet the capabilities of VA were not tapped to support other federal, state, and local agencies that struggled to react to these events.

The Independent Budget veterans service organizations (IBVSOs) are concerned that VA lacks the resources to meet its fourth mission responsibilities. Actions in Louisiana, Mississippi, and Alabama prove that VA has done everything it can to prepare itself under the requirements of the fourth mission. It has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not specifically received funding specifically to support the fourth mission. Although VA has testified previously that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. This funding is simply drawn from the medical care account, providing VA with fewer resources with which to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned as part of the fourth mission, but if sufficient funding is not provided, already scarce resources will continue to be diverted from direct health-care services.

VA has statutory authority under 38 U.S.C. § 8111A to serve as the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed into law "Authorization for Use of Military Force," which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. This resolution, P.L. 107-40, satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the DOD.

As part of its fourth mission, VA has a critical role in homeland security and in responding to domestic emergencies. The National Disaster Medical System (NDMS), created by PL 107-188 (the "Public Health Security and Bioterrorism Preparedness Response Act of 2002") has the responsibility for managing and coordinating the federal medical response to major emergencies and federally declared disasters, including natural disasters, technological disasters, major transportation accidents, and acts of terrorism, including weapons of mass destruction events, in accordance with the National Response Plan. The NDMS is a partnership between the Department of Homeland Security (DHS), VA, the DOD, and the Department of Health and Human Services (HHS). According to the VA Web site (www.va.gov), some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance, and evaluation of the local NDMS program. VA has also assigned "area emergency managers" (AEMs) to each Veterans Integrated Service Network to support this effort and assist local VA management in fulfilling this responsibility.

In addition, PL 107-188 required VA to coordinate with HHS to maintain a stockpile of drugs, vaccines, and other biological products, medical devices, and other emergency supplies. In addition, the Secretary was directed to enhance the readiness of medical centers and provide mental health counseling to those individuals affected by terrorist activities.

In 2002, Congress also enacted P.L. 107-287, "Department of Veterans Affairs Emergency Preparedness Act of 2002." This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and would develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary, or other explosive weapons or devices posing threats to the public health and safety; providing education, training, and advice to health-care professionals; and providing laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care agencies and personnel involved in or responding to a disaster or emergency. These centers, although authorized by law, have yet to receive any funding.

VA's fourth mission is vital to our defense, homeland security, and emergency preparedness needs. In light of the natural disasters that wreaked havoc on this country in 2005, this fact has never been more apparent. The important role once again reiterates the critical need to maintain the integrity of the VA system and its ability to provide a full range of health-care services. If VA is to fulfill its responsibilities it must be provided these resources.

Recommendations:

Congress should provide funds necessary in the VHA's FY 2007 appropriation to fund the VA's fourth mission.

Funding for the fourth mission should be included in a separate line item in the Medical Care Account.

Congress and the Administration should provide the funds necessary to establish and operate the four emergency preparedness centers created by PL 107-287.

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Seamless Transition from the Department of Defense to Veterans Affairs:

The Department of Defense (DOD) and the Department of Veterans Affairs (VA) must ensure that all servicemen and women separating from active duty have a seamless transition from military to civilian life.

As servicemen and women return from the conflicts in Iraq and Afghanistan, the DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service and become veterans. Currently, the transition from the DOD to VA is anything but seamless, and undue hardship is placed on new veterans trying to gain access to VA services. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The Independent Budget supported the recommendations of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report released in May 2003 regarding transition of soldiers to veteran status. The PTF report stated that "providing these individuals [veterans] timely access to the full range of benefits earned by their service to the country is an obligation that deserves the attention of both VA and DOD. To this end, increased collaboration between the Departments for the transfer of personnel and health information is needed." This need has not yet been met.

The IBVSOs believe the DOD and VA must develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. We applaud the DOD for beginning to collect medical and environmental exposure data electronically while personnel are still in

theater, and this must continue. But it is equally important that this information be provided to VA. These electronic medical records should also include an easily transferable electronic DD214 forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and benefits.

The departments have each taken positive steps to share data through the Federal Health Information Exchange initiative and the pharmacy data project; however, obstacles remain. The IBVSOs are not encouraged by reports that in some instances medical data gathered in theater and stored on electronic smart cards provided to the service member are not even readable by other military medical facilities upon the service member's return. This does not bode well for an electronic system meant to exchange information between federal agencies.

The Independent Budget is not the only party concerned about this exchange of information. In June 2004, the Chairman and Ranking Member of House Committee on Veterans' Affairs and the House Armed Services Committee sent letters to then Secretary Principi and Secretary Rumsfeld expressing concern with the current transition of servicemen and women and indicating that "despite earnest desire by both the DOD and VA to provide each service member with a seamless transition, their efforts remain largely uncoordinated in important respects and suffer from the failure to make planning for transition a high priority for the Executive Branch."

The Independent Budget concurs with the PTF's recommendation that "DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process." The problem with separation physicals identified for active duty members is compounded when mobilized reserve and National Guard forces enter the mix. A mandatory separation physical is not required for demobilizing reservists. Though the physical examinations of demobilizing service members have improved in recent years, there are still a number of service members who "opt out" of the physical exams, even when encouraged by medical personnel to have them. Though the expense, manpower, and delays needed to facilitate these physicals might be significant, the separation physical is critical to the future care of demobilizing soldiers. We cannot allow a recurrence of the lack of information that led to so many issues and unknowns with Gulf War syndrome, particularly among our National Guard and Reserve forces. This would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

The IBVSOs also support the Disabled Soldier Support System (DS3) implemented by the DOD in spring 2005. This has proven to be a very successful program. Its responsibility is to assist the most severely injured service members and their families during the transition from military to civilian life. However, the program maintains only minimal staff with a limited budget to assist these service members. With a high number of severely injured service members returning from Iraq and Afghanistan, it is essential that Congress and the Administration support and enhance this successful program.

In the past several years, the DOD and VA have made good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's (DOL) Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) handled by the Veterans Employment and Training Service (VETS) is generally the first service that a separating service member will receive. In particular, local military commanders, through the insistence of the DOD, began to allow their soldiers, sailors, airmen, and marines to attend in advance so as to take greatest advantage of the program. The programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their situations and then seek answers prior to discharge.

The TAP and DTAP programs continue to improve. But challenges continue at overseas locations and with services and information for those with injuries. Disorganization and inconsistency in providing this information remain. Though individuals are receiving the information, the haphazard nature may allow some individuals to fall through the cracks. This is of particular risk in the DTAP program for those with

severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center despite still being on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. DTAP has not had the same level of success as TAP, and to improve this, it is critical that coordination be closer between the DOD, VA, and VETS.

Though the achievements of the DOD and VA have been good with departing active duty service members, there is a much greater concern with the large numbers of Reserve and National Guard service members moving through the discharge system. Due to the number of troops that are on "stop loss"—a DOD action that prevents troops from leaving the military at the end of their enlistments during deployments—large numbers of troops rapidly transition to civilian life upon their return. Both the DOD and VA seem ill-prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life. Unless these service members are injured, they may clear the demobilization station in a few days. Little of this time is dedicated to informing them about veterans' programs. Additionally, DOD personnel at these sites are most focused on processing service members through the site. Lack of space and facilities often allow for limited contact with the demobilizing service members by VA representatives.

The IBVSOs believe the DOD and VA have made progress in the transition process. Unfortunately, limited funding and a focus on current military operations interfere with providing for service members who have chosen to leave military service. If we are to ensure that the mistakes of the first Gulf War are not repeated during this extended global war on terrorism, a truly seamless transition must be created. In doing so, it is imperative that proper funding levels be provided to VA and the other agencies providing services for the vast increase in new veterans from the National Guard and Reserves. Servicemen and women exiting military service should be afforded easy access to the health care and benefits that they have earned. This can only be accomplished by ensuring that the DOD and VA improve their coordination and information sharing to provide a seamless transition.

Recommendations:

The DOD and VA must ensure that servicemen and women have a seamless transition from military to civilian life.

The DOD and VA must develop electronic medical records that are interoperable and bidirectional, allowing for two-way electronic exchange of health information and occupational and environmental exposure data. The records should also include an electronic DD214.

The DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process.

Congress and the Administration must provide additional funding for the Disabled Soldier Support System program to allow the DOD to expand this program so that it can address the needs of more seriously disabled soldiers.

CARES Impact on Long-Term Care and Mental Health Services:

The Independent Budget *veterans service organizations (IBVSOs) believe mental health services and long-term care are part of the full continuum of care for veterans and should not be excluded from the Capital Asset Realignment for Enhanced Services (CARES) process.*

In 2006, CARES will be moving toward a final decision-making plateau. As *The Independent Budget for Fiscal Year 2006 (IB)* reported, the CARES Commission, appointed by then-Secretary Principi, found that the Department of Veterans Affairs (VA) had not developed the forecasts and policies needed to project and plan to meet future demands for long-term care and chronic mental illness. The commission's central recommendation was that VA develop a strategic plan for long-term care that included policies and strategies for the delivery of care in domiciliaries, residential treatment facilities, nursing homes, and facilities for seriously mentally ill veterans. The commission further recommended that the plan include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to population concentrations as feasible and identifying sites for freestanding VA nursing homes as an acceptable care model. Pending completion of VA's long-term care strategic plan, the commission recommended that VA only proceed with long-term care projects that make necessary life-safety and maintenance improvements to existing facilities.

Secretary Principi's response to the CARES Commission's recommendations was supportive and indicated that VA would move forward to formulate the forecasts and policies necessary to implement a strategic plan to address consistency of access across VA's health-care system. Also, the Secretary's response noted the importance of keeping veterans in need of long-term care in the least restrictive settings possible—allowing them to remain in their homes or alternative community residencies with family caregivers when feasible, but recognizing that many veterans would need continuing inpatient nursing home and inpatient mental health care based on a variety of conditions and circumstances.

The Independent Budget for Fiscal Year 2006 recommended that VA proceed with the development of its strategic plan for long-term care. A decade of rising demand for long-term care is already upon VA, and the Department long ago should have developed the necessary models to analyze workload and project long-term care demand. *The Independent Budget for Fiscal Year 2006* called upon VA to explain its current viewpoint regarding various modeling techniques and to provide a timetable for the publication of its long-term care strategic care plan. To date, it has not done so to our knowledge, and the absence of an appropriate and responsible plan for long-term care could provide a fatal blow to the CARES process.

Instead of responding to the *IB's* call for creative planning for long-term care to better inform the CARES process and fulfill its potential as a major planning tool, under current VA Secretary James Nicholson, VA proposed in the FY 2006 budget a severe curtailment of institutional long-term care. VA proposed that Congress permit it to close 4,000 of its current 13,000 nursing beds and to restrict future admissions to long-term care in VA, community, and state home beds to a very small cohort of typical and expected placements. The National Association of State Veterans Homes testified before Congress that VA's proposal on long-term care would decimate the state home program, removing up to 80 percent of VA-certified placements.

On a much smaller scale, VA announced an intention to expand non-bed long-term care programs, but the IBVSOs concluded, as did Congressional reviewers, that VA was ill-prepared to carry forward its own proposals. Subsequently, VA failed to submit legislation for Congressional consideration to authorize its proposed plan, and VA witnesses testifying before Congress in effect admitted that these proposals were not well considered. Eventually, in the summer of 2005, Congress added several hundred million dollars to VA's FY 2005 and 2006 appropriations bills to fill the long-term care void created by VA's unfortunate and inadequate budget proposal.

In his decision on CARES, Secretary Principi called for a comprehensive VA Mental Health Strategic Plan. This strategic plan, subsequently issued in 2005, incorporated the recommendations of the report of the President's New Freedom Commission on Trans-

forming Mental Health Care in America. The Mental Health Strategic Plan requires each Veterans Integrated Service Network (VISN) to develop mental health market plans that incorporate revised projections and include projected demand for both outpatient mental health services and acute psychiatric inpatient care. Additionally, policies developed in the Mental Health Strategic Plan, such as special emphasis on integrating strategies to meet the future geropsychiatric needs of the enrolled veteran population and incorporating the findings of VHA's Work Group reviewing the President's New Freedom Commission on Mental Health Report, were to be incorporated in the VISNs' plans to ensure that comprehensive mental health services are included in VA community-based outpatient clinics; that veterans have access to a full continuum of mental health care services, which are consistent across all VISNs; and that acute inpatient mental health services are combined with other inpatient services.

The IBVSOs are pleased with VA's efforts to date on developing and implementing a national mental health strategy. We particularly commend the work of the Veterans Health Administration Committee on Care of Veterans with Serious Mental Illness in guiding and informing this new plan. Secretary Nicholson has announced his intention to fuel this strategy with $100 million annually in earmarked resources to ensure its viability in VA's competitive internal health care allocation environment. The IBVSOs intend to monitor the implementation of this plan closely to ensure it remains consistent with CARES. The IBVSOs also commend the committee for its work on mental health projection data as it relates to CARES. VA should continue to work with the committee to make necessary adjustments in the CARES model to enhance mental health services for veterans.

■ *Summary*

VA's Office of Geriatrics and Extended Care must make every effort to ensure the availability and quality of its institutional and noninstitutional long-term care programs to meet the increasing veteran demand for these services. According to the Government Accountability Office (GAO), "VA will experience a significant increase in long-term care needs over the next decade because of the aging veteran population." Despite this GAO prediction, and the presence of mandatory capacity legislation by Congress, VA has once again failed to meet the nursing home daily census required by Public Law 106-117, "The Veterans Millennium Health Care and Benefits Act" (Millennium Act). Additionally, when viewed systemwide, many of VA's long-term care services are provided in a haphazard manner from site to site. The GAO found that each program in the long-term care benefits package was not provided for in a uniform fashion across the VA facilities surveyed. Access to these programs is further complicated by individual facility and regional interpretations of basic health-care eligibility rules that are freelance inconsistencies of existing law and regulation. VA should be required to develop new, and improve existing, long-term care program tracking and reporting measures so Congress and America's veterans can better understand the quality and quantity of long-term care services veterans may receive in VA, community, and state veterans nursing homes.

Congress must also shoulder its share of responsibility for VA's long-term care problems. Mandating benefits and levels of service without providing VA the necessary financial resources to achieve these goals, combined with a lack of oversight to hold VA accountable for meeting them, constitutes a recipe for disaster—a disaster that revealed itself fully in 2005's VA health-care budget debacle. With inadequate resources, VA is put in the impossible position of pitting one health-care program against another, ultimately at the expense of veterans.

For several years VA has requested that Congress amend the Millennium Act's capacity mandate by allowing VA to count within its capacity nursing home care furnished by private providers and state veterans homes at VA expense or subsidy. VA's 2006 budget submission evidenced VA's desire to further reduce in-house nursing home capacity and fall farther behind the Congressional capacity mandate. These disturbing trends make veterans and the organizations that represent them question VA's commitment to aging veterans.

The looming long-term care crisis that is so evident now has been predicted for more than two decades. The Department and other federal agencies have been acutely aware, as early as the late 1970s, that a surge of long-term care demand was coming from aging

World War II and Korean War veterans. Now, at the beginning of the 21st century, millions of these elder veterans are needing long-term care in its many forms, and given that VA has known about this for so many years, it is disturbing—even shocking—to realize that VA is not nearly prepared today to meet these needs, and in fact was preparing to abandon tens of thousands of these veterans rather than attempting to meet at least some of their needs.

Recommendations:

Congress must insist VA comply with the CARES Commission's and the Secretary's final CARES decision recommendation from 2004 that it develop a long-term care strategic plan.

Congress should maintain oversight to restrict politicization of the results of the CARES process, irrespective of the good intentions that may be motivating the protection of certain facilities from the impact of CARES.

In general, as it enters its final decision plateau, Congress must provide closer oversight on the CARES process to ensure commitments made are still supported with capital investments through appropriations.

Congress must provide the resources necessary for VA to meet the capacity mandate to provide the long-term care services required by P.L. 106-117 (Millennium Act).

VA must ensure that it provides comprehensive coverage of all mandated long-term care services in each VA facility and that this coverage be consistent with the intent of law and the CARES process. Also, VA must ensure that implementation of its new national mental health strategic plan remains consistent with CARES.

Congress should reject VA's desire and request to water down the capacity mandate to include workloads from community and state veterans' nursing homes.

VA should be required to develop better tracking measures to monitor quality, quantity, and access to its own, community, and state veterans' nursing home services, and to its noninstitutional approaches to long-term care.

VA must eliminate service gaps and freelance eligibility determinations in the delivery of institutional and noninstitutional long-term care programs from facility to facility.

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Inappropriate Billing:

Service-connected veterans and their insurers are constantly frustrated by inaccurate and inappropriate billing for services related to conditions secondary to their service-connected disability.

The Veterans Health Administration (VHA) continues to bill veterans and their insurers for care provided for conditions directly related to service-connected disabilities. Reports of veterans with service-connected amputations being billed for the treatment of associated pain and of veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers continue to surface. Inappropriate billing for secondary conditions forces veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden both to veterans and an already backlogged claims system.

Additionally, veterans with more than six service-connected disability ratings are frequently billed improperly due to VA's inability to electronically store more than six service-connected conditions in the Compensation and Pension (C&P) Benefits Delivery Network (BDN) master record and the lack of timely and/or complete information exchange about service-connected conditions between the Veterans Benefits Administration and the VHA.

VA has undertaken a five-step approach to change the process by which it electronically shares C&P eligibility and benefits data with the VHA, particularly infor-

mation about service-connected conditions that exceed the six stored in the C&P BDN. According to the Department of Veterans Affairs (VA), because of difficulties in the development and implementation of the first two steps, the plan for improving VBA/VHA sharing of information about veterans' service-connected conditions has been delayed. Furthermore, VA acknowledges that not all these cases, with six service-connected conditions, have been identified under the new plan; however, it will determine the best course of action to take to further address the cases with incomplete service-connected disability information.

Recommendations:

The Under Secretary for Health should firmly establish and enforce policies that prevent veterans from being billed for service-connected conditions and secondary symptoms or conditions that relate to an original service-connected disability rating.

The Under Secretary for Health should establish specific deadlines for the action plan to develop methods to improve the electronic exchange of information about service-connected conditions that exceed the maximum of six currently captured in the C&P BDN master record.

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Waiver of Health-Care Copayments and Fees for Catastrophically Disabled Veterans:

Veterans in priority group 4 should not be subject to copayments.

Veterans meeting the definition of having catastrophic disabilities as a result of nonservice-connected causes and having incomes above means tested levels can still enroll in the Department of Veterans Affairs (VA) as priority 4 veterans rather than the less-preferential categories 7 and 8. This heightened priority for VA health-care eligibility was granted in recognition of the unique nature of these disabilities and the need for these veterans to avail themselves of the complex specialized health-care services in many cases unique to the mission of the VA health-care system. The higher, priority 4, enrollment category would also protect these veterans from having access to the system denied were they, under usual circumstances, to be considered in the lower priority category 7 or 8 if VA health-care resources were to be curtailed.

However, current VA regulation stipulates that even though these veterans are to be considered priority 4 for the purpose of enrollment due to their specialized needs, they still have to pay all health-care fees and copayments as though they were still in the lower eligibility category. This interpretation violates the intent of the statute in recognizing the unique needs of these veterans and the role of the VA in providing their care. It also puts great financial hardship on these catastrophically disabled veterans who need to use far more VA health-care services at a far greater extent than the average VA health-care user. In many instances, fees for medical services equipment and supplies can climb to thousands of dollars per year.

It is certainly a tribute to these individuals to have sought gainful employment to support themselves and their families despite the nature of their catastrophic disabilities. Far too often veterans with such disabilities give up opportunities to lead productive lives, falling back on low-income pensions and other federal and state support systems. In so doing, they fall within the complete definition of priority 4 health-care enrollment and are exempt from all fees and copayments. Yet, a veterans' industry and employment that brings annual income above the means test levels is then unduly penalized by exorbitant fees. This "Catch-22" status does little to reward or provide an incentive for a highly disabled veteran to maintain employment and a productive life.

Recommendation:

Those veterans designated by VA as being catastrophically disabled for the purpose of enrollment in health-care eligibility category 4 should be exempt from all health-care copayments and fees.

ACCESS ISSUES

While the Veterans Health Administration (VHA) has made commendable improvements in quality and efficiency, veterans' access to their health-care system is severely limited. Excessive waiting times and delays imposed to keep health-care demand within the limits of available resources amount to health-care rationing for enrolled veterans.

Advanced Clinic Access Initiative:

Veterans have to wait too long for appointments.

Limited access is the primary problem in veterans' health care. The significant backlog of delayed appointments is an end result of severe funding shortfalls. Demand for care at many Department of Veterans Affairs (VA) facilities are straining capacity, and with limited resources, VA has had to restrict enrollment. Perennially inadequate health-care budgets have resulted in a VA health-care system struggling to meet the needs of our nation's sick and disabled veterans. Without funding to increase clinical staff, veterans' demand for health care will continue to outpace the VHA's ability to supply timely health-care services and erode the world-renowned quality of VA medical care.

At its peak in July 2002, the VHA had more than 310,000 veterans waiting for medical appointments, half of whom must wait six months or more for care and the other half having no scheduled appointment. Despite the reduction in the number of veterans waiting for medical care, the Secretary of Veterans Affairs instituted regulations in 2004 to allow the most severely disabled service-connected veterans priority access in the VA health-care system. Though caring for veterans with service-connected disabilities is a core commitment for VA, these actions have not provided timely access to quality heath care for veterans eligible for VA health care under the provisions of the Health Care Eligibility Reform Act of 1996.

To reduce waiting times for sick and disabled veterans seeking care, the Advanced Clinic Access (ACA) Initiative, a program designed to eliminate waiting times and reject the supply constraint theory of managing health-care demand, has been implemented and continues to show promise. The goal is to build a system in which veterans can see their health-care providers when needed. Through the work of a few leaders, this program reduced average waiting times and significantly improved veterans' access to their health-care system.

Making improvements on the wait-time reports has been made part of this initiative, and in 2004 a change in reporting measurements was established. Operating on the premise that not all veterans waiting six months or greater should automatically be considered delayed care, particularly for such appointments as routine or follow-up care, VA instituted a new standard of measuring waiting times. VA reports that as of November 2005, there were 22,338 veterans who are "new enrollees" to the VA health-care system and waiting for their first clinic appointment to be scheduled. The number of veterans, both established patients, and new enrollees, waiting six months or greater for an appointment has risen to 33,919.

While the total number of veterans who will likely have to wait six months or more decreased from 60,713 in October 2003 to 27,034 in September 2004, it increased steadily to 56,257 in September 2005, which coincides with the VA's budget shortfall for fiscal year 2005. Although VA states that the current number of veterans on the wait list is an improvement from 2002, this measurement is not equivalent to that used in 2002 and 2003. *The Independent Budget* veterans service organizations (IBVSOs) are concerned that these data are only for six types of clinics (primary care and five types of specialty care clinics) and are derived from approximately 80 percent of the VA's overall health-care workload. Recognizing the change in measuring veterans' access to care reflects VA's struggle to best capture and measure the veterans' experience in seeking VA medical care. The IBVSOs are also concerned that changing benchmarks for waiting times may have a deleterious effect on the ACA initiative's ability to gauge its progress and on medical facilities to accurately report its workload for resource projection.

Despite any measurable improvements in waiting times for needed appointments, continued disparities

exist in the implementation of the ACA initiative nationwide. With a growing number of volunteer coaches who serve as consultants and trainers and growing support from Veterans Integrated Service Networks (VISNs) and facilities, success is largely dependent upon the availability of funding. In addition to a fully staffed ACA initiative, the IBVSOs encourage greater support from VA leaders for recommendations made by the ACA initiative toward a more robust tool to accurately measure patient experiences and waiting times, link performance measures to improvements in waiting times, and compare VHA patients' waiting times with those of private sector patients.

While the IBVSOs believe it is imperative that our government provide a health-care budget that will enable VA to serve the needs of disabled veterans nationwide, both increased medical care appropriations and VA's Advanced Clinical Access Initiative are needed to improve veterans' access and ensure that all service-connected disabled veterans and all other enrolled veterans have access to the system in a timely manner.

Recommendations:

VISNs and facility directors should evaluate whether veterans, as well as the clinics in their area, would benefit from the Advanced Clinic Access Initiative.

The VHA should include improvements in waiting times as part of administrators' performance measures.

The VHA should provide the necessary support to implement the Advanced Clinic Access Initiative recommendations for improving veterans' access to medical care.

VA should establish a physician-led program within VHA national headquarters and provide six full-time staff to the Advanced Clinic Access Initiative.

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Community-Based Outpatient Clinics:

Many community-based outpatient clinics (CBOCs) lack staff and equipment to serve the specialized needs of veterans.

As of November 2005, the Veterans Health Administration (VHA) operated 862 outpatient clinics and ambulatory care clinics; 712 were CBOCs. Additionally, the Secretary's Capital Asset Realignment for Enhanced Services (CARES) decision mandated that 156 priority CBOCs be established by 2012, pending availability of resources and validation with the most current data available.

The Independent Budget veterans service organizations (IBVSOs) commend VHA efforts to expand access to needed primary care services. For many veterans who live long distances from Department of Veterans Affairs medical centers (VAMCs) and for those whose medical conditions make travel to VAMCs difficult, CBOCs reduce the need/necessity for travel. CBOCs also improve veterans' access to timely attention for medical problems, reduce hospital stays, and improve access to and shorten waiting times for follow-up care. As VA proceeds in implementing the CBOCs and engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant. VA will need to enhance access to care in underserved areas with large numbers of veterans outside of access guidelines and in rural and highly rural areas. VA also needs to enable overcrowded facilities to better serve veterans and will have to support sharing with the Department of Defense. Of the more than 250 CBOCs originally proposed by the CARES decision, when activated, the percentage of enrollees within primary care access guidelines will increase from 73 percent to 80 percent.

While the IBVSOs support establishment of CBOCs, we remain concerned that they often fail to meet the needs of veterans who require specialized services. For

example, many CBOCs do not have appropriate mental health providers on staff, nor do they necessarily improve access to specialty health care for either the general veteran population or those with service-connected mental illness. To VA's credit, the revised criteria for establishment of CBOCs includes the availability of mental health with disease specific documentation. Moreover, too often CBOC staff lack the required knowledge to properly diagnose and treat conditions commonly secondary to spinal card dysfunction, such as pressure ulcers and autonomic dysreflexia. Indeed, some veterans service organizations caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care programs.

Inadequately trained providers are less likely to render appropriate primary or preventive care or to accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with Section 504 of the Rehabilitation Act (29 U.S.C. § 791 et seq.). Regarding physical accessibility to medical facilities, veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

CBOCs must contribute to the accomplishments of the VHA mission to provide health services to veterans with specialized needs. The individuals also require primary and preventive care, which in many cases can be appropriately provided in CBOCs. It is essential however that CBOCs use clinically specified referral protocols to ensure veterans receive care at other facilities when CBOCs cannot meet their specialized needs.

Unless the VHA is adequately funded and properly managed, the proliferation of CBOCs could ultimately reduce the comprehensive scope of VA hospitals and impact in VHA care.

Recommendations:

The VHA must ensure CBOCs are staffed by clinically appropriate providers capable of meeting the special health-care needs of veterans wherever those needs justify specialized resources.

The VHA must develop and use clinically specific referral protocols to guide patient management in cases where a patient's condition calls for expertise or equipment not available at the facility at which the need is recognized.

The VHA must ensure that all CBOCs fully meet the accessibility standards set forth in section 504 of the Rehabilitation Act.

Veterans Rural Access Hospital (Critical Access Hospital):

The Department of Veterans Affairs (VA) must ensure a standard of high quality of care at all of its medical facilities.

VA must carefully monitor the scope of services performed at its small facilities, specifically those procedures that are complex in nature. Further, as medical care sees advances in technology, small facilities may find it difficult to effectively maintain and use the tools necessary to provide health care at its most sophisticated levels. To establish parameters for how these facilities should prepare to meet future challenges, VA introduced the concept of the Critical Access Hospital (CAH), modeled after a Medicare designation for small hospitals.

The CAH was introduced to help ensure that veterans receive quality care at VA's small facilities, though the CARES Commission found the definition applied to these facilities in the Draft National Cares Plan (DNCP) to be lacking in specificity. VA needs a framework that will ensure the ongoing and future quality of care provided at its small and rural facilities. Recognizing that some small and rural facilities will be unable to maintain the workload necessary to perform certain surgical procedures or manage some complex illnesses effectively, VA must define the appropriate scope of services that should be provided at small and rural facilities.

The IBVSOs' concern has been and remains whether VA new CAH policy and facilities consider the implications referrals will have on providing quality health care in a timely manner, particularly at other medical centers within a veterans integrated service network. VA must also consider patient satisfaction in the criteria they use for determining which facilities will retain acute care services. If acute care beds are to remain in one facility because of distances that veterans must travel to access inpatient care/services, the same logic should be used systemwide.

Recommendation:

VA must ensure that the distance veterans must travel to obtain inpatient medical and surgical services be considered before determining the appropriate location for providing these services.

VHA-DOD Sharing:

The Independent Budget *encourages collaboration between Department of Veterans Affairs (VA) and Department of Defense (DOD) health care and recommends careful oversight of sharing initiatives to ensure beneficiaries are assured timely access to partnering facilities.*

The Independent Budget veterans service organizations (IBVSOs) have been discussing this initiative for a number of years, as has Congress, with little success for our efforts. The United States Constitution, Article I, Section 8 requires Congress: *"To raise and support Armies… To provide and maintain a Navy... [and] To make all laws which shall be necessary and proper for carrying into Execution the foregoing Powers…"* Additionally, federal law (38 U.S.C. § 8111(a)) states: *"The Secretary and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed to operate such facilities properly[.]."*

However, there appears to be a number of gaps in what is required by statute and what actually occurs. In a report released in January 1999, the Congressional Commission on Servicemembers and Veterans Transition Assistance *(The Principi Commission)* addressed the need for greater sharing between VA and the DOD. The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), created by Executive Order in May 2001, was asked to:

- "identify ways to improve benefits and services for VA beneficiaries and DOD military retirees who are also eligible for benefits from VA through better coordination of the two departments;
- review barriers and challenges that impede VA-DOD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement; and
- identify opportunities for partnership between VA and the DOD to maximize the use of resources and infrastructure."

The Capital Asset Realignment for Enhanced Services (CARES) Commission report of February 12, 2004, states: "Over the past decade, a number of commissions, advisory organizations, and the General Accounting Office [now the General Accountability Office] have studied various approaches to providing quality health care to veterans. One of the recurring recommendations to fulfill this obligation has been to improve collaboration and sharing between VA and DOD."

> *It is time to stop doing studies, writing reports, and taking minimal action. It has become imperative that in this time of tight funding and a war against world terrorism, VA begin implementing many of the recommendations made by these various reports, as well as take further actions to foster VHA-DOD sharing.*

The IBVSOs continue to support the careful expansion of VA-DOD sharing agreements. However, we concur with the statement of Dr. C. Ross Anthony (one of the PTF commissioners) before the House Committee on Veterans' Affairs in June 2003, when he said that the PTF "concluded that it would be almost impossible for there to be effective collaboration between two systems if one was well funded and the other was not. While not always the case, DOD presently appears, to have adequate funding to fulfill its health-care responsibilities. As this committee is well aware and our report details, the same is not true in the case of the Department of Veterans Affairs. As an economist, I feel that it is important to fashion good policy and then finance it adequately—hopefully in a manner that creates incentives for efficiency."

VA and the DOD will not be able to accomplish either their mandated or recommended sharing goals until Congress addresses the mismatch between veterans' demand for services and the appropriated resources made available to the Veterans Health Administration of VA.

■ *Leadership and Reporting*

The VA-DOD Joint Executive Council should report, at least annually, to the House Committees on Armed Services and Veterans' Affairs on collaborative activities, including development of tools to measure outcomes relating to access, quality, cost, and progress toward meeting goals set for collaboration, sharing, and outcomes. Not only do the IBVSOs believe that there has been insufficient transparency in the work of various DOD and VA executive planning forums, but we also believe that without direct guidance from the respective Secretaries, to include *responsibility and accountability of local management personnel,* these sharing agreements are doomed to failure. This has also been announced as the view point of the Chairman of the House Committee on Veterans' Affairs.

Neal P. Curtin, director, Operations and Readiness Issues, General Accountability Office, stated, in GAO Letter GAO-04-292R to the Chairman of House Committee on Veterans' Affairs, *"VA and DOD have been pursuing ways to share in their health information systems and create electronic records since 1998…"* They still haven't accomplished that goal. Without the successful electronic integration of health-care information, neither *"seamless transition"* nor joint ventures will be successful.

The CARES Commission report states:

> At those locations where collaboration was not successful or where it had been proposed for some time but had not gained momentum, the Commission found…no mutual commitment to the proposed collaboration, no dedication, and no effort. At such sites the Commission also detected a lack of direction from national leadership, in some instances, particularly from the Department of Defense to the local leadership in support of the collaboration.
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> From its review, the Commission concluded that to ensure a successful collaborative relationship

between DOD and VA, there must be a clear commitment from their senior leadership, both to the initial establishment of collaboration and to its ongoing maintenance, especially when there is a change in leadership. The Commission noted a number of collaborations that did not continue after one or both of the senior local leaders was reassigned or retired.

To this end, we believe that sharing agreements should be negotiated and written by local leadership, as they are now, but when ready for signature, they should be signed by the VA Under Secretary for Health and the appropriate service Secretary. This would preclude future local management personnel from repudiating the agreements.

■ Joint Venture Sites

The DOD and VA have identified 74 sharing initiatives at the facility level, 35 of which appear promising to VA. The DOD has identified 20 and VA has identified 21 of these as priority initiatives. In addition, the DOD and VA announced, in October 2003, a series of demonstrations, required by P.L. 107-314, to test improving business collaboration between the DOD and VA health-care facilities. The Departments will use the demonstration projects at eight locations to test initiatives in joint budget and financial management, staffing, and medical information and information technology systems. *The Independent Budget* does not object to these ventures, but we do have serious concerns about their interaction with the VA CARES and DOD military transition facility (MTF) planning processes.

One issue regarding joint venture sites of real concern to the IBVSOs is physical access. Appendix A of the Secretary of Veterans Affairs CARES decision, released in May 2004, lists a number of existing or proposed joint venture sites located aboard military installations. In event of an increase in either terrorist threat level, or force protection level, the probability is that military installations will go into "lock down" status. This would effectively deny Veterans Health Administration (VHA) enrolled patients, who are not military retirees, access to their health-care facility. We suggest that the involved military installations accept the VA universal identification card for access to the installation and issue a vehicular decal to VHA patients. Currently the DOD issues color-coded vehicular decals to personnel requiring access to the facility. These decals are blue for military officers, red for enlisted personnel, green for civilian employees, and black for vendors and contractors. A fifth color could be used for VHA patients.

Of the 21 sites identified by VA as primary joint venture locations, only two have been opened: Bassett ACH, Alaska, and Patterson ACH, New Jersey. However, Patterson ACH is a joint venture with Fort Monmouth, New Jersey. The 2005 Base Realignment and Closure (BRAC) recommended Fort Monmouth be closed. Of the two joint venture clinics in Puerto Rico, one was to have been in conjunction with Naval Hospital Roosevelt Roads, which was closed in 2004. Of the remaining 19 sites, 2 were heavily affected by Hurricane Katrina and to the best of our knowledge only the VAMC North Chicago-USNACC Great Lakes project is in work. Of the other 16 sites, 9 of them could result in veterans being denied health care during increased force readiness conditions.

■ VA and DOD Access Standards

VA has had access standards since 1995, but *these standards have not been enforced.* The DOD, however, has mandatory standards and is required, by statute, to meet them. The DOD standards drive funding levels to meet demand for care at MTFs and within TRICARE. In examining the funding mismatch, the PTF, in its report, concluded that the VHA should receive *"full funding to meet demand, within access standards[.] PTF Report at 81."*

■ Fully Funded Enrolled Veterans

The PTF recommended that the *"Federal Government should provide full funding to ensure that enrolled veterans...are provided the current comprehensive benefit inn accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism[.] PTF Report at 77."*

The PTF recommendation is clear: The gap between resources and demand must be closed by increasing, *and by sustaining,* VA health-care funding. As outlined elsewhere, *The Independent Budget* strongly recommends mandatory funding for all enrolled veterans for whom the Secretary has directed care be provided.

The IBVSOs appreciate that the PTF acknowledged the funding mismatch problem and expressed concern that VA-DOD collaboration cannot work without fundamentally addressing this issue.

Recommendations:

Congress should provide the necessary resources to accelerate the creation of a single separation physical and "one-stop shopping" to enable veterans' benefits decisions to be made more expeditiously.

Congress should provide sufficient resources to enable the DOD and VA to enhance information management interoperability and efficiency.

Congress should mandate establishment of VA's published access standards in title 38 United States Code.

Congress should mandate that all interdepartmental agreements between departments of the executive branch be approved/signed off at the Under Secretary level or higher.

Congress should mandate that, in the case of joint health-care facilities operated by the DOD/VA, procedures be implemented to preclude the loss of health care to veterans in case of an increased force protection condition.

Congress should mandate that in locations where VA-DOD joint sharing agreements will be involuntarily dissolved due to a BRAC, VA be completely funded to assume total control of the facility or facilities.

Congress should require mandatory funding of VA health care.

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Classification of Priority 4 Veterans Remains a Problem:

Catastrophically disabled veterans may be incorrectly classified as enrollment priorities 5, 6, 7, and 8.

The Department of Veterans Affairs (VA) has acknowledged Public Law 104-262, which specifies that veterans who are receiving an increased pension based on a need for regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled will be classified as enrollment priority 4. However, the Veterans Health Administration (VHA) has not developed a consistent and effective mechanism for identifying eligible veterans and properly classifying them.

Individual requests are processed when brought to the attention of VA; however, national service officers still experience some reluctance when requesting a reclassification. This has a direct effect on new injuries and those that have not enrolled in the VA health-care system. Many of these veterans may have been classified as a priority 8 prior to the injury, and now when they need the services of VA, may be denied care as VA is not accepting priority 8 veterans. This is further affected by concerns for future VA reductions in priority levels, which could result in denied care for the catastrophically disabled veteran.

Recommendations:

The VHA should develop a program to identify veterans with disabilities as defined in PL 104-262 and properly classify them as priority 4.

The VHA should report to Congress the number of veterans reclassified as a result of PL 104-262.

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Non-VA Emergency Services:

Enrolled veterans may be excluded from non-Department of Veterans Affairs (VA) emergency medical services due to established eligibility.

The non-VA emergency medical care benefit was established as a safety net for veterans who have no other health-care insurance. An eligible veteran who receives such care is not required to pay a fee to the private facility. However, eligibility criteria prohibit many veterans from receiving emergency treatment at private facilities.

To qualify under this provision, veterans must be enrolled in the VA health-care system, and must have been seen by a VA health-care professional within the previous 24 months. In addition, the veteran must not be covered by any other form of health-care insurance, including Medicare or Medicaid.

The Independent Budget veterans service organizations object to eligibility limitations on enrolled veterans: All enrolled veterans should be eligible for emergency medical services at any medical facility.

A related concern is the frequency with which VA denies payment for the emergency care to veterans, who, as a result, are charged by the private facilities. At times VA denies payment even after advising the veteran (or family member) to request transport by emergency medical services to, and receive emergency care at, a non-VA medical facility. On occasion, the decision relative to approval or denial of a claim is based on the discharge diagnosis, e.g., esophogitis, instead of the admitting diagnosis, e.g., chest pain. Veterans should not be penalized for seeking emergency care when experiencing symptoms that manifest a life-threatening condition.

Recommendations:

Congress must enact legislation eliminating the provision requiring veterans to be seen by a VA health-care professional at least once every 24 months to be eligible for non-VA emergency care service.

VA must establish and enforce a policy that it will pay for emergency care received by veterans at a non-VA medical facility when they exhibit symptoms that a reasonable person would consider a manifestation of a medical emergency.

VA should establish a policy allowing all enrolled veterans to be eligible for emergency medical services at any medical facility.

SPECIALIZED SERVICES ISSUES

Prosthetics and Sensory Aids

Continuation of Centralized Prosthetics Funding:

Problems in the distribution of Department of Veterans Affairs (VA) prosthetics and sensory aids continue. Veterans continue to encounter obstacles in receiving timely and appropriate services and equipment. Program enhancements have been developed to eliminate or minimize these obstacles; however, they have not been fully implemented throughout the VA health-care system.

Continuation of the national centralized prosthetics budget has proven to benefit veterans significantly. The protection of these funds for prosthetics has had a major positive impact on disabled veterans. *The Independent Budget* veterans service organizations (IBVSOs) applaud Veterans Health Administration (VHA) senior leadership for remaining focused on the need to ensure that adequate funding is available, through centralization and protection of the prosthetics budget, to meet the prosthetics needs of veterans with disabilities.

The IBVSOs also are in full support of the decision to distribute FY 2006 prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures and utilization reporting. This decision continues to improve the budget reporting process.

Detractors of a centralized prosthetics budget continue to argue that when prosthetics funds are diminished, the facility or VISN is required to replenish the prosthetics account by utilizing general operating funds. Many facility and fiscal managers who manage the general operating funds believe because they are responsible for the general operating funds that they should also control the prosthetics funds. However, historical evidence has strongly proven that this practice results in funds being diverted from the prosthetics budget to other areas of the VHA facility. Conversely, historical evidence also shows that centralization and protection of prosthetics dollars has resulted in improved services to disabled veterans.

The IBVSOs believe the requirement for increased managerial accountability through extensive oversight of the expenditures of centralized prosthetics funds through data entry and collection, validation, and assessment has had positive results and should be continued. This requirement is being monitored through the work of VHA's Prosthetics Resources Utilization Workgroup (PRUW). The PRUW is charged with conducting extensive reviews of prosthetics budget expenditures at all levels, primarily utilizing data generated from the National Prosthetics Patients Database (NPPD). As a result, many are now aware that proper accounting procedures will result in a better distribution of funds.

The IBVSOs continue to applaud senior VHA officials for implementing and following the proper accounting methods and holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate accounting and requesting of prosthetics funds.

The IBVSOs are pleased that centralized funding continued in FY 2006. The present 2006 proposed allocated budget for prosthetics is approximately $1.2 billion, up from $947 million in FY 2005. Funding allocations for FY 2006 were primarily based on FY 2005 National Prosthetic Patient Database (NPPD) expenditure data, coupled with Denver Distribution Center (DDC) billings, and other pertinent items, but allocations were not primarily based on NPPD and DDC. The VHA also looked at VISN requests, past accuracy between request and expenditures, new programs (new or suite, new catch lab, etc.) The prosthetics budget also includes funds for surgical, dental, and radiology implants.

Because of the increased compliance rate between prosthetics obligations and NPPD expenditure data, most VHA facilities received FY 2006 budget allocations at their requested levels. However, prosthetics is requesting approximately $1.3 billion to cover the actual anticipated FY 2007 prosthetics budget. The advancements in prosthetics technology bring with them a high price. For example, a single prosthetic limb, the C-leg, has an anticipated cost of $36,000; a

single IBOT wheelchair, $30,000; and a single service dog, $20,000.

In FY 2007 the IBVSOs anticipate that the prosthetics budget will need to be increased to more than $1.5 billion. If the prosthetics budget were to reflect the Home Oxygen Program, for which prosthetics is responsible, an additional $5 million is needed. Part of these funds must be used to allocate the latest technological advances in prosthetics and sensory aids. Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. VA was once the world leader on developing new prosthetics devices. The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. As new technologies and devices become available for use, the VHA must ensure that these products are appropriately issued to veterans and that funding is available for such issuance.

Listed below are examples of NPPD expense costs in fiscal year 2005. These costs are not total costs for those NPPD groups; these are only the new items cost, which does not include any repair cost.

Wheelchairs & Access – total cost	$108,810,945
Artificial Legs – total cost	$52,459,114
Artificial Arms – total cost	$2,252,392
Orthosis/Orthotics – total cost	$29,040,710
Shoes/Orthotics – total cost	$24,064,498
Sensori-Neuro Aids – total cost	$52,334,085
Restorations – total cost	$2,609,169
Oxygen & Respiratory – total cost	$47,786,930
Medical Equip & Supplies – total cost	$97,303,390
Home Dialysis – total cost	$1,731,184
HISA – total cost	$6,586,230
Surgical Implants – total cost	$312,494,258
Other Items – total cost	$2,113,117

Recommendations:

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled veterans, including the latest advances in technology, so that funding shortfalls do not compromise other programs.

The Administration must allocate an adequate portion of its appropriations to prosthetics to ensure that the prosthetics and sensory aids needs of veterans with disabilities are appropriately met.

The VHA must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

The VHA should continue to utilize the PRUW to monitor prosthetics expenditures and trends.

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the NPPD.

The VHA's senior leadership should continue to hold its field managers accountable for failing to ensure that data is properly entered into the NPPD.

Single-Source National Prosthetics Contracts:

Single-source national contracts for specific prosthetic devices may lead to inappropriate standardization of prosthetic devices.

The Veterans Health Administration (VHA) continues to follow a "best practice" model to improve quality and accuracy of prosthetics' prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). *The Independent Budget* veterans service organizations (IBVSOs) continue to cautiously support the VHA in these efforts. The concern is that the PCMP could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

The IBVSOs have concerns about the procedures being used as part of the PCMP process to award single-source national contracts for specific prosthetic devices, mainly the high compliance rates in the national contracts. The typical compliance rate, or performance goal, in the national contracts awarded so far as a result of the PCMP has been 95 percent. This means that for every 100 devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased "off contract" (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such high compliance rates is that inappropriate pressure may be placed on clinicians to meet these goals due to a counterproductive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe national contract awards should be multiple- sourced. Additionally, compliance rates, if any, should be reasonable. National contracts need to be designed to meet individual patient needs. Extreme target goals or compliance rates will most likely be detrimental to veterans with special needs. The high compliance rates set thus far appear arbitrary and lack sufficient clinical trial.

Under VHA Directive 1761.1, prosthetic items intended for direct patient issuance are exempted from the VHA's standardization efforts because a "one-size-fits-all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. Yet despite this directive, the PCMP process is being used to standardize the majority of prosthetic items through the issuance of high compliance rate national contracts. This remains a matter of grave concern for the IBVSOs, and we remain opposed to the standardization of prosthetic devices and sensory aids.

Significant advances in prosthetics technology will continue to dramatically enhance the lives of disabled veterans. In our view, standardization of the prosthetic devices that the Department of Veterans Affairs (VA) will routinely purchase threatens future advances. VA was once the world leader in developing new prosthetics devices. The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. Formulary-type scenarios for standardizing prosthetics will likely cause advances in prosthetic technologies to stagnate to a considerable degree because VA has such a major influence on the market. Disabled veterans must have access to the latest devices and equipment, such as computerized artificial legs, stair climbing, and self-balancing wheelchairs and scooters, if they are to lead as full and productive lives as possible.

Another problem with the issuance of prosthetic items relates to surgical implants. While funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device, coronary stents, cochlear implants), the surgical costs associated with implanting the devices come from local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule implant surgeries or are limiting the number of surgeries because of the costs involved. If true, the consequences to those veterans could be devastating and life threatening.

Recommendations:

The VHA should continue the prosthetics clinical management program, provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to

inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

The VHA must continue to exempt prosthetic devices and sensory aids from standardization efforts. National contracts must be designed to meet individual patient needs, and single-item contracts should be awarded to multiple vendors/providers with reasonable compliance levels.

VHA clinicians must be allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical condition, not costs associated with equipment and services. VHA clinicians must be permitted to prescribe devices that are "off contract" without arduous waiver procedures or fear of repercussions.

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent regarding the appropriate provision of care and services. Such policies and procedures should address issues of prescribing, ordering, and purchasing based on patient needs—not cost considerations.

The VHA must ensure that new prosthetic technologies and devices that are available on the market are appropriately and timely issued to veterans.

Congress should investigate any reports of VHA facilities withholding surgeries for needed surgical implants due to cost considerations.

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Restructuring of Prosthetics Programs:

Not all Veterans Integrated Service Networks (VISNs) have taken necessary action to ensure that their respective prosthetics programs have been restructured to provide timely and consistent service to the patients.

The Independent Budget veterans service organizations (IBVSOs) continue to support the VISN and its field efforts to ensure an acceptable consistent degree of medical services to meet the special needs of veterans. The IBVSOs believe Veterans Health Administration (VHA) headquarters must provide more specific information and direction to VISNs on the restructuring of their prosthetics programs. Communication inconsistencies in the current organizational structure have left the VHA central office trying to respond to various local interpretations of Department of Veterans Affairs (VA) policy. VHA headquarters *must* direct VISN directors to:

- Designate a qualified VISN prosthetics representative who will be the technical expert on all issues of interpretation of the prosthetics policies.
- Ensure that VISN prosthetics representatives have direct input into the performance evaluation of all prosthetics full-time employee equivalents at local facilities who are organized under the consolidated prosthetics program or product line.
- Ensure that VISN prosthetics representatives do not have collateral duties as prosthetics representatives to local VA facilities.
- Hold each VISN prosthetics representative responsible for ensuring implementation and compliance with national prosthetics and sensory aids goals, objectives, policies, and guidelines
- Provide a single VISN budget for prosthetics and ensure that the VISN prosthetics representative has control of and responsibility for that budget.

Recommendation:

The VHA must require all VISNs to adopt consistent operational parameters and authorities for prosthetics policies. The individual VISN directors as well as the VHA central office should be held responsible for a consistent prosthetics program that reduces the need for central office interpretations.

Failure to Develop Future Prosthetics Managers:

There continues to be a serious shortage in the number of qualified prosthetics representatives to fill current or future vacant positions. The suspension of an ongoing training program in fiscal year 2005 has added to the shortage.

The Veterans Health Administration (VHA) has developed and requested 12 training billets for the National Prosthetics Representative Training Program in past years; however, in FY 2005, trainee recruitment for the program was stopped by the Technical Career Field per request of the National Leadership Board (NLB). The NLB decided to reallocate funds for other services. *The Independent Budget* veterans service organizations (IBVSOs) would like to see the training program continued in fiscal year 2006; however, the NLB must have the funds set aside in a special account to only be used for this training program, with no interruption or reallocations of training funds.

This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. In the past there was a serious shortage in the number of qualified prosthetic representatives who were available to fill current or future vacancies. This led to many inappropriate prosthetics personnel selections around the country. Currently seven prosthetics representative trainees from the 2003 program will graduate in 2005 and be ready for permanent placement. Twelve slots were approved for FY 2004, with 7 current trainees participating in the program due to graduate in 2006 and another 12 trainee slots are pending approval for FY 2006.

In the past, some Veterans Integrated Service Networks (VISNs) have selected individuals who do not have the requisite training and experience to fill the critical VISN prosthetics representative positions. The IBVSOs believe the future strength and viability of VA's prosthetics programs depends on the selection of high-caliber prosthetics leaders. To do otherwise will continually lead to grave outcomes based on the inability to understand the complexity of the prosthetics needs of patients or the creation of prosthetics gatekeepers: individuals whose primary mission would be to save dollars at the expense of the veteran.

The prosthetics program must be improved. Continuing education and certification for field prosthetics staff is essential to this effort. The IBVSOs strongly encourage the VHA to continue to conduct quarterly VISN prosthetics representative training meetings. The prosthetics chief's national training conferences, which are usually held in conjunction with other rehabilitation services (e.g., blind rehabilitation, spinal cord injury, traumatic brain injuries, etc.), should continue.

In addition, appropriate prosthetics procurement personnel need to become certified as assistive technology suppliers, and orthrotists/prosthetists need to be certified in their respective fields.

Recommendations:

The VHA must fully fund and implement its National Prosthetics Representative Training Program, with responsibility and accountability assigned to the chief consultant for Prosthetics and Sensory Aids, and continually allocate sufficient training funds and full-time employee equivalents to ensure success.

VISN directors must ensure that sufficient training funds are reserved for sponsoring prosthetics training conferences and meetings for appropriate managerial, technical, and clinical personnel.

The VHA must be assured by the VISN directors that their selected candidates for vacant VISN prosthetics representative positions possess the necessary competency to carry out the responsibilities of these positions.

The VHA and its VISN directors must ensure that prosthetics and sensory aids departments are staffed by appropriately qualified and trained personnel.

VHA Prosthetics Policies and Procedures Are Not Applied Consistently within VA:

Prosthetics services (e.g., the provision of hearing aids and eyeglasses, wheelchairs, artificial limbs, etc.) are still not provided uniformly across the nation to veterans who are enrolled and eligible for the Department of Veterans Affairs (VA) care and treatment.

There continues to be a disparity in the application of a uniform national policy of distribution of prosthetics services across the nation. It is clear that senior leadership in the Veterans Health Administration (VHA) recognizes that this problem exists. Prosthetics and Sensory Aids continues to receive repeated requests to clarify instructions to its Veterans Integrated Service Network (VISN) prosthetics representatives concerning the "local" interpretation of policy in reference to the issuance of medically needed adaptive equipment (ingress/egress items). The policy for issuance of this equipment was clearly listed in VHA's prosthetics handbook (VHA Handbook 1173). In fact, the prosthetics handbook contains key language that addresses the problem of inconsistent application of prosthetic policies and provisions. The handbook indicates that the VHA is striving to provide a uniform level of services on a national level. Every section of the handbook specifically indicates that the policies contained therein are intended to set uniform and consistent national procedures for providing prosthetics and sensory aids and services to veteran beneficiaries. We believe national VHA officials need to review the training provided to the prosthetics representatives to ensure that national prosthetics policies are properly followed. Prosthetics leadership needs to ensure that VHA Handbook 1173 is translated in VISN and facility-level operating guidelines accurately.

As noted above, policy enforcement and individual accountability is needed to effect positive change in local practices. In addition, the chief consultant for Prosthetics and Sensory Aids must work with all the VISNs to develop VISN-wide training initiatives that provide emphasis on ensuring that the interpretation of these national VHA policies and procedures on the issuance of prosthetic devices is consistent and appropriate, regardless of facility.

Recommendations:

The VHA must ensure that national prosthetics policies and procedures are followed uniformly at all VHA facilities.

All 21 VISN prosthetics representatives, in cooperation with the chief consultant for Prosthetics and Sensory Aids, need to develop, conduct, and/or continue appropriate prosthetics training programs for their VISN prosthetics personnel.

Mental Health Care

Mental Health Services:

Mental health services for older veterans must be maintained along with the Department of Veterans Affairs (VA) efforts to care for increased mental health challenges arising from the ongoing conflicts in Iraq and Afghanistan.

■ Overseas Engagement

The U.S. military engagement in Southwest Asia extends into its fourth year. This is a difficult, dangerous campaign for American troops, whether they are regular active duty members, Reserves, or National Guard. Ground combat units have faced fierce fighting, whether in close combat in the streets and buildings of urban areas, or while traversing rugged mountain passes. Danger is imminent, even for military members working in support positions. The ever-present roadside bomb threatens U.S. convoys as they travel treacherous roadways and trails. Vehicular accidents are commonplace, and no one is immune. Two members of Congress visiting troops were recently injured in a military vehicle rollover in Iraq. And suicide bombers are perhaps the most terrifying threat of all, since they are determined to die and to kill simultaneously as many of our troops (and their own fellow citizens) as possible to make a statement on behalf of tyranny.

Despite the threats and risks, our regular active duty, National Guard, and Reserve forces are performing magnificently in current conflicts. Many Guard and Reserve members have served multiple tours of duty, leaving families and full-time civilian jobs in America when they were called to duty as citizen soldiers. Their families are making extreme sacrifices so that this nation can free foreign nations from tyranny. Some make the supreme sacrifice. In fact, for the first time in American history in an overseas engagement by the U.S. military, the majority of our combat, occupational, and accidental deaths in the conflicts in Afghanistan and Iraq have occurred to members of the Guard and Reserves rather than regular active duty forces.

Thousands are now injured, some physically and some with wounds that are not physically apparent. A recent study conducted by the Army, published in the *New England Journal of Medicine,* found that 17 percent of U.S. combat troops, including Army and Marines, experienced major depression and combat stress, the highest rate recorded since the years of U.S. engagement in Vietnam. VA reports that one of the most common reasons that veterans of Operation Enduring Freedom/Operation Iraqi Freedom contact VA facilities once home from deployments is for mental health reasons, such as adjustment disorder, anxiety, depression, and substance abuse. Exposure to the stresses of combat produces these and other manifestations of acute post-traumatic stress. To date, of the 360,000 veterans who have returned stateside from these wars, about 10,000 have established VA service connection for post-traumatic stress disorder (PTSD). *The Independent Budget* veterans service organizations (IBVSOs) are convinced these numbers will inevitably grow as the conflicts wear on.

■ VA's Implementation of the "National VA Mental Health Strategic Plan"

The authors of *The Independent Budget* insist the VA system be capable of receiving these wounded veterans, whether they are active duty, Guard, or Reserve, and of giving them the highest quality and level of services to restore them at the earliest possible time. Our ongoing military engagement in Iraq and Afghanistan dramatically heightens the importance of ensuring that the VA health-care system is set to effectively treat veterans' mental health challenges on an equal basis with the care of their physical injuries and illnesses. We are pleased that VA leaders have taken steps over the past year to establish a national mental health strategic plan as an outgrowth of the President's New Freedom Commission report and to commit significant resources to its implementation. It is now up to Congress to provide needed funding/support to ensure a dependable, uninterrupted flow of those resources to make this plan a reality and to provide oversight to ensure VA keeps its own promises with respect to the delivery of mental health services to veterans who need them.

VA has long had a special obligation to veterans with mental illness, given both the prevalence of mental health and substance-use problems among veterans and the high numbers of those whose illness was of service origin. Fiscal year 2004 VA data show that 494,655 veterans are service connected for a mental disorder. Of that number, 241,543 are service connected for PTSD. More than 833,000 of the nearly 5 million who received VA care in fiscal year 2004 received some type of mental health service.

■ Congress Earmarked 2006 Funding for Mental Health

The Independent Budget applauds Congress for having codified into law special safeguards to ensure that VA gives a priority to the needs of veterans with mental illness, particularly one element of the fiscal year 2006 Appropriations Act, which earmarks at least $2.2 billion from the VA Medical Services appropriation account to be used solely for mental health services. The IBVSOs believe Congress was well justified to establish this requirement, and we urge the Committees on Appropriations and on Veterans' Affairs of both chambers to provide continuing oversight of the expenditure of these funds to ensure they are used for the purposes Congress intended and to extend this earmark for 2007 with an incremental increase. Major beneficiaries of these funds are recently repatriated combatants from Southwest Asia and older veterans suffering from chronic mental illnesses. Congress needs to take care to ensure that one group is not pitted against the other in VA's allocation of these funds.

■ President's New Freedom Commission on Mental Health

Unfortunately, the VA health-care system has had an uneven record of service to veterans with mental health needs. Years of oversight repeatedly hammered at the enormous variability across the country in the availability of mental health treatment services and, where services were available, the relatively limited capacity devoted to rehabilitation. But following the release of the report of the President's New Freedom Commission on Mental Health in July 2003, VA undertook an unprecedented, critical examination of its mental-health services. Like other institutions providing mental health care, VA found that it tended to focus on managing symptoms of patients' mental health problems, rather than aiding patients' recovery. Yet the President's New Freedom Commission found that many people with mental illness can regain a productive life, and it provided the President with a blueprint for system change based on the goal of recovery. VA leaders, to their credit, understood the importance of the mental health system change the commission envisioned and developed an agenda (built in significant part on recommendations of VA's Committee on the Care of Severely Mentally Ill Veterans) for realizing that goal. Under VA Secretary Anthony J. Principi's leadership, the transformation under way in VA mental health service delivery—built on an understanding that veterans with mental disorders can recover and lead productive lives—is vitally important to keeping faith with VA's obligations to America's veterans. We urge Secretary James Nicholson to follow Secretary Principi's example and maintain mental health reform as a major priority in his term of office.

Any transformation or major change—from eliminating the long-standing variability in VA mental health care to changing its mission from symptom-management to recovery—will take sustained leadership and support on the part of VA and Congress. Given the gap between VA's mental health capacity and the needs of veterans for mental health treatment and support services, these changes justify the Congressional decision to earmark funding for these purposes.

■ Major Challenges Continue

While VA and Congressional leaders have taken important initial steps to move VA toward better care for veterans with mental health problems, we must acknowledge, and set a course to meet, the many serious needs the system still faces. Among the gaps yet to be bridged:

- VA does not have in place the needed arsenal of rehabilitative services—from supported employment to housing assistance to peer supports—that veterans need to achieve the fullest possible recovery from chronic mental illness.
- VA and the DOD have not perfected a systematic approach to provide screening and intervention services to help returning service members transition from early intervention for war-related

mental health problems to sustained support and care, leading to recovery.

- Veterans with substance use problems, and particularly those with co-morbid mental health challenges, do not have adequate access to VA treatment programs. The very definition of integrated substance abuse and mental health services is yet to be promulgated throughout the system.
- VA lacks the capacity to make available appropriate programs for veterans with specialized treatment needs, including elderly veterans with psychoses and/or dementia-related conditions and female veterans who have mental health needs associated with sexual assault in military service.
- The task of improving the strategic planning projection model, built on the Capital Asset Realignment for Enhanced Services (CARES) methodology, is particularly important for mental health services and requires attention until it is adequate for the needs of the system. This is vital for implementation of the mental health strategic plan to eliminate the still large variability in access to mental health programs.

■ *Summary*

In what should be a shared journey, VA and Congress each must do its part to take VA mental health care to a higher priority and ensure that it is sustained as a high priority. Both must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all the positive benefits this brings to veterans, their families, and American society, becomes the guiding beacon for VA mental health planning, programming, and budgeting.

Recommendations:

With the advent of the VA national mental health strategic plan, Congress should consider supplementing the existing capacity reporting requirement in 38 U.S.C. § 1706 with an annual report about progress in implementing specific milestones from VA's strategic plan as part of its reportable capacities in providing mental health services. Such a report should include an independent assessment of progress in implementing the mental health strategic plan from the Special Committee on Veterans with Serious Mental Illness, the Special Committee on Veterans with PTSD and the Secretary's Homeless Advisory Committee.

Congress should continue to earmark, and incrementally augment, funding for specialized treatment and support services for veterans who have mental illness, PTSD, and substance-use disorders. We recommend the addition of $500 million each year to the earmarked baseline from fiscal year 2007 through FY 2011. Thus, for FY 2007 the appropriate total earmark would be $2.7 billion.

The Veterans Health Administration must invest resources in programs to develop a continuum of care that includes intensive case management, psychosocial rehabilitation, peer support, integrated treatment of mental illness and substance-use disorders, housing alternatives, work therapy and supported employment, and other necessary support services, with an overarching goal of recovery. To do this rationally throughout the system will require completing the refinement of the mental health strategic planning model, based on the original CARES method.

VA must work more effectively with the DOD to ensure the establishment of a seamless transition of early intervention services to help returning service members obtain treatment for war-related mental health problems.

Special Needs Veterans

Blinded Veterans:

The Veterans Health Administration (VHA) needs to provide a full continuum of vision rehabilitation services.

The Department of Veterans Affairs (VA) Blind Rehabilitation Service (BRS) is known worldwide for its excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. VA currently operates 10 comprehensive residential blind rehabilitation centers (BRCs) located across the country. Currently, approximately 41,000 blind veterans are enrolled in Visual Impairment Service Teams (VIST) coordinators' offices, and more than 125 Operation Enduring Freedom/Operation Iraqi Freedom service members have sustained visual injuries. Projected demographic data estimates that by 2009 the VA system could sustain a rise to approximately 55,000 enrolled blind and visually impaired veterans requiring services. Historically, the residential BRC program has been the primary option for severely visually impaired and blinded veterans to receive services. As the VHA transitioned to a managed outpatient primary care system of health-care delivery, the BRS failed to make the same transition for rehabilitation services for blinded veterans. *The Independent Budget (IB)* agrees with the recommendations from the Government Accountability Office (GAO) testimony on July 22, 2004, that it is imperative that the VA BRS expand its capacity to provide a full continuum of blind rehabilitation services on an outpatient basis. Currently, approximately 1,600 blinded veterans are waiting an average of 24 weeks for entrance into one of the 10 VA BRCs. The GAO found that 21 percent of these blinded veterans do not require a residential program and could benefit from an increase in blind rehabilitative outpatient specialists (BROS) or other outpatient low vision programs. Under the present system, many older veterans cannot or will not attend a residential BRC—therefore they do not receive any type of rehabilitation.

The Independent Budget (IB) encourages funding for additional research into alternative models of service delivery to identify more cost-efficient methods of providing essential blind rehabilitation services. The *IB* supports current Congressional legislation to increase the number of BROS in H.R. 3579 by 35 new positions to meet the demand for more outpatient blind services. Alternative methods of delivering rehabilitative services must be identified, tested, refined, and validated, and such innovative programs as the outpatient nine-day rehabilitation program called Visual Impairment Services Outpatient Rehabilitation Program (VISOR) at the VAMC Lebanon, Pennsylvania, be expanded with recommendation that 11 new VISOR programs be established. VISOR offers daily living skills training, orientation and mobility, and low vision therapy, and this new approach combines the features of a residential program with those of outpatient service delivery.

Congressionally mandated capacity must be maintained. The BRS continues to suffer losses in critical full-time employee equivalents (FTEEs), compromising its capacity to provide comprehensive residential blind rehabilitation services. Some of the blind rehabilitation centers are unable to operate all of their beds because of the reduction in staffing levels. Other critical BRS positions, such as full-time Visual Impairment Services Team (VIST) coordinators, suffer shortfalls. Currently there are only 24 Blind Rehabilitation Outpatient Specialists (BROS), and three of the four Poly Trauma Centers have no BROS on staff. In addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a blind rehabilitation center, BROS provide blind rehabilitation training in veterans' homes. This service is particularly important for blinded veterans who cannot be admitted to a residential blind rehabilitation center.

Recommendations:

The VHA must restore the bed capacity in the blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

The VHA must rededicate itself to the excellence of programs for blinded veterans.

The VHA must require the networks to restore clinical staff resources in both inpatient and outpatient blind rehabilitation programs.

The VHA headquarters must undertake aggressive oversight to ensure full continuum of care for blind services both in increasing VISOR programs and staffing levels for blind rehabilitation specialists at each Poly Trauma Center.

Congress must pass H.R. 3579 to increase the FTEEs of blind rehabilitative outpatient specialists with appropriate funding.

The VHA should expand capacity to provide computer access evaluation and training for blinded veterans by contracting with qualified local providers when and where they can be identified.

The VHA should ensure that concurrence is obtained from the director of the Blind Rehabilitation Service in VA headquarters before a local VA facility selects and appoints key BRS management staff. When disputes over such selections cannot be resolved between the BRS director and local management, they must be elevated to the Under Secretary for Health for resolution.

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Spinal Cord Dysfunction:

The recruitment of qualified staff to support the mission of the Spinal Cord Injury/Spinal Cord Dysfunction (SCI/D) program remains the major impediment to providing quality care to the spinal cord dysfunctional patient.

The Department of Veterans Affairs (VA) continues to experience a serious shortage of qualified, board certified spinal cord injury physicians, making it difficult to fill the role of chief of the SCI/D service. Several major SCI/D programs are under "acting" management with resultant delays in policy development and a loss of continuity of care. In some VA hospitals the recruitment for a new chief of service has been inordinately prolonged with acting chiefs assigned for indefinite time periods.

It must be recognized that SCI/D medicine is a major subspecialty and clinical leadership of these departments is as vital to the VA's Healthcare Program as the specialties of general medicine and surgery. Vacancies, specifically in chief positions, reflect adversely on the management of the local VA hospital and the VA Veterans Health Administration (VHA) system of care. It can be assumed that either the hiring process is flawed, applicants were not available, or that appropriate incentives have not been included to make these positions attractive.

■ Nursing Staff

The Independent Budget veterans service organizations continue to support the belief that basic salary for nurses who provide bedside care is still too low to be competitive with community hospital nurses. This results in high attrition rates as these individuals leave the VA for more attractive compensation in the community.

Recruitment and retention bonuses have been effective at several VA spinal cord injury centers, resulting in an improvement in both quality of care for veterans and the morale of the nursing staff. The facilities are faced with the local budget dilemma when considering the offering of any recruitment or retention bonus. The funding necessary to support this effort is taken from the local budget, thus shorting other needed medical programs. Because these efforts have only been used at local or regional facilities, there is only a partial improvement of a systemwide problem.

VA has a system of classifying patients according to the amount of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of injury, amount of time spent with the patient, technical expertise, and clinical needs of each patient. A category III patient, in the middle of the scoring system is the "average" SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. These hours are

converted into the number of full-time employee equivalents (FTEEs) needed for continuous coverage. This formula covers *bedside nursing care hours* over a week, month, quarter, or year. It is adjusted for net hours of work with annual, sick, holiday, and administrative leave included in the formula.

The emphasis of this classification system is based on *bedside nursing care*. It does not include administrative nurses, non-bedside specialty nurses or light-duty nursing personnel, as these individuals do not or are not able to provide full-time labor-intensive bedside care for the spinal cord injured/dysfunctional patient. According to the *California Safe Staffing Law*, which is about registered nurses (RN) to patient staffing ratios, "Nurse administrators, nurse supervisors, nurse managers, and charge nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those administrators are providing direct patient care."

Nurse staffing in SCI/D units has been delineated in VHA Handbook 1176.1 and VHA Directive 2005-001. It was based on 71 FTEEs per 50 staffed beds, using an average category III SCI/D patient. Currently nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

VHA Directive 2005-001 mandates 1,347.6 bedside nurses to provide nursing care for 85 percent of the available beds at the 23 SCI centers across the country. This nursing staff consists of RNs, licensed vocational/practical nurses, nursing assistants, and health technicians.

At the end of fiscal year 2005, nurse staffing was 1,290.7, which is 56.9 FTEEs short of the mandated requirement of 1,347.6. The 1,290.7 FTEEs includes nursing administrators and non-bedside RNs (76.4) and light duty staff (29.5). Removing the administrators and light duty staff makes the total number of nursing personnel at 1,184.8 FTEEs to provide *bedside nursing care*.

The regulation calls for a staff mix of approximately 50 percent RNs. Not all SCI centers are in full compliance with this ratio of professional nurses to other nursing personnel. There are 583.39 RNs working in SCI. Out of that, 76.4 are in non-bedside or administrative positions, leaving 507 RNs providing bedside nursing care. With 1,290.7 nursing personnel and 507 of those RNs, this leaves an RN ratio of 39 percent to provide *bedside nursing care*. Even if the non-bedside RNs were included, the percentage of RNs would only be 45 percent. These numbers fail to meet the mandated 50 percent RN ratio.

SCI facilities recruit only to the minimum nurse staffing required by VHA Directive 2005-001. As shown above, when the minimal staffing levels include non-bedside nurses and light duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with lower levels of nurses.

The low percentage of professional registered nurses providing bedside care and the high acuity of SCI/D patients puts SCI/D veterans at increased risk for complications secondary to their injuries. The Agency for Healthcare Research and Quality published information showing that low RN staffing caused an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their condition. A staff in the SCI service that is 50 percent registered nurses is crucial in promoting optimal outcomes.

The nurse shortage has increased as VA facilities have begun to admit non-SCI patients to the SCI center wards. Reports of bed consolidations or closures due to nursing shortages have been received. Such situations create a severe compromise of patient safety and continue to stress the need to enhance the nurse recruitment and retention programs.

Recommendations:

The VHA should authorize substantial recruitment incentives and bonuses to attract board certified physicians for staff as well as the SCI chief position.

The VHA should establish a policy that would improve the recruitment process for chiefs of SCI and eliminate long delays in filling these positions.

The VHA needs to centralize policies and funding for systemwide recruitment and retention bonuses for nursing staff.

Congress should appropriate funding necessary to provide competitive salaries and bonuses for SCI/D nurses.

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Gulf War Veterans:

Gulf War veterans still suffer from undiagnosed illnesses related to their service.

In the 14 years since the Gulf War, both the Department of Defense and the Department of Veterans Affairs (VA) have seen many service members and veterans with undiagnosed illnesses and or Gulf War syndrome. The controversy over Gulf War syndrome still exists, and sick Gulf War veterans suffer from a wide range of chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, gastrointestinal problems, and chest pain.

Scientists and medical researchers who continue to search for answers and contemplate the various health risks associated with service in the Persian Gulf theater report illnesses affecting many veterans who served there. To date, experts have concluded that while Gulf War veterans suffer from real illnesses, there is no single disease or medical condition affecting them. Although some headway has been made in diagnosis, treatment, and adjudication of claims for disability compensation, greater focus and management of research by both departments is needed, particularly when laboratory and research findings translate to clinical care and new therapies for Gulf War veterans.

The conflict in Iraq has troops fighting and living in the same areas as our Gulf War veterans. VA's response to this unique situation was to broaden the scope of Gulf War illness research to include "deployment related health research." In 2004, VA committed for fiscal year 2005 up to $15 million in additional research funding for Gulf War illnesses. Only $9.1 million was allocated in FY 2005 for Gulf War illness research projects; $1.7 million was spent on new research; however, less than half was for research related to Gulf War veterans' multisymptom illnesses or the effects of Gulf War-related exposures. According to a November 2005 VA news release, the total cost of FY 2006 research spending for Gulf War illness is estimated by VA to be $11.3 million with $1.7 million going toward new research.

In reviewing VA funded research on Gulf War illness, the Research Advisory Committee on Gulf War Veterans' Illnesses has raised questions on the nature of some VA funded research as to whether these research projects will directly affect veterans suffering from Gulf War illnesses. *The Independent Budget* veterans service organizations (IBVSOs) are concerned that the decision to extend the umbrella of Gulf War illness research will dilute the focus and erode the management of VA research.

While it is unclear whether veterans of the current Persian Gulf conflict should be categorically grouped with veterans of the first Gulf War for VA research on Gulf War illnesses, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of the other. The IBVSOs believe that funding for research proposals categorized under Gulf War illness should be subject to a review of relevancy by experts in this

area to ensure precious research funding that is committed is properly managed, particularly with Congress's sustained interest in this issue depicted in the conference report of the Military Quality of Life and Veterans Affairs Appropriations Act of 2006 (Public Law 109-114), which directs VA to provide no less than $15 million to be used for Gulf War illness research and to evaluate establishing a research center of excellence devoted specifically to Gulf War illness.

As testing and research continue, veterans affected by these multisymptom-based illnesses hope answers will be found and that they will be properly recognized as disabled due to their military service in the Gulf War. The IBVSOs expect to see additional health-care issues and disability claims related to some of the same undiagnosed illnesses the veterans of the Gulf War have experienced.

Unfortunately, veterans returning from all of our nation's wars and military conflicts have faced similar problems attempting to gain recognition of certain conditions as service connected. With respect to Gulf War veterans, even after countless studies and extensive research, there remain many unanswered questions. Accordingly, the IBVSOs urge Congress to extend the provision of P.L. 107-135, thus prolonging eligibility for VA health care for veterans who served in Southwest Asia during the Gulf War and current conflicts. In this connection, we strongly recommend establishment of an open-ended presumptive period until it is possible to determine "incubation times" in which conditions associated with Gulf War service will manifest.

Many Gulf War veterans are frustrated over VA medical treatment and denial of compensation for their poorly defined illnesses. Likewise, VA health-care professionals face a variety of unique challenges when treating these veterans, many of whom are chronically ill and complain of numerous, seemingly unrelated symptoms. Physicians must devote ample time to properly assess and treat these chronic, complex, and debilitating illnesses. In this connection, VA uses clinical practice guidelines for chronic pain and fatigue. VA has not yet, however, developed clinical practice or treatment guidelines for management of patients with multisymptom-based illnesses. Nor has VA tailored its health-care or benefits systems to meet the unique needs of Gulf War veterans; instead, VA continues to medically treat and handle these cases in a traditional manner.

The IBVSOs believe Gulf War veterans would greatly benefit from such guidelines, as well as from a medical case manager. Oversight, coupled with a thorough and comprehensive medical assessment, is not only crucial to treatment and management of the illnesses of Gulf War veterans, but also to VA's ability to provide appropriate and adequate compensation.

Equally essential is continuing education for VA health-care personnel who treat this veteran population. VA physicians need current information about the Gulf War experience and related research to appropriately manage their patients. VA should request expedited peer reviews of its Gulf War-related research projects, such as the antibiotic medication trial and the exercise and cognitive behavioral therapy study. Moreover, the Secretary should support vigorously significant increases in the effort and funds devoted to such research by both federal government and private entities.

Recommendations:

VA should continue to foster and maintain a close working relationship with the National Academy of Science (NAS) in an effort to determine which toxins Gulf War veterans may have been exposed to and what illnesses may be associated with such exposure.

Congress should continue prudent and vigilant oversight to ensure both VA and the NAS adhere to time limits imposed upon them so they effectively and efficiently address the continuing health-care needs of veterans who have served in Persian Gulf theaters.

Women Veterans:

The Department of Veterans Affairs (VA) must be prepared to meet the needs of increasing numbers of women veterans seeking health-care services and ensure that its special disability programs are tailored to meet the unique health concerns of our newest generation of women veterans, especially those who have served in combat theaters.

In contrast to the overall declining veteran population in the United States, the female veterans' population is increasing. According to a 2003 United States Census Bureau survey, of the 23.7 million veterans, 1.4 million, or 6 percent, were women. Today, more than 210,000 (nearly 15 percent) women serve on active duty in the military services of the Department of Defense (DOD). Another 4,400 women serve in the active Coast Guard. The Reserve and National Guard components also have an increasing percentage of women, whose 148,659 members constituted 17.3 percent of the current personnel as of the start of fiscal year 2005.

As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health-care services. As reported by VA, women veterans enrolled in the veterans health-care system increased from 330,904 in fiscal year 2003 to 352,128 in fiscal year 2004. Additionally, according to the Women Veterans Health Program Office, as of July 18, 2005, 43,925 women veterans served and have separated from military service in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) theaters of operations. Among the more than 43,000 women having served in OIF/OEF, 31.2 percent, or 13,693 have received health care from VA since separation from military service. Currently, women veterans comprise approximately 5 percent of all users of VA health-care services, and within the next decade this figure is expected to double. The average female veteran is younger (estimated median age 46) than her male counterpart (estimated median age 60) and more likely to belong to a minority group. With increased numbers of women veterans seeking VA health care following military service, it is essential that VA is responsive to the unique demographics of this veterans' population and adjust programs and services as needed to meet their changing health-care needs. As we see growth in the number of women veterans using VA health-care services, we also expect to see increased VA health-care expenditures for women's health programs.

VA is obligated to deliver health-care services to women veterans equal to those provided to male veterans. The VA Veterans Health Administration (VHA) Handbook 1330.1, "VHA Services for Women Veterans," states:

> It is a VHA mandate that each facility, independent clinic and Community-Based Outpatient Clinic (CBOC) ensure that eligible women veterans have access to all necessary medical care, including care for gender-specific conditions that is equal in quality to that provided to male veterans.

The Independent Budget veterans service organizations (IBVSOs) are concerned that although VA has markedly improved the way health care is provided to women veterans, privacy and other deficiencies still exist at some facilities. VA needs to enforce, at the Veterans Integrated Service Network (VISN) and local levels, the laws, regulations, and policies specific to health-care services for women veterans. Only then will women veterans receive high-quality primary and gender-specific care, continuity of care, and the privacy they expect and deserve at all VA facilities. The VHA has an excellent handbook for providing services for women veterans. Unfortunately, these guidelines and directives are not always followed at the VISN or local level.

According to VHA Handbook 1330.1, "VHA Services for Women Veterans":

> Clinicians caring for women veterans in any setting must be knowledgeable about women's health care needs and treatments, participate in ongoing education about the care of women, and be competent to provide gender-specific care to women. Skills in screening for history of sexual trauma and working with women who have experienced sexual trauma are essential.

The model used for delivery of primary health care to women veterans using VA health-care services is variable. There has been a trend in the VHA away from comprehensive or full-service women's health clinics dedicated to both the delivery of primary and gender-specific health care to women veterans. According to VA, 46 percent of VA facilities surveyed provide care to women through mixed gender primary care teams and refer these patients to specialized women's health clinics for gender-specific care. In the mid-1990s, VA reorganized from a predominantly hospital-based care delivery model to an outpatient health-care delivery model focused on preventative medicine. The IBVSOs are concerned about the incidental impact of the primary care model on the quality of health care delivered by VA to women veterans. VA's 2000 conference report "The Health Status of Women Veterans Using Department of Veterans Affairs Ambulatory Care Services" stated, in part:

> VA women's clinics were established because, unlike the private sector, where women make up 50 to 60 percent of a primary care practitioner's clientele, women veterans comprise less than 5 percent of VA's total population. As a result, VA clinicians are generally less familiar with women's health issues, less skilled in routine gender specific care, and often hesitant to perform exams essential to assessing a woman's complete health status. With the advent of primary care in VA, many women's clinics are being dismantled and women veterans are assigned to the remaining primary care teams on a rotating basis. This practice further reduces the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women's health.

VA acknowledges, and the IBVSOs agree, that full-service women's primary care clinics that provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care for women veterans. In cases where there are relatively low numbers of women being treated at a given facility, it is preferable to assign all women to one primary care team in order to facilitate the development and maintenance of the provider's clinical skills in women's health. Likewise, we agree that the health-care environment directly affects the quality of care provided to women veterans and has a significant impact on the patient's comfort, feeling of safety, and sense of welcome.

We are pleased that VA, in recognition of the changing demographics in the veteran population and the special health-care needs of women veterans, has established women's health as a research priority to develop new knowledge about how to best provide for the health and care of women veterans. In 2004 VHA's Office of Research and Development held a groundbreaking conference, "Toward a VA's Women's Health Research Agenda: Setting Evidence-Based Research Priorities for Improving the Health and Care of Women Veterans." The participants of the conference were tasked with identifying gaps in understanding women veterans' health and health care and with identifying the research priorities and infrastructure required to fill these gaps. According to VA's Office of Research and Development, it is completing a final report on the conference and VA women's health agenda setting process. The IBVSOs strongly encourages VA, as it takes steps to advance this agenda, to include evaluation of its clinical guidelines, best practice models, and performance and quality improvement measures to determine which health-care delivery model demonstrates the best clinical outcomes for women veterans.

VA should also ensure equal access to quality mental health services for women veterans, especially women veterans who have mental health needs associated with sexual trauma during military service. The VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services, found that active duty military personnel report rates of sexual assault higher than comparable civilian samples, and there is a high prevalence of sexual assault and harassment reported among women veterans accessing VA services. The study noted, and the IBVSOs agree, that it is "essential that VA staff recognize the importance of the environment in which care is delivered to women veterans, and that VA clinicians possess the knowledge, skill, and sensitivity that allows them to assess the spectrum of physical and mental conditions that can be seen even years after assault."

According to VA, approximately 20.1 percent of the women screened between fiscal years 2002 and 2005 responded "yes" to experiencing military sexual trauma (MST) compared to 1 percent of men screened. In response to these reports, VA has established a committee to explore ways to address the mental health needs of women veterans and to improving mental health services to women who have experienced MST. We still encourage the VHA to implement earlier recommendations made by the Mental Health Strategic Health Care Group Subcommittee on Women's Mental Health, including development of an MST provider certification program, providing separate subunits for inpatient psychiatry and other residential services, improved coordination with the DOD on transition of women veterans, and promotion and advancement of women's health research agenda.

The IBVSOs are pleased that VA is addressing the needs of women veterans returning from combat theaters and has provided guidance for medical facilities to evaluate the adequacy of programs and services for returning OIF/OEF women veterans in anticipation of gender-specific health issues, including recommendations for women veteran program managers to develop educational literature targeting women veterans and listing VA contacts in local catchment areas. We are also pleased that the Women Veterans Health Program Office and the local women veteran program managers (WVPMs) have partnered with the VA Seamless Transition Office to provide information at National Guard, Reserves, and family member demobilization briefings on VA services and programs for women veterans. VA should continue to strengthen its partnership with the DOD to ensure a seamless transition for women from military service to veteran status. Improvements in sharing data and health information between the departments is essential to understanding and best addressing the health concerns of women veterans.

Women veterans program managers and benefits coordinators are another key component to addressing the specialized needs of women veterans. These program directors and benefits coordinators are instrumental to the development, management, and coordination of women's health and benefits services at all VA facilities.

According to VHA Handbook 1330.1, "VHA Services For Women Veterans":

> Each VHA facility must have an appointed WVPM. [The WVPM appointed by the medical center Director should be] a health care professional…who provides health care services to women as a part of their regular responsibilities. The WVPM will be a member of the Women Veterans Primary Health Care Team [and must participate] in the regular review of the physical environment, to include the review of all plans for construction, for the identification of potential privacy deficiencies, as well as availability and accessibility of appropriate equipment for the medical care of women.

Given the importance of this position, the IBVSOs are concerned about the actual amount of time WVPMs are able to dedicate to women veterans issues. According to VA, 71 percent of all WVPMs serve in a collateral role. Only 20 percent reported they were allocated more than 20 administrative hours per week to fulfill their program responsibilities during the fiscal year. With increasing numbers of women veterans, VA WVPMs must have adequate time allocated to successfully perform their program duties and to conduct outreach to women veterans in their communities. Increased focus on outreach to these veterans is especially important because they tend to be less aware of their veteran status and eligibility for benefits than male veterans.

In a period of fiscal austerity, VA hospital administrators have sought to streamline programs and make every possible efficiency. Often, smaller programs, such as programs for women veterans, are left at risk of discontinuation. The loss of a key staff member responsible for delivering specialized health-care services or developing outreach strategies and programs to serve the needs of women veterans can threaten the overall success of a program.

VA needs to ensure priority is given to women veterans' programs so quality health care and specialized services are equally available to women veterans as to male veterans. VA must continue to work to provide an appropriate clinical environment for treatment where there is a disparity in numbers, such as exists between women and men in VA facilities. Given the changing roles of women in the military, VA must also be prepared to meet the specialized needs of women veterans who were sexually

assaulted in military service or catastrophically wounded in combat theaters, suffering amputations, blindness, spinal cord injury, or traumatic brain injury. Although it is anticipated that many of the medical problems of male and female veterans returning from combat operations will be the same, VA facilities must address the health issues that pose special problems for women. The IBVSOs also recommend that VA focus its women's health research on finding the health-care delivery model that demonstrates the best clinical outcomes for women veterans. Likewise, VA should develop a strategic plan with the DOD to collect critical information about the health and health-care needs of women veterans with a focus on evidence-based practices to identify other strategic priorities for women's health research agenda.

Recommendations:

VA must ensure laws, regulations, and policies pertaining to the health care of women veterans are enforced at VISN and local levels.

VA must ensure that priority is given to women veterans' programs and determine which health-care delivery model demonstrates the best clinical outcomes for women.

VA needs to increase its outreach efforts to women veterans, as women veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

VA must ensure that clinicians caring for women veterans are knowledgeable about women's health, participate in ongoing education about the health-care needs of women, and are competent to provide gender-specific care to women.

VA must ensure that WVPMs are authorized sufficient time to successfully perform their program duties and to conduct outreach to women veterans in their communities.

VA must ensure that its specialized programs for post traumatic stress disorder, spinal cord injury, prosthetics, and homelessness are equally available to women veterans as to male veterans.

VA should collaborate with the DOD to collect critical information about health and the health-care needs of women veterans to best identify strategic priorities for a women's health research agenda.

Homeless Veterans:

Congress should reauthorize, strengthen, and expand the Department of Veterans Affairs (VA) and Department of Labor (DOL) homeless veteran programs.

VA estimates that on any given day as many as 200,000 veterans (male and female) are living on the streets or in shelters, and perhaps twice as many experience homelessness at some point during the course of a year. Conservatively, one of every three homeless adult males sleeping in a doorway, alley, car, barn, or other location not fit for human habitation in our urban, suburban, and rural communities has served our nation in the armed forces. Homeless veterans are mostly male (2 percent are female); 54 percent are people of color; the vast majority are single, although service providers are reporting an increased number of veterans with children seeking their assistance; 45 percent have a mental illness; 50 percent have an addiction.

America's homeless veterans have served in World War II, Korea, the Cold War, Vietnam, Grenada, Panama, Lebanon, anti-drug cultivation efforts in South America, Afghanistan, and Iraq. Forty-seven percent of homeless veterans served during the Vietnam Era. More than 67 percent served our nation for at least three years, and 33 percent were stationed in a war zone.

Male veterans are twice as likely to become homeless as their nonveteran counterparts, and female veterans are about four times as likely to become homeless as their nonveteran counterparts. Like their nonveteran counterparts, veterans are at high risk of homelessness due to extremely low or no income, dismal living conditions in cheap hotels or in overcrowded or substandard housing, and lack of access to health care. In addition to these shared factors, a large number of at-risk veterans live with post traumatic stress disorders and addictions acquired during or exacerbated by their military service. In addition, their family and social networks are fractured due to lengthy periods away from their communities of origin. These problems are directly traceable to their experience in military service or to their return to civilian society without appropriate transitional supports.

Congress has established a small set of programs to address homelessness among veterans. The bulk of these programs are administered by VA. Collectively, they are identified as VA's "specialized homeless programs" and include medical care, domiciliary care, transitional housing, and supportive services centers. Total spending on VA specialized homeless programs amounted to $207 million in FY 2005. In addition, the DOL administers the Homeless Veterans Reintegration Program (HVRP), a job placement and supportive services program targeted to veterans experiencing homelessness. Total spending on the HVRP was $20.8 million in FY 2005.

Many of the programs Congress has authorized to address homelessness among veterans are scheduled to sunset in 2006 or 2007 but merit extension. In addition, new issues affecting homeless veterans and a greater understanding of the gaps in supports for them have emerged and require a Congressional response.

Recommendations:

Congress should make permanent the VA Homeless Providers Grant and Per Diem Program (GPD) and set an authorization level of at least $200 million annually. GPD provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans.

Congress should require VA to pay GPD grantees per diem payments without adjustments, rather than requiring them to submit extensive documentation on all of their sources of project funding in order to secure per diem payments at the maximum rate permitted by statute.

Congress should include permanent housing assistance as an eligible use of GPD funds, provided that GPD transitional housing providers are not forced to convert their units to permanent units and that permanent housing is not given a preference for funding over transitional housing.

Congress should authorize VA to make grants to nonprofit organizations and consumer cooperatives to

make supportive services available to low-income veterans in permanent housing.

Congress should reauthorize the Homeless Veterans Reintegration Program (HVRP) through FY 2011 at the $50 million level annually. HVRP provides competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans.

Congress should expand the eligible population for HVRP to include veterans at imminent risk of homelessness so that HVRP may have both preventative and remedial purposes.

Congress should make permanent VA's Treatment and Rehabilitation for Seriously Mentally Ill and Homeless Veterans authority. Under this authority VA provides outreach services; care, treatment, and rehabilitative services; and therapeutic transitional housing assistance to veterans with serious mental illness, including veterans who are homeless.

Congress should make permanent VA's Additional Services at Certain Locations Program authority, through which VA provides comprehensive services centers to homeless veterans.

Congress should reauthorize the Grant Program for Homeless Veterans with Special Needs through FY 2011 for at least the $5 million level annually. Through this program, VA makes grants available to health-care facilities of the department and to GPD providers to encourage development of programs for homeless veterans with special needs, including women (with and without children), frail elderly, terminally ill, or chronically mentally ill.

Congress should reauthorize the Homeless Veteran Service Provider Technical Assistance Program through FY 2011 for at least the $1 million level annually. Through this program, VA makes competitive grants to organizations with expertise in preparing grant applications to provide technical assistance to nonprofit community-based and faith-based groups with experience in providing assistance to homeless veterans in order to assist such groups in applying for homeless veteran grants and other grants addressing problems of homeless veterans.

Congress should establish a specialized homeless program specific purpose account within the VA medical services appropriation and ensure that of such sums appropriated annually for VA medical services, the greater of $350 million annually or a fixed percentage of the total medical services appropriation be reserved for specialized homeless programs.

Congress should authorize VA to make grants available to homeless veteran service providers for public benefit and veteran benefit outreach, application assistance, and reconsiderations and appeals support. Congress should authorize the program for a five-year period at the $10 million level annually.

Congress should expand the eligible population for the homeless veteran dental care benefit by eliminating the requirement that homeless residents in VA residential program eligible for the benefit be residents for 60 days before gaining access to dental care.

Congress should ensure the provision of Mental Health Intensive Case Management (MHICM) to all homeless veterans who meet clinical eligibility criteria for this type of mental health service by codifying in statute MHICM as a health-care benefit for eligible homeless veterans.

Congress should incorporate homelessness prevention content into VA outreach efforts to separating service members at high risk of immediate or future homelessness.

Congress should require VA to report on homeless veteran coordination efforts with other federal departments and agencies as part of its annual report on assistance to homeless veterans.

Congress should reauthorize the Advisory Committee on Homeless Veterans through FY 2011.

Congress should add the executive director of the Interagency Council on Homelessness to the Advisory Committee on Homeless Veterans.

Congress should require VA to use the McKinney-Vento Title V Surplus Property Program as its first method for transferring real property to homeless service providers.

Congress should require VA to enter into lease agreements to rent space to homeless service providers at no charge or at least at no greater than an amount sufficient to cover the direct costs associated with making it available.

Congress should make permanent VA's authority to transfer properties obtained through foreclosure on VA home mortgages to homeless service providers.

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Permanent Housing for Low-Income Veterans

Congress should develop permanent housing opportunities targeted to low-income veterans.

There is a subset of the United States veteran population that either lacks basic housing or is at very high risk of losing it any day. According to the U.S. Census Bureau, 1.5 million veterans have incomes that fall below the federal poverty level. More than 634,000 veterans have incomes below 50 percent of the federal poverty level, leaving them especially vulnerable to inadequate housing or housing loss. The Department of Veterans Affairs (VA) estimates that on any given day, as many as 200,000 veterans (male and female) are living on the streets or in shelters, and perhaps twice as many experience homelessness at some point during the course of a year.

Many of our nation's veterans, especially those with low incomes, go without the services they require and deserve for their service to our nation. This is nowhere more apparent than in their need for safe, affordable, and permanent housing. While the federal government makes a sizeable investment in homeownership opportunities for veterans, its commitment to rental housing for low-income veterans is nonexistent. There is no national rental housing assistance program targeted to veterans. Low income veterans without disabilities, dependent children, and/or old age are not well served through existing housing assistance programs because of their eligibility criteria. Veterans are not a national priority population for subsidized housing assistance. The Department of Housing and Urban Development (HUD) devotes minimal attention to the housing needs of low-income veterans, illustrated by its discontinued participation in a joint HUD-VA program to target Housing Choice Vouchers to homeless veterans and the long-standing vacancy in the position of special assistant for veterans programs within the Office of Community Planning and Development. Simply, veterans are overlooked and underserved in subsidized housing programs.

Recommendations:

Congress should authorize and appropriate funds for a permanent housing production and supportive services program for low-income veterans with supported housing needs.

Congress should authorize and establish budget authority for the allocation of at least 20,000 new housing choice vouchers for veterans experiencing homelessness.

Congress should identify veterans as a special needs population to be considered in the development of public housing agency plans and consolidated plans.

Congress should exclude veterans' compensation and pension amounts from consideration as adjusted income for purposes of determining the amount of rent paid by a family for a federally assisted housing unit, just as these amounts are excluded from consideration as taxable income.

Congress should authorize and appropriate funds for HUD to make competitive grants to organizations with expertise in housing for veterans to provide technical assistance to nonprofit community-based and faith-based groups in order to assist such groups in accessing federal, state, and local housing assistance funds; participating in housing and community development planning processes; and matching their

residents and service users to permanent housing opportunities.

Congress should authorize HUD to prepare reports on its activities related to veterans, including a periodic assessment of the housing needs of low-income veterans.

Congress should establish the position of special assistant for veterans within the Office of the Secretary of Housing and Urban Development in order to give HUD a focal point for coordination on veterans' affairs and housing.

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LONG-TERM CARE ISSUES

The Department of Veterans Affairs (VA) must develop a long-term care (LTC) strategic plan to meet the increasing needs of America's aging veterans. This plan must address the increasing demand for VA nursing home care services and a growing demand for home and community-based care. The plan should have immediately achievable short-term objectives and accomplishable long-range program goals. Congress must then provide the necessary financial resources that will enable VA to make the strategic plan a reality.

Increasing Demand for VA Long-Term Care Services

During testimony concerning VA long-term care issues on May 12, 2005, before the Senate Committee on Veterans' Affairs, the Hon. Jonathan Perlin, VA Under Secretary for Health stated:

> Between 2004 and 2012, the total number of enrolled veterans is projected to increase only 0.5 percent, from 7.37 million to 7.4 million. However, during this same period, the number of enrolled veterans aged 65 and older is projected to increase 8.6 percent (from 3.44 million to 3.73 million). At the same time period, the number of enrolled veterans aged 85 and over will increase from 278,400 to 681,400, an increase of 145 percent. Looked at another way, in FY 2004 3.8 percent of all enrollees were ages 85 and over. In FY 2012, it is estimated that 9.2 percent of our total enrollment will be ages 85 and over…These veterans, particularly those over 85, are the most vulnerable of the older veteran population and are especially likely to require not only long-term care, but also health care services of all types.

Despite this knowledge, VA's budget submission for 2006 called for dramatic reductions in funding to support its institutional long-term care (nursing home) services. These VA long-term care reductions included cutting VA's institutional (nursing home) budget by $494 million; a one-year moratorium on grants to construct new state veterans' homes; a two-thirds reduction in the per diem for state veterans' homes; and a request that Congress repeal the average daily census capacity mandate for VA nursing home care.

Additionally, VA also proposed a $250 user fee for categories 7 and 8 veterans and increasing the copays for VA prescription drugs from $7 to $15. The impact of these cost increases would have had a devastating effect on aging nonservice-connected veterans. To its credit, Congress recognized the harm associated with these proposals and rejected each of them last year.

VA Institutional Care

Concern over VA's ability and desire to meet current and future demand for VA nursing home services is not only an issue for America's veterans but for the Congress and for the Government Accountability Office (GAO) as well.

■ *VA's Nursing Home Care Program*

VA operates 130 nursing home facilities. VA facilities provide excellent care and are often the only venue that will accept aging veteran residents with catastrophic disabilities. VA nursing homes are usually co-located with VA acute medical centers. These convenient locations facilitate prompt and efficient access to VA medical services for a population of veterans that often have complex medical needs.

While these numbers for VA nursing home care seem impressive, VA continues to fail to meet the VA nursing home average daily census (ADC) capacity mandate imposed by Congress as reflected in Table 1. LTC. This failure comes at a time of increasing veterans demand and the provision of "The Veterans' Millennium Health Care and Benefits Act of 1999" (Mill Bill) that requires VA to maintain its nursing home average daily census at the 1998 level of 13,391. VA's nursing home ADC has been trending downward since 1998.

(Tables 1, 2, 3 LTC taken from VA's 2006 Budget Submission)

TABLE 1. LTC

Average Daily Census (ADC)
VA's Nursing Home Care

2004	2005	EST. 2006	INCREASE/ DECREASE
12,354	11,548	9,975	(1,753)

NOTE: VA recently reported its actual VA nursing home care ADC for FY 2005 to be 11,958.

■ *VA's Community Nursing Home Program*

VA has contracts with more than 2,500 community nursing homes located across the country. This arrangement often brings nursing home care closer to the veteran's family and his/her own community.

TABLE 2. LTC

Average Daily Census (ADC)
VA's Community Nursing Home Program

2004	2005	2006	INCREASE/ DECREASE
4,302	4,254	4,177	(77)

NOTE: VA recently reported its actual community nursing home ADC for FY 2005 to be 4,423.

■ *State Veterans' Homes*

The state veterans' home program currently encompasses 119 nursing homes in 48 states and Puerto Rico. According to the GAO, half of VA's total nursing home workload in FY 2003 was provided in state veterans' homes. Table 3 LTC shows a dramatic decline in estimated ADC, which is believed to be a result of proposed cuts to the state veterans' home program in VA's FY 2006 proposed budget. This decline reflects poor judgment by VA in light of the GAO's findings (GAO-05-65) that VA pays about one-third the cost of care in state veterans' nursing homes.

TABLE 3. LTC

Average Daily Census (ADC)
State Veterans' Homes

2004	2005	2006	INCREASE/ DECREASE
17,328	18,500	7,217	(11,283)

NOTE: VA recently reported its actual state veterans' home ADC for FY 2005 to be 17,355.

Because of VA's proposed cuts to VA's various nursing home programs and the downward VA nursing home average daily census spiral, veterans are concerned about VA's desire and ability to meet increasing demand for nursing home care. VA's nursing home average daily census has been steadily diminishing since 1998 despite a clear Congressional mandate to maintain capacity and a projected increase in the demand for these services over the next decade.

The GAO is similarly concerned about VA's nursing home program. In its November 2004 report (GAO-05-65), the GAO pointed out several problems that prevent VA from having a clear understanding of its program's effectiveness. The GAO recommended that VA collect and report data for community nursing homes and state veterans' nursing homes on the numbers of veterans who have long and short stays. GAO also recommended that VA collect data on the number of veterans in these homes whom VA is required to serve based on the requirements of the Mill Bill. The GAO believed this information would assist VA to conduct adequate monitoring and planning for its nursing home care program.

Congress has shown concern about VA's long-term care planning, evidenced by its rejection of VA's proposals to halt construction and reduce per diem funding to state veterans' homes and to repeal the Mill Bill's VA nursing home capacity mandate. Also, in July of 2005, Congress was asked to provide VA with an additional $1.997 billion to meet higher than expected health-care demands. Of this amount, $600 million was to be used to correct for the estimated cost of long-term care (VA press release July 14, 2005).

VA's lack of appropriate workload information gathering and data analysis has placed it in a weak position to effectively plan for the immediate and future long-term care needs of America's veterans. Although VA can only advise Congress about the program requirements necessary to meet these needs, it is their duty to do so. The Department of Veterans Affairs should be the advocate for veterans' long-term care needs not just the provider.

VA Noninstitutional Care

VA offers a spectrum of noninstitutional long-term care services to veterans enrolled in its health-care system. In fiscal year 2003, 50 percent of VA's total long-term care patient population received care in noninstitutional care settings. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, home respite care, home hospice care, and community residential care.

In recent years VA has been increasing its noninstitutional (home and community-based) budget and services. However, more needs to be done in this area. VA must take action to ensure the programs mandated by the Mill Bill are available in each VA network. In May of 2003, the GAO (GAO 03-487) reported: "VA service gaps and facility restrictions limit veterans' access to VA non-institutional care." The GAO also reported that of the 139 VA facilities reviewed, 126 did not offer all six services mandated by the Mill Bill. In order to eliminate these service gaps, VA must survey each VA network to determine that all of its noninstitutional services are operational and readily available.

The Independent Budget *supports the expansion of VA's noninstitutional long-term care services and also supports the adoption of innovative approaches to expand this type of care*. Noninstitutional long-term care programs can sometimes obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his/her own home promote individual productivity and independence. *However, the expansion of these valuable programs should not come by cutting the resources that support more intensive institutional long-term care.*

TABLE 4. LTC

Average Daily Census (ADC) for VA's Noninstitutional Care Programs

	2004	2005	2006	INCREASE/DECREASE
Home-based primary care	9,825	11,594	13,681	2,087
Purchased skill home care	2,606	3,075	3,629	554
VA/Contract adult day care	1,493	1,762	2,079	317
Homemaker health aid services	5,580	6,584	7,769	1,185
Community Residential Care	5,771	6,810	8,036	1,226
Home Respite	84	99	117	18
Home Hospice	164	194	229	35
Total Home & Community-Based Care	25,523	30,118	35,540	5,422

■ *VA Must Develop a Strategic Plan for Long-Term Care*

VA must develop a long-term care strategic plan for providing the resources and programs necessary to meet the current and future needs of America's aging veterans.

According to the GAO, demand for VA long-term care services will increase over the next decade. Additionally, the VA's Capital Asset Realignment for Enhanced Services (CARES) Commission final report issued in February 2004, listed the following findings regarding VA long-term care:

1. Developing a model for the deployment of LTC beds across VA is a complex undertaking, VA has yet to complete.
2. Strategic planning for LTC has not adequately addressed the needs of aging, seriously mentally ill patients for whom resources are scarce.
3. VA has not developed a consistent rationale for the placement of LTC units that addresses stakeholder concerns regarding access to care.
4. The Draft National CARES Plan (DNCP) proposals for the movement of residential rehabilitation and domiciliary beds are inconsistent, at times recommending that programs designed to rehabilitate urban homeless veterans be moved away from the metropolitan area.
5. Seriously mentally ill patients currently cared for in VA nursing homes located in VA's LTC facilities are extremely difficult to place in community nursing homes.
6. There appears to be opportunity for greater collaboration between VA and state veterans' homes.
7. Freestanding nursing homes are the norm in the private sector.

Based on these findings, the CARES Commission made the following recommendations:

1. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities, VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, should address access to services, and should integrate planning for LTC of the seriously mentally ill.
2. An integral part of the strategic plan should be maximizing the use of state veterans' homes.
3. Domiciliary care programs should be located as close as feasible to the population they serve.
4. Freestanding LTC facilities should be permitted as an acceptable care model.
5. VA should implement Veterans Integrated Service Network-specific recommendations for upgrading existing LTC and chronic psychiatric care units, recognizing that some renovations are needed to improve safety and maintenance of the facilities' infrastructure and to modernize patient area.

To date, VA has not released a strategic long-term care plan despite the obvious need for one. Instead, VA has applied an incremental approach to its planning. It has ignored demand projections for increased VA nursing home care need and proposed dramatic budget cuts to its nursing home program. It has proposed catastrophic budget reductions that, if enacted, would decimate the state veterans' homes program, and it has not taken the proper action to ensure its noninstitutional care programs are evenly distributed across the entire VA health-care system.

■ *VA Long-Term Care for Veterans with Spinal Cord Injury/Dysfunction (SCI/D)*

Both institutional and noninstitutional VA long-term care services designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D. Older veterans with these conditions are especially vulnerable and require a high degree of long-term and acute care coordination. A major issue of concern is the fact that a recent VA survey indicated that in FY 2003 there were 990 veterans with SCI/D residing in non-SCI/D designated VA nursing homes. However, VA cannot identify the exact locations of these veterans, and the facilities that house them are not specifically engineered to meet the accessibility needs of this patient population. The special needs of these veterans often go unnoticed and are only discovered when the patient requires admission to an acute care SCI center.

VA must develop a program to locate and identify veterans with SCI/D receiving care in non-SCI/D designated long-term care facilities and ensure that their unique needs are met. In addition, these veterans must be monitored by the nearest SCI center to ensure they receive the specialized care they require. Veterans with SCI/D who receive VA institutional long-term care services require specialized care from specifically trained professional long-term care providers in an environment that fully meets their accessibility needs.

Currently, VA operates only four designated long-term care facilities for patients with spinal cord injury or disease, and none of these facilities are located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility Chicago, Illinois (28 staffed beds); and Castle Point, New Jersey (16 staffed beds). Unfortunately, these limited staffed (121 total) beds are usually filled, and there are waiting lists for admittance. In addition, these four VA SCI/D long-term care facilities are not geographically located to meet the needs of a nationally distributed veteran population.

Although VA's CARES initiative has called for the creation of additional long-term care beds in four new locations (30 in Tampa, Florida; 20 in Cleveland, Ohio; 20 in Memphis, Tennessee; and 30 in Long Beach, California), these additional services are not yet available and would only provide 30 beds west of the Mississippi River. These new CARES long-term care beds present an opportunity for VA to refine the paradigm for SCI/D long-term care facility design and to develop a new SCI/D long-term care staff training program. Additionally, VA should work with the Paralyzed Veterans of America to develop staffing guidelines for VA long-term care facilities and create a "SCI/D Long-Term Care Handbook" that identifies the operational policies of SCI/D long-term care.

Recommendations:

VA must develop a strategic plan for long-term care that meets the current and future needs of America's veterans.

Congress must provide the financial resources for VA to implement its long-term care strategic plan.

VA must abide by the Mill Bill's capacity mandate for VA nursing home care.

VA must provide the construction and per diem funding necessary to support state veterans' homes.

VA must do a better job of tracking the quality of care provided in VA contract community nursing homes.

VA must increase its capacity for noninstitutional, home, and community-based care, including assisted living.

VA must ensure that each noninstitutional program mandated by the Mill Bill is operational and available across the entire VA health-care system.

VA must implement the CARES long-term care recommendations and expand its nursing home capacity for veterans with spinal cord dysfunction.

VA should emphasize the importance of the CARES recommendation that called for adding 30 SCI/D long-term care beds at the Long Beach, California, facility.

VA must develop a mechanism to locate and identify veterans with SCI/D residing in non-SCI/D long-term care facilities.

VA should develop a VA nursing home care staff training program for all VA long-term care employees who treat veterans with SCI/D.

VA should develop a VA SCI/D long-term care handbook that identifies the operational policies for VA SCI/D long-term care in all VA long-term care environments. This new VA handbook must include provisions to regularly monitor the quality of care being provided in all facilities that provide services to veterans with SCI/D.

Assisted Living

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with the activities of daily living (ADLs) or the instrumental activities of daily living (IADLs). Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, Secretary Principi forwarded a VA report to Congress concerning the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by the Veterans Millennium Health Care and Benefits Act, P.L. 106-117. The Assisted Living Pilot Program (ALPP) was carried out in VA's Veterans Integrated Service Network (VISN) 20. VISN-20 includes Alaska, Washington, Oregon, and the western part of Idaho.

VA's ALPP was implemented in seven medical centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Oregon; Roseburg, Oregon; White City, Oregon; Spokane, Washington; and Puget Sound Health Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

VA's report on the overall assessment of the ALPP stated: *"The ALPP could fill an important niche in the continuum of long-term care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."*

Some of the main findings of the ALPP report include:

- *ALPP veterans showed very little change in health status over the 12 months post-enrollment.* As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that ALPP may have helped maintain veterans' health over time.

- *The mean cost per day for the first 515 veterans discharged from the ALPP was $74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.*

- *The mean cost to VA for the veterans stay in an ALPP facility was $5,030 per veteran. The additional cost of case management during this time was $3,793 per ALPP veteran.*

- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.

- *The average ALPP veteran was a 70 year-old unmarried white male who was not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.*

- *ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment:* 22 percent received assistance with between four and six ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with one to three ADLs; while 35 percent received no assistance.

- *Case managers helped ALPP veterans apply for VA Aid and Attendance and other benefits to help cover some of the costs of staying in an ALPP facility at the end of the VA payment period.*

- *Veterans were very satisfied with ALPP care.* The highest overall scores were given to VA case managers (mean = 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82).

- *Vendors are quite satisfied with their participation in ALPP with a mean score of almost 8 (of 10).*

- *Case managers were very satisfied with ALPP.* Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall in between the cracks."

While assisted living is not currently a benefit that is available to veterans, even though some veterans have eligibility for nursing home care, the authors of *The Independent Budget* believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care. *The Independent Budget* recommends that Congress expand VA's ALPP across the entire country, in every VA health-care network.

Secretary Principi's cover letter that conveyed the ALPP report to Congress stated that VA is not seeking authority to provide assisted living services, believing this is primarily a housing function. The authors of *The Independent Budget* disagree and believe that housing is just one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is just part of the mix. VA already provides housing in its domiciliary and nursing home programs, and an assisted living benefit should not be prohibited by VA on the basis of its housing component.

■ CARES and Assisted Living

Secretary Principi's final CARES decision document and the VA's CARES Commission recommended utilizing VA's enhanced-use leasing authority as a tool to attract assisted living providers. The enhanced-use lease program can be leveraged to make sites available for community organizations to provide assisted living in close proximity to VA medical resources.

The authors of *The Independent Budget (IB)* concur with these recommendations and the application of VA's enhanced-use lease program in this area. However, the *IB* authors believe that any type of VA enhanced-use lease agreement for assisted living must be accompanied with the understanding that veterans have first priority for care.

■ Summary

VA's ALPP report seems most favorable and appears to be an unqualified success. However, *The Independent Budget* authors believe that to gain further understanding of how the ALPP program can benefit all veterans, it should be replicated across the entire country.

Regarding CARES, the *IB* authors believe VA enhanced-use lease agreements can be a useful tool in attracting the assisted living industry to vacant and underutilized VA property for their future site needs.

Recommendations:

Congress should authorize VA to expand the ALPP to include an initiative in each VA VISN. This expanded effort will allow VA to gather important regional program cost and quality information.

Congress should call upon VA to conduct a cost and quality comparison study that compares the ALPP experience to cost and quality information it has compiled for VA nursing home care, community contract nursing home care, and state veterans nursing home care. When completed, this long-term care program cost comparison study should be made available to Congress and veterans service organizations.

Congress should consider adding assisted living as a covered benefit as an alternative to VA provided or paid nursing home care.

Regarding CARES, VA should cultivate the assisted living industry as a possible market for vacant and underutilized VA space. However, VA should insist that veterans be given a residency preference whenever an assisted living enhanced-use lease proposal becomes a reality.

VA MEDICAL AND PROSTHETIC RESEARCH

Funding for Medical and Prosthetic Research:

Funding for Department of Veterans Affairs (VA) Medical and Prosthetic Research is inadequate to support the full range of programs needed to meet current and future health challenges facing veterans. Additionally, VA's aging research facilities are in urgent need of maintenance, upgrades, and in some cases, total replacement.

VA medical and prosthetic research is a national asset that attracts high-caliber clinicians and researchers to VA health-care facilities. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA and ultimately benefits all Americans.

Focused entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population, VA research is patient oriented. Sixty percent of VA researchers treat veterans. As a result, the Veterans Health Administration (VHA), which is the largest integrated medical care system in the world, has a unique ability to translate progress in medical science directly to improvements in clinical care.

VA leverages the taxpayer's investment via a nationwide array of synergistic partnerships with the National Institutes of Health and other federal research funding agencies, for-profit industry partners, nonprofit organizations, and academic affiliates. This highly successful enterprise demonstrates the best in public-private cooperation. However, a commitment to steady and sustainable growth in the annual research and development (R&D) appropriation is necessary for maximum productivity.

The annual appropriation for the Medical and Prosthetic Research Program, which makes this leveraging and synergy possible, relies on an outdated funding system. A thorough review of VHA research funding methodology, including the adequacy and distribution of the Veterans Equitable Resource Allocation (VERA) research allocation, is needed to ensure sufficient funds for both the direct and indirect costs of all aspects of this world-class research program. The Office of Research and Development allocates R&D funding for the direct costs of projects, while indirect costs and physicians' and nurses' salaries are covered by the medical care appropriation, with no centralized means to ensure that each facility research program receives adequate support.

For decades VA has failed to request—and Congress has failed to mandate—construction funding sufficient to maintain, upgrade, and replace VA's aging research facilities. The result is a backlog of research sites in need of minor and major construction funding, and researchers are often stymied by the lack of state-of-the-art facilities. Cutting-edge research demands cutting-edge facilities. Congress and VA must work together to establish a funding mechanism designated for research facility maintenance and improvements, as well as at least one major research construction project per year, until this backlog is addressed.

Medical and Prosthetic Research (in thousands)

FY 2006	$412,000
FY 2007 Administration Request	$399,000
FY 2007 *Independent Budget* Recommendation	$460,000

Medical and Prosthetic Research Account:

The Department of Veterans Affairs (VA) needs significant growth in the annual Research and Development appropriation to continue to achieve breakthroughs in health care for its current population and to develop new solutions for its most recent veterans.

VA strives for improvements in treatments for conditions long prevalent among veterans, such as diabetes, spinal cord injury, substance abuse, mental illnesses, heart diseases, infectious diseases, and prostate cancer. VA is equally obliged to develop better responses to the grievous conditions suffered by veterans of the conflicts in Afghanistan and Iraq, such as extensive burns, multiple amputations, compression injuries, and mental stress disorders. VA research needs to be refocused so as to address the complex short and long-term needs of veterans who survive blast polytraumas —as opposed to the projectile injuries more common in previous wars—which often include major burns and multiple sensory loss.

Recommendation:

The Independent Budget veterans service organizations recommend an FY 2007 appropriation of at least $460 million to support major new initiatives in neurotraumas, including head and cervical spine injuries; wound and pressure sore care; pre- and post-deployment health issues with a particular focus on post-traumatic stress disorder; and the development of improved prosthetics and strategies for rehabilitation from polytraumatic injuries. Additionally, funding is needed to take advantage of VA's unique qualifications to lead advances in genomics, the burgeoning science of modifying drugs to match an individual's unique genetic structure. Finally, the appropriation must offset the higher costs of established research resulting from biomedical inflation and wage increases.

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Medical and Prosthetic Research Issues

A Clear Vision for VA Research:

The Department of Veterans Affairs (VA) research program is in need of thorough review and long-term planning involving external stakeholders.

During 2005, VA researchers added to their remarkable record of achievement in advances in both basic and clinical care. However, there remains a need to build a broad consensus about the purpose and scope of the VA research program.

Recommendation:

Congress should charge the National Research Advisory Council and the Field Research Advisory Council with conducting a thorough review of the VA research program and proposing to the Secretary and Congress a clear vision for the future with recommendations on complex policy matters in need of resolution.

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Research Facilities Consistent with Scientific Opportunity:

Many Department of Veterans Affairs (VA) research facilities are outdated and in need of repair or renovation. At some VA medical centers, new construction of entire buildings is required.

In House Report 109-95, providing appropriations for FY 2006, Congress expressed concern that "equipment and facilities to support the research program maybe be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." It noted that "more resources may be required to ensure that research facilities are properly maintained to support the Department's research mission." To assess VA's research facility needs, Congress directed the Department to conduct a comprehensive review of its research facilities and report to Congress on the deficiencies found, along with suggestions for correction.

Recommendation:

Congress should establish and appropriate a funding stream specifically for research facilities, using the VA assessment to ensure that amounts provided are sufficient to meet both immediate and long-term needs.

Congress should also use the VA report as the basis for prioritizing allocation of such funding to ensure that the most urgent needs are addressed first.

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Paralysis Research, Education, and Clinical Care Center and Quality Enhancement Research Initiatives for Paralysis:

Congress and the Department of Veterans Affairs (VA) should support the Christopher Reeve Paralysis Act, which would address needs of the paralyzed veteran community through research, rehabilitation, and quality-of-life programs.

VA through the Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical, and rehabilitative care to veterans. Among VHA developments are research, education, and clinical centers (RECCs), which focus on specific conditions common in veterans. RECCs are designed around the idea of translational research, and they develop educational and training initiatives to implement best practices into the clinical settings of VA.

VA research opportunities attract first-rate clinicians to practice medicine and conduct research in VA healthcare facilities, thereby keeping veterans' health care at the cutting-edge of modern medicine. By promoting consortia-style research, research conducted in conjunction with the nation's leading medical schools, VA promotes an environment of medical excellence and ingenuity that benefits every veteran receiving VA care and, ultimately, all Americans.

VA's Quality Enhancement Research Initiative (QUERI) is designed to translate research discoveries and innovations into better patient care and systems improvements. QUERI focuses on eight high-risk and/or highly prevalent diseases or conditions among veterans: chronic heart failure, diabetes, HIV/AIDS, ischemic heart disease, mental health, spinal cord injury, stroke, and substance abuse.

VA could expand and coordinate the activities of the VHA to develop a paralysis research, education, and clinical care center, as well as establish a Quality Enhancement Research Initiative for paralysis. Together, the programs would encourage collaborative research, identify best practices, define existing practice patterns and outcome measurements, and improve patient outcomes associated with improved health-related quality of life through rehabilitation research.

Recommendations:

Congress should enact the Christopher Reeve Paralysis Act (S. 828, H.R. 1554), which would establish a paralysis RECC and consortia and QUERIs for paralysis.

The VHA should establish a paralysis RECC and consortia to focus on basic biomedical research on paralysis; rehabilitation research on paralysis; health services and clinical trials for paralysis that results from central nervous system, trauma, or stroke; dissemination of clinical and scientific findings; and replication of the findings of the centers for scientific and translational purposes.

The formation of centers into consortia provide for the linkage and coordination of information among the centers to ensure regular communication between members.

The VHA should establish QUERIs for paralysis, which translate clinical findings and recommendations into practices within the VHA; identify best practices; define existing practice patterns and outcome measurements; improve patient outcomes associated with improved health-related quality of life; and evaluate a quality enhancement intervention program for the translation of clinical research findings into routine clinical practice.

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Attracting and Retaining a Quality VHA Nursing Workforce:

The shortage of nursing personnel is an underlying symptom of the veterans' health-care crisis.

The Department of Veterans Affairs (VA) Veterans Health Administration's (VHA) Succession Strategic Plan FY 2006–2010 (Strategic Plan) provides an in-depth analysis of the VHA workforce. It states:

> VHA faces significant challenges in ensuring it has the appropriate workforce to meet current and future needs. These challenges include continuing to compete for talent as the national economy changes over time and recruiting and retaining health care workers in the face of significant anticipated workforce supply and demand gaps in the health care sector in the near future. These challenges are further exacerbated by an aging federal workforce and an increasing percentage of VHA employees who receive retirement eligibility each year. With health care being primarily a people-based process, it is essential to ensure the continuous presence of an effective workforce to achieve VHA mission to provide exceptional health care to America's veterans. VHA's overall goal for its workforce succession programs is to "Recruit, develop and retain a competent, committed, and diverse workforce that provides high quality service to veterans and their families."

VA is the third-largest civilian employer in the federal government and one of the largest health-care providers in the world.

■ Nursing Workforce

The VHA has the largest nursing workforce in the country with nearly 59,000 registered nurses (RNs), licensed practical nurses (LPNs), and other nursing personnel. VA and the country at large are experiencing a shortage of nursing personnel. VA staffing levels are frequently so marginal that any loss can result in a critical staffing shortage and present significant clinical challenges. Staffing shortages can result in the cancellation or delay of surgical procedures and closure of intensive care beds. It also causes diversions of veterans to private sector facilities at great cost. This situation is complicated by the fact that VA has downsized inpatient capacity in an effort to provide more services on an outpatient/ambulatory basis. The remaining inpatient population is generally sicker, has lengthier stays, and requires more skilled nursing care.

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis. Because the VA health-care budget has not kept up with rising health-care costs, the situation grows more critical each fiscal year. Inadequate funding has resulted in nationwide hiring freezes. These hiring freezes have had a negative impact on the VA nursing workforce as nurses have been forced to assume non-nursing duties as a result of shortages of ward secretaries, building management, and other support personnel. These staffing deficiencies have an impact on patient programs as well as VA's ability to retain an adequate nursing workforce.

The *Strategic Plan* identified 10 occupations as national priorities for recruitment and retention and rated these occupations. RNs, LPNs, and nursing assistants were rated as one, four, and nine, respectively, on the priority list.

■ *National Commission on VA Nursing*

Like other health-care employers, the VHA must actively address the factors known to affect retention of nursing staff: leadership, professional development, work environment, respect and recognition, and fair compensation. In addition, it is essential adequate funds are appropriated for recruitment and retention programs for the nursing workforce.

In 2002 the National Commission on VA Nursing was established through Public Law 107-135 and charged to consider and recommend legislative and organizational policy changes that would enhance the recruitment and retention of nurses and other nursing personnel and address the future of the nursing profession within the Department. The commission developed the desired future state for VHA nursing and recommendations to achieve that vision.

The Executive Summary of the Commission Report states:

> Providing high quality nursing care to the nation's veterans is integral to the mission of the Department of Veterans Affairs. The current and emerging gap between the supply of and the demand for nurses may adversely affect the VA's ability to meet the healthcare needs of those who have served our nation. The men and women of the uniformed services who have defended our nation's freedoms in global conflicts deserve the best treatment our nation can provide. Nurses comprise the largest proportion of healthcare providers in the Department of Veterans Affairs. Action is required now to address underlying issues of nursing shortage and retention while simultaneously implementing strategies that assure the availability of a qualified nursing workforce to deliver care and promote the health of America's veterans in the future.

Simultaneously, the Office of Nursing Service developed a strategic plan to guide national efforts to advance nursing practice within the VHA and engage nurses across the system to participate in shaping the future of VA nursing practice. This strategic plan embraces six patient-centered goals. These goals encompass and address many of the recommendations of the VA Nursing Commission, as well as the findings in current literature:

- **Leadership Development:** This goal focuses on supporting and developing new nurse leaders and creating a pipeline to continuously "grow" nursing leaders throughout the organization. The objective is to operationalize the High Performance Development Model for all levels of nursing personnel. This goal also addresses issues related to the nursing professional qualification standards and the Nurse Professional Standards Board as discussed in the commission report.
- **Technology and System Design:** This goal focuses on creating mechanisms to obtain and manage clinical and administrative data to empower decision making. The objective is to develop and enhance systems and technology to support nursing roles. The commission report highlighted the importance of nursing input in the development stage of new technologies for patient care.
- **Care Coordination and Patient Self-Management:** This strategic goal focuses on promoting and recognizing innovations in care delivery and facilitating care coordination and patient self-management. The objectives are to strengthen nursing practice for the provision of high-quality,

reliable, timely, and efficient care in all settings and to enhance the use of evidence-based nursing practice. This goal also encompasses recommendations from the commission related to the work environment of VA nurses.

- **Workforce Development:** This goal focuses on improving the recognition of and opportunities for the VA nursing workforce. Areas of emphasis are:

  - *utilization:* to maximize the effective use of the available workforce;

  - *retention:* to retain a qualified and highly skilled nursing workforce;

  - *recruitment:* to recruit a highly qualified and diverse nursing staff into VHA;

  - *outreach:* to improve the image of nursing and promote nursing as a career choice through increased collaboration with external partners.

  This goal also includes an emphasis on the importance of striving for the values exhibited by the philosophy of the Magnet Recognition Program of the American Nurses Credentialing Center. The commission report addresses all of these areas as critical to the future of VA nursing.

- **Collaboration:** This goal focuses on forging relationships with professional partners within VA, across the federal community, and in public and private sectors. The objective is to strengthen collaborations in order to leverage resources, contribute to the knowledge base, offer consultation, and lead the advancement of the profession of nursing for the broader community. The priorities of this goal align with VHA's Vision 2020 and the commission recommendations related to collaboration and professional development.

- **Evidence-Based Nursing Practice:** This goal focuses on identifying and measuring key indicators to support evidence-based nursing practice. The objective is to develop a standardized methodology to collect data related to nursing sensitive indicators of quality, workload, and performance within VHA facilities, which will be integrated into a standardized national database. The commission report applauded VA's progress to date related to this goal.

As noted earlier, the VHA, in its assessment of current and future workforce needs, identifies RNs as the number one priority in recruitment with LPNs and nursing assistants also among the top 10 occupations with critical recruitment needs. Recommendations from this workforce assessment include implementing the commission's recommendations, enhanced new employee induction programs, and supervisory training. Additionally, the plan recommends continuing support of employee education programs, implementation of new initiatives for student (including high school outreach) recruitment, and improving the retention of trainees as permanent employees. Finally, the VHA recommends the continuing need to maintain a national recruitment program with innovative approaches and effective outcomes.

The Independent Budget veterans service organizations (IBVSOs) support the commission's recommendations, the VA's Office of Nursing Service's strategic plan, and the *VHA Workforce Succession Strategic Plan FY 2006–2010 (October 2005)*. We strongly urge Congress to develop a budget for VA health care that will allow VHA to invest resources—human, fiscal, and technological—for recruiting and retaining nurses and proactively testing new and emerging nursing roles. The commission's legislative and organizational recommendations are a blueprint for the reinvention of VA nursing. The VA model will serve as a foundation for the creation of a care delivery system that meets the needs of our nation's sick and disabled veterans and those providing their care.

At the end of the 108th Congress, two measures were enacted that signal a good start to address medical personnel recruitment and retention issues in general and the nursing shortage in particular. The first measure attempts to simplify and improve pay provisions for physicians and dentists and authorizes alternative work schedules and executive pay for nurses. The second measure seeks to improve VA's program for recruiting nursing personnel authorizing a pilot program to study the use of outside recruitment, advertising and communications agencies, and interactive and online technologies. However, to date, VA has not taken any action to initiate the pilot. The

IBVSOs believe VA should take every opportunity, including using online technologies, to recruit qualified nursing personnel.

One very successful program requiring annual funding is the Veterans Affairs Learning Opportunities Residency (VALOR) program. This program is designed as a recruitment tool for new graduates of baccalaureate nursing programs. VALOR recruits outstanding students who have completed the final semester or quarter of their junior year and enables them to develop competencies in clinical nursing while working at an approved VA health-care facility. VA medical centers provide both didactic and experiential learning and exposure to the VA health-care environment. Based on this positive student experience, the program promotes VA employment as registered nurses upon graduation.

In an attempt to address issues having an impact on registered nurses in the workplace, the Nurses Organization of Veterans Affairs (NOVA), a professional organization of more than 35,000 RNs employed by VA, conducts a biennial survey of its membership. The 2005 membership survey identified an adequate budget for the VHA as the legislative issue most important to NOVA members, followed by patient safety, locality pay, and the nursing shortage.

Members identified their greatest challenges as computerized charting and adequate computers. Problems with bar code medication administration (BCMA) equipment can lead to frustration with computerized charting, although it has reduced medication errors. NOVA nurses find state-of-the-art informatics and the ability to provide education to patients and families as highly rewarding. NOVA identified salaries competitive with the private sector as having the highest impact on recruitment, followed by flexible work schedules and adequate staffing. When asked how many additional days per month respondents had to work to cover patient care needs, 32.6 percent indicated that they stayed an additional one to four days per month, and another 27.8 percent indicated they worked more than four additional days per month.

Because many VA nurses are now eligible to retire, or will become eligible in the next five years, the top enticement to stay in VHA nursing was flexible working hours. Only 37.5 percent of NOVA members considered VHA nursing salaries competitive with the private sector, and even fewer, 20.4 percent, indicated their facility would meet the criteria for magnet hospital designation.

Finally, the survey included several questions about the legislative process because Congress, during each legislative session, initiates and passes legislation that affects the VA nursing workforce. Educating legislators was identified as important for improving the image of VA nursing. Additionally, a majority of nurses (63.9 percent) believe they have the ability to make a difference in legislative areas.

Recommendations:

VA should establish recruitment programs that enable the VHA to remain competitive with private-sector marketing strategies.

Congress must provide sufficient funding to support programs to recruit and retain critical nursing staff.

ADMINISTRATIVE ISSUES

Volunteer Programs:

The Veterans Health Administration (VHA) volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

Since its inception in 1946, the Department of Veterans Affairs Voluntary Service (VAVS) has donated in excess of 676.5 million hours of volunteer service to America's veterans in the Department of Veterans Affairs (VA) health-care facilities. As the largest volunteer program in the federal government, the VAVS program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee, composed of 60 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and seven of their subordinate organizations, which report to the VA Under Secretary for Health.

With the recent expansion of VA health care for patients in a community setting, additional volunteers have become involved. They assist veteran patients by augmenting staff in such settings as hospital wards, nursing homes, community-based volunteer programs, end-of-life care programs, foster care, and veterans' outreach centers.

During FY 2005, VAVS volunteers contributed a total of 13,016,548 hours to VA health-care facilities. This represents 6,258 full-time employee equivalent (FTEE) positions. These volunteer hours represent more than $224 million if VA had to staff these volunteer positions with FTEE employees.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The annual contribution made to VA is estimated at $42 million. These significant contributions allow VA to assist direct patient care programs, as well as support services and activities that may not be fiscal priorities from year to year.

Monetary estimates aside, it is impossible to calculate the amount of caring and sharing that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers continues to increase dramatically as more demands are being placed on VA staff. Health care is changing, which provides opportunity for new and nontraditional roles for volunteers. New services are also expanding through community-based outpatient clinics that create additional personnel needs. It is vital that the VHA keep pace with utilization of this national resource.

At national cemeteries, volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on graves for Memorial Day and Veterans Day. More than 287,000 volunteer hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our nation.

Recommendation:

VHA facilities should designate a staff person with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.

Contract Care Coordination

The Department of Veterans Affairs (VA) does not ensure an integrated program of continuous care and monitoring for veterans who receive at least some of their care from private, community-based providers at VA expense.

Current legislation allows VA to contract for non-VA health-care (on a fee basis) and scarce medical specialty contracts only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to the veteran, and in certain emergency situations. *The Independent Budget* veterans service organizations (IBVSOs) agree that contract care should be used judiciously and only in the specific circumstances previously mentioned so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all veterans. We have consistently opposed proposals seeking to contract out health care provided by non-VA providers on a broad basis. Such proposals, ostensibly seeking to expand VA health-care services into broader areas serving additional veteran populations, in the end only dilute the quality and quantity of VA services for new as well as existing veteran patients.

However, VA currently spends approximately $2 billion each year on purchased care outside the walls of VA. Unfortunately, VA is not able to track the care, related costs, outcomes, or veteran satisfaction, and has no consistent process for veterans receiving contracted-care services to ensure that:

- effective care is delivered by certified or credentialed providers;
- continuity of care is properly monitored by VA and that patients are directed back to the VA health-care system for follow-up when possible;
- veterans' medical records are properly updated with any non-VA medical and pharmaceutical information; and
- the process is part of a seamless continuum of care/services to facilitate improved health-care delivery and access to care.

To ensure a full continuum of health-care services, it is critical that VA implement a program of contract care coordination that includes integrated clinical and claims information for veterans referred to community-based providers at VA expense. Preferred pricing allows VA medical facilities to save money when veterans use non-VA medical services by receiving network discounts through a preferred pricing program. However, VA currently has no system in place to direct veteran patients to the participating preferred provider network (PPO) providers so that VA can:

- receive a discounted rate for the services rendered;
- use a mechanism to refer patients to credentialed, quality providers; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VA medical centers (VAMCs), when a veteran inadvertently uses a PPO provider, not all facilities have taken advantage of the cost savings available to them. Therefore, in many cases VA has paid more for contracted medical care than is necessary. We are pleased that in response to this the VA made participation in the Preferred Pricing Program mandatory for all VAMCs beginning in October 2005. As a result of mandatory facility participation, VA will likely yield $80 million in savings for fiscal year 2006.

Despite the significant savings achieved through this program (more than $53 million to date), there are several major improvements that can be made to improve the access, quality, and cost of non-VA care.

The Preferred Pricing Program is the foundation upon which a more proactively managed care program should be established that will not only save significantly more money in the purchased care programs, but, more important, will provide VHA a mechanism to fully integrate veterans' community-provided medical care into the VHA health-care system. By partnering with an experienced managed-care contractor, VA can define a care management model with a

high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value.

Components of the program should include the following:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks should address timeliness, access, and cost effectiveness. Additionally, the care coordination contractor should require providers to meet specific requirements, such as the timely communication of clinical information to VA, proper and timely submission of electronic claims, meeting VA established access standards, and complying with director's performance standards.
- Customized care management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical condition, the care coordination contractor addresses appropriateness of care and continuity of care. The result being an integrated seamless health-care delivery system.
- Improved veteran satisfaction through integrated, efficient, and appropriate health-care delivery across VA and non-VA components of the continuum of care.
- Optimized workload for VA facilities and affiliates while cost for non-VA care is lowered.

Currently, many veterans are disengaged from the VA health-care system when receiving medical services from private nonparticipating PPO physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to medical care through coordination of private contracted community-based care. Prior to the implementation of the Capital Asset Realignment for Enhanced Services (CARES) plan, it is important for VA to develop an effective care coordination model that achieves its health-care and economic objectives. A care coordination contractor could be used to ensure successful implementation of CARES plans, thereby preventing unexpected backlogs. Doing so will improve patient care quality, optimize the use of VA's increasingly limited resources, and prevent overpayment when utilizing community contracted care.

■ Summary

Current legislation allows VA to contract for non-VA health care (on a fee-basis) and scarce medical specialty contracts only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to the veteran, or in certain emergency situations. The IBVSOs support a limited VA contract care coordination effort that includes integrated clinical and claims information for veterans referred to community-based providers at VA expense.

However, VA contracted care should be used judiciously in the specific circumstances mentioned so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all veterans. The IBVSOs have consistently opposed proposals seeking to contract out health care provided by non-VA providers on a broad basis. Such proposals, ostensibly seeking to expand VA health-care services into broader areas serving additional veteran populations, in the end only dilute the quality and quantity of VA services for new as well as existing veterans.

Recommendations:

VA should establish a phased-in, contracted-care coordination program that incorporates the preferred pricing program and is based on principles of sound medical management.

Veterans who receive care outside VA, at VA expense, should be required to participate in the care coordination model. This program should be tailored to VA and veterans' specific needs.

Contract care should be used judiciously and only in specific circumstances when VA facilities are incapable of providing the necessary care or geographically inaccessible to the veteran, and in certain emergency situations so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all veterans.

VA should engage an experienced contractor willing to go "at risk" to implement and manage a care coor-

dination program that will deliver improvements in medical management, access, timeliness, and cost efficiencies. VA and the contractor should jointly develop identifiable metrics to assess program results and share these results with stakeholders. Care should be taken to ensure inclusion of important affiliates in this program.

The components of a care coordination program should include claims processing and centralized appointment scheduling. VA should also implement a call center or advice line for veterans who are referred outside the VA health-care system for medical consults and treatment.

Veterans Affairs Physician Assistant:

The position of physician assistant advisor to the Under Secretary for Health should be a full-time employee equivalent (FTEE).

The Department of Veterans Affairs (VA) is the largest single federal employer of physician assistants (PAs), with approximately 1,574 PA FTEE positions. Since the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed that the Under Secretary for Health appoint a PA advisor to his office, VA has continued to assign this duty, as a part-time field FTEE, as a collateral administrative duty in addition to their clinical duties. *The Independent Budget* has requested for five years that this be a full-time FTEE within the Veterans Health Administration. In addition, in Senate Appropriations language in 2002 and again in 2003, it was requested and ignored.

This is the third Under Secretary for Health who has refused to establish this important FTEE as full time, and despite numerous requests from members of Congress, the veterans service organizations, and professional PA associations, VA has maintained this position as part-time, field-based with a very limited travel budget. This important occupation's representative has not been appointed to any of the major health-care VA strategic planning committees, has been ignored in the entire planning on seamless transition, and was not utilized during the emergency disaster planning and VA response to Hurricane Katrina.

PAs in the VA health-care system were the providers for approximately 8,700,000 veteran visits in FY 2004, and PAs work in primary care, ambulatory care clinics, emergency medicine, and in 22 other medical and surgical specialties. PAs are a vital part of VA health-care delivery and *The Independent Budget* supports the inclusion of a PA advisor in VA Headquarters Patient Care Services, full-time FTEE in very close proximity to Washington, DC, which was the intent of the law. We urge Congress to enact and fund this FTEE within the budget for FY 2007 and to ensure the position is in Washington, DC.

Recommendation:

Congress should legislatively mandate the Veterans Affairs physician assistant advisor to the Under Secretary for Health as a full-time FTEE within VA's budget for FY 2007.

Federal Supply Schedule for Pharmaceuticals

The Department of Veterans Affairs (VA) must maintain and protect the ability to achieve pharmaceutical discounts through the Federal Supply Schedule for Pharmaceuticals (FSS-P).

A number of states and the District of Columbia have recently introduced legislation that would tie Medicaid drug prices to the FSS-P. Passage of federal legislation mandating that FSS-P pricing be opened to Medicaid programs could threaten VA's ability to receive discounted pricing because vendor contracts contain a clause allowing the cancellation of these contracts in this event. Legislation has been previously introduced in Congress that would tie the new Medicare Part D Prescription Drug Benefit to the FSS-P. Prior experience, most notably with Medicaid drug provisions contained in the Omnibus Budget Reconciliation Act of 1990 (PL. 101-508), has demonstrated that if these legislative initiatives are enacted VA's pharmaceutical costs would undoubtedly increase, harming both the VA health-care system and veterans.

Under the FSS-P, VA purchases, on behalf of itself and other federal entities through contracts with responsible vendors, approximately 24,000 pharmaceutical products annually. These purchases are made at discounts ranging from 24 to 60 percent below drug manufacturers' most favored nonfederal, nonretail customer pricing. Since VA's pharmaceutical purchases are now roughly $4 billion annually, the loss of these discounts would dramatically increase the costs of pharmaceuticals, as well as the cost of providing care, to an already underfunded health-care system. These added costs could also be passed on to veterans in the form of dramatically higher copayments.

Recommendation:

Congress and the Administration need to address pharmaceutical cost-related issues in a manner that does not result in a reduction of veterans' benefits or threaten discounts VA currently receives under the FSS-P.

Challenges in VA Information Technology:

The Independent Budget *veteran service organizations (IBVSOs) oppose centralization of Information Technology (IT) in the Veterans Health Administration (VHA) if it portends any diminution or disruption of the vital link that has been established between quality of The Department of Veterans Affairs (VA) health care and innovative IT programs supporting that care.*

The IBVSOs are concerned about the status of IT in VA. For years, some of VA's approaches, budgets, policies and initiatives in information technology have been controversial, especially those that were managed "from the top" for the benefit of the entire system or were efforts applied across the diversity of programs that constitute VA benefits and services. Over several recent years on the topic of IT, Congress has applied increasing pressure in an effort to raise and affix accountability for major IT failures after large expenditures, of which, unfortunately, there have been several notable examples, such as "HRLinks" and "CoreFLS." Consequently, Congress has made a number of fresh demands on VA, including the need to centralize budget and authority in one chief information officer (CIO) who would report to the Secretary; to apply more acute, detailed and timely reporting requirements to Congress; and, in general to advance more acute scrutiny of a variety of VA IT practices, initiatives, policies, and expenditures. The CoreFLS catastrophe in 2003–2004 triggered a number of investigations and resulted in the resignation of the then–Under Secretary for Health and a VHA network director, as well as a shakeup of assignments and cancellation of contracts with possible litigation still yet unfolding. The CoreFLS incident brought new energy to the calls for VA IT reform.

Were IT functions across the three VA administrations and numerous staff offices centralized to one official in VA central office, as some have urged, the CIO, working under the tutelage of the Secretary and influence of the Office of Management and Budget and other regulators, would control all budget, policy, planning, and personnel decisions (including selection of personnel) associated with all VA IT activities in the Washington and field facilities where veterans receive VA services. The House of Representatives passed such a bill, offered by the Committee on Veterans' Affairs, in the first Session of the 109th Congress. The Senate has not moved such legislation and gives no indication that it will do so.

The IBVSOs share an agreement that a number of problems plague VA's IT program, and that better means need to be identified to avoid wasting precious resources on frivolous ideas or applications or in investing in monumental initiatives that are unsupported by the thousands of staff who must implement them (such as in the HRLinks and CoreFLS failures). Nevertheless, the IBVSOs are convinced that whatever course is taken to reform IT at the departmental "enterprise" level (where we observe the bulk of the problem usually resided), the Veterans Health Administration's seminal work to establish and manage the world's foremost computerized patient care record system should not be compromised at the expense of sick and disabled veterans.

The VA health-care system has been iteratively developing a unique VA computerized patient care record system for more than 30 years. The most important, impressive, and lasting value of the VHA's automated system is that it was conceived and developed by VA clinical and informatics specialists—those who actually deliver VA health-care day to day in VA settings. The current version of this system, based on the VHA's self-developed VistA software, sets the standard for electronic medical records in the United States and has been publicly touted by the President as a model for all health-care providers throughout the nation. In fact, VistA, available free of charge in the public domain, is being imported into data-management systems of a number of U.S. and foreign health-care systems.

The existence of automated records enables the VHA to provide better and more efficient health care to veterans, and VistA empowers VA—uniquely—to avoid medical mistakes routinely being made by other providers in the private and public sectors. Given that the Institute of Medicine estimates that medical mistakes cost 90,000 lives annually, it is no exaggeration to say VistA saves veterans' lives.

VA more than proved the value and power of its electronic medical record during the 2005 Gulf Coast storms. Nearly every provider, from single-clinician private practices to major teaching hospitals, lost its entire library of medical records to the storm or consequent flooding. VA abandoned the New Orleans Medical Center and lost the Gulfport center as well as a number of community-based outpatient clinics, but *not a single patient care record was lost* because VA's records are not recorded on paper but in cyberspace. In very short order, VA was able to "move" records electronically to the sites of its Gulf Coast patients' relocation. Whether patients were evacuated to Houston or Minneapolis, their records were transferred instantly and were reestablished in their new treatment locations with no loss of data and no disruption of care. The current reported cost of $78 per record seems a pittance compared to the incalculable cost of the loss of millions of paper records by other provider institutions and the unfortunate impact those losses are still having on the health of millions of citizens of Mississippi, Louisiana, Texas, Florida, and Alabama.

The VHA's health-care quality improvements over the past decade have been lauded by many independent and outside observers, including the Institute of Medicine of the National Academy of Sciences, the Joint Commission on the Accreditation of Healthcare Organizations, the National Quality Forum, and the Agency for Health Care Quality and Research of the Department of Health and Human Services. For the first time in history, mainstream media and press are reporting VA health care's high quality as a news item. While the IT accomplishments alone certainly did not improve VA health care, the integration of IT with VA's enrollment, laboratory, radiology, pharmacy, scheduling, personnel, logistics, management, and reporting systems enables VA to operate and coordinate care as never before, and to do so at a level well beyond the capabilities of other public and private practitioners. The VHA's IT system cannot be segregated from its clinical care system. They are one and the same.

Given the degree of success evident in the VHA, the authors of *The Independent Budget* see no defensible justification for centralizing VHA IT to a non-VHA environment. The principal reason we believe VHA IT has been so successful is that the Under Secretary has controlled and managed IT programming and the budget for the VHA, and thousands of clinical and other personnel involved in delivering direct health care also have served as software developers, subject matter experts on technical evaluation panels, and thus substantive advisors, to achieve an IT system that supports the delivery of coordinated clinical care—care that they themselves largely manage. Without IT sophistication and integration to this degree, we contend that the VHA would never have been able to double enrollment since 1995, nor to significantly reduce the cost of care, while improving its quality for America's veterans.

The IBVSOs do not believe VA can manage VHA IT from an extramural platform with the same degree of success or with the same sensitivities the VHA has achieved. We feel certain that this will be true with respect to the next generation of VHA software, HealtheVet, a Web-enabled system already well into development by VHA clinicians. We acknowledge that centralization of any governmental or business function probably can be made to save dollars; however, these dollar savings in the case of the VHA may come at a cost of eroded quality of care to sick and disabled veterans with an inevitable overlay of bureaucracy that is endemic to centralization. Removing field facility personnel, especially clinical caregivers and management personnel, from the planning and development ends of IT could doom future development and investment to mediocrity and ultimate decline.

Dr. Jonathan C. Javitt, former IT advisor to President Bush, testified as follows at a Congressional hearing on September 28, 2005:

> The centralization of VHA's electronic health records program is likely to have a disastrous effect on the continued success of that program, which President Bush identified as the only place IT has really shown up in health care; a terrible effect on the morale of VA care providers; and on the system's productivity. Worst, it will damage the health of our nation's veterans to whom we owe so much.

The IBVSOs believe Dr. Javitt's analysis is the correct assessment.

The IBVSOs have no objection to the Secretary restructuring IT to give a departmental CIO more authority. The Secretary retains authority today to empower the current CIO or a successor with additional responsibilities, including some of the ideas embedded in the arguments that would centralize IT completely. The current CIO exercises authority delegated by the Secretary and mandated by the Chief Information Officer Act, now codified in title 40, United States Code. Nevertheless, VHA's relative IT independence from strong central control is a transparent story characterized by marked success. We believe this unique progress should be sustained by enabling the VHA, with the Under Secretary for Health in the lead, to retain its current authority in IT planning, programming, operations, and budgeting.

The IBVSOs are concerned that total centralization, with a recurring reliance on absolutes, would retard the creative elements that so characterize VA's current IT environment and its future viability. VA clinicians have high motives toward investigation, research, and teaching. VHA's IT environment feeds innovation and creative applications to solve difficult and often complex problems in clinical care, particularly in the university-affiliated environment. How long could such an environment be sustained if all decisions on IT would need to be made in Washington and permission obtained through a centralized bureaucracy? The dampening effect would creep across the system and could well alter the career choices of thousands of creative VA clinical professionals. This, in turn, would erode VA's rich programs in health professions education, clinical care, and biomedical research. Such erosion places veterans' health in jeopardy.

VA recently announced a plan to create a so-called "federated" model for IT management, to address many of the external criticisms of VA's current practices and to move the entire IT apparatus in a similar management vein. The federated model is characterized by some elements of centralization; some continuance of independence similar to the current decentralized state; and some elements of accountability and control not present in the current practices. VA officials believe the federated model offers the best balance between the speed at which IT efficiencies can be achieved and mitigation of the risk that the delivery of service to veterans will suffer unintended disruption or degradation.

The IBVSOs will reserve judgment on the ultimate acceptability of the model recently adopted by VA, but the record should be clear: The IBVSOs oppose centralization of IT in the Veterans Health Administration if it portends any diminution or disruption of the vital link that has been established between quality of VA health care and innovative IT programs supporting that care.

Recommendation:

The VHA, with the Under Secretary for Health in the lead, should retain its current authority in IT planning, programming, operations, and budgeting.

VA Physician and Dentist Pay Reform:

The Independent Budget *veterans service organizations (IBVSOs) are concerned that stakeholders from the Department of Veterans Affairs (VA) clinical professional and labor arenas have not been sufficiently or properly consulted or involved in establishing the new pay system.*

In 2004, Congress passed the Department of Veterans Affairs Personnel Enhancement Act, Public Law 108-445. This new law reformed the pay and performance system used by VA in employment of its physicians and dentists. In 2003, in a hearing before the Committee on Veterans' Affairs, VA's Under Secretary for Health urged Congress to pass this authorization because VA was "in a critical situation with increasing needs of veterans for health care while our current pay system leaves us in a very noncompetitive position for recruiting the staff we need today and into the future." This proposal was considered VA's top legislative goal for the 108th Congress. Enactment of this proposal was supported by the major veterans organizations, including the IBVSOs, who expressed their concern that VA be given new authority to attract and retain the best physicians and dentists for the care of sick and disabled veterans, particularly at a time of engagement.

VA has been working for the past year to prepare for implementation of this significant new authority, which took effect in January 2006. This act is the most significant reform of pay systems for VA employees since the enactment of the Civil Service Reform Act in 1978 and represents the first real change in physician pay since 1991.

Congress has stated its intention for VA to work closely in conjunction with stakeholders in fashioning the new pay system. Senate Report 108-357, supporting the purposes of the act, stated: "Finally, the Committee bill requires that practicing physicians have a significant role in making recommendations to the Secretary or his or her designee as to the appropriate levels of salaries paid to members of their professions. Physicians and dentists are at the front-lines of medicine; they know what is needed to provide care for veterans. This provision advances the tradition of cooperation among labor and management in the Federal sector, particularly within the healthcare environment."

The IBVSOs are concerned about whether VA met clear Congressional intent in that regard. Stakeholders from the VA clinical professional and labor arenas have reported to us that they were not sufficiently or properly consulted or involved in establishing the new pay system, which, at issuance of the FY 2007 *Independent Budget,* was in the final stages of development and early roll out to 14,000 VA physicians and 700 VA dentists and oral surgeons. It was presumed that VA would consult and involve VA physicians and dentists and their representatives in circumscribing the news principles and procedures that govern both the pay and performance elements of the new authority, and those that demark the variety of tiers of pay across professional specialties.

We urge VA to actively engage both labor and professional associations that remain concerned about the new pay and performance system to ensure it gains their assent and continuing cooperation as VA implements these new rules in the current workforce. Physicians and dentists are essential caregivers, educators, and researchers in the VA health-care system. This act was intended for their benefit, to attract them to VA careers and to keep them providing outstanding care to veterans. We would hope these purposes would be transparent and that VA would voluntarily involve representatives of professions in their establishment and implementation.

Recommendation:

We urge VA to actively engage both labor and professional associations that remain concerned about the new pay and performance system, to ensure it gains their assent and continuing cooperation as VA implements these new rules in the current workforce.

Fee-Basis Care:

The extent of its decentralized structure, complex legislative authority, and the inadequate funding to local VA facilities for fee-basis care continues to erode the effectiveness of this necessary health-care benefit.

Fee-basis care allows eligible service-connected veterans who live in areas that are geographically inaccessible to Department of Veterans Affairs (VA) medical facilities or who need specific services unavailable at VA to use private sector clinicians at VA expense. Veterans authorized for fee-basis care may choose their own medical providers.

While VA is the sole payer for any medical services and inpatient hospital days of care that it approves, VA will at times approve only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities. Moreover, veterans who are approved by VA to utilize fee-basis care are unable to secure treatment from a community provider due to VA's regulated level of payment for medical services.

Recommendation:

VA should continue to pursue the regulatory changes needed for its payment methodology to provide equitable payments for care veterans receive in the community.

Construction Programs

The Department of Veterans Affairs (VA) construction budget includes major construction, minor construction, grants for construction of state extended-care facilities, and grants for state veterans' cemeteries. VA's construction budget annual appropriations for major and minor projects decreased sharply to an all-time low in fiscal year 2003. Over the past several years there has been political resistance to funding of any major projects before the Capital Assets Realignment for Enhanced Services (CARES) process was completed. The prospect of systemwide capital assets realignment through the CARES process continues to be used as an excuse to hold many construction projects hostage.

The CARES process has concluded its first two major phases, in which VA has engaged first in a regional, and now national, process to reorganize the Veterans Health Administration (VHA) through a data-driven assessment of VA health-care infrastructure and programs. Through CARES, VA has been evaluating the demands for health-care services and identifying changes to help meet veterans' current and future health-care needs. The CARES process included developing, testing, and applying sophisticated actuarial models to forecast tomorrow's demand for veterans' health care and the calculation of the supply and identification of current and future gaps in infrastructure capacity. This resulted in a Draft National CARES Plan (DNCP) to rectify deficiencies through the realignment of VA's capital asset infrastructure, including closures of unnecessary facilities and construction of new ones to meet 21st century demands.

The Independent Budget veterans service organizations (IBVSOs) appreciated former Secretary Anthony J. Principi's efforts to establish a CARES Implementation Board to oversee the national CARES effort and the plan to begin further feasibility studies of the 22 VA facilities identified for major mission changes in the Secretary's CARES decision document. However, as stakeholders, again we remind VA of the imperative to keep national veterans service organizations fully involved and engaged in all phases of the CARES process, which was divided into three different segments: a health-delivery study, a comprehensive capital plan, and an excess property plan identifying potential new land usages or disposals. We remain supportive of the CARES process as long as the primary emphasis is on the "ES" portion of the acronym. We still understand that the locations and missions of some VA facilities may need to change to improve veterans' access, to allow more resources to be devoted to medical care rather than upkeep of inefficient, antiquated VA buildings, and to accommodate modern methods of health-service delivery. Accordingly, in *The Independent Budget for Fiscal Year 2006*, we concurred with VA's plan to proceed with the feasibility studies of the 22 facilities identified in the Secretary's decision document that required further review. The IBVSOs remain concerned that Congress may not adequately fund all CARES-proposed changes when CARES implementation costs are factored into the appropriations

process. Lack of funding will further exacerbate the current obstacles impeding veterans' timely access to quality heath care. We remain firm in the position that that VA should not proceed with final decision making on CARES until sufficient funding is appropriated and made available for construction of new facilities and renovation of existing sites, as identified through the open process of CARES.

CHART 3. CARES IDENTIFIED CONSTRUCTION PROJECTS

V	MARKET/FACILITY	STAKEHOLDERS COMMUNICATION PLAN	FINANCIAL ANALYSIS	HEALTH-CARE DELIVERY STUDY	GENERAL CAPITAL PLAN	GENERAL REUSE PLAN	COMPREHENSIVE CAPITAL PLAN	COMPREHENSIVE REUSE PLAN
1	Boston	X	X	X	X	X	X	x
3	New York City	X	X	X	X	X		
9	Louisville	X	X	X	X	X		
17	Waco	X	X	X	X	X		
18	Big Spring	X	X	X	X	X		
20	Walla Walla	X	X	X	X	X		
7	Montgomery, AL	X	X	X	X			
16	Muskogee	X	X	X				
2	Canandaigua	X	X			*	X	*
3	Montrose/Castle Point	X	X			*	X	*
3	St. Albans	X	X			*	X	*
9	Lexington	X	X			*	X	*
21	Livermore	X	X			*	X	*
20	White City	X	X			*	X	*
5	Perry Point	X	X			*	X	*
16	Gulfport	X	X			*	X	*
22	West Los Angeles	X	X			*	X	X
15	Poplar Bluff		X					

x=Performed by contractor

*=Performed by other VA contractor. Contractors to work collaboratively on development.

MAJOR CONSTRUCTION ACCOUNT

The Independent Budget veterans service organizations (IBVSOs) recommend that Congress appropriate $1.447 billion to the major construction account for FY 2007. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition, and claims.

Construction, Major Appropriation
FY 2007 IB Recommendation
(Dollars in thousands)

CARES	$860,000
Architectural Master Plans Program	100,000
Historic Preservation Grant Program	25,000
Seismic	285,000
Advanced Planning Fund (VHA)	43,000
Asbestos Abatement	6,000
Claims Analyses	3,000
Judgment Fund	10,000
Hazardous Waste	3,000
National Cemetery Administration	89,000
Design Fund	6,000
Advanced Planning Fund	11,000
Staff Offices	6,000
Total, Major Construction	$1,447,000

MINOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate $505 million to the minor construction account for FY 2007. These funds contribute to construction projects costing less than $7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, staff offices account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects.

Construction, Minor Appropriation
FY 2007 Recommended
(Dollars in thousands)

CARES/Non-CARES	$392,000
National Cemetery Administration	32,000
Veterans Benefits Administration	38,000
Staff	6,000
Advanced Planning Fund	35,000
Inspector General	2,000
Total, Minor Construction	$505,000

CONSTRUCTION ISSUES

Increase Spending on Nonrecurring Maintenance:

The deterioration of many Department of Veterans Affairs properties calls for increased spending on nonrecurring maintenance.

The Independent Budget veterans service organizations (IBVSOs) support the Price Waterhouse recommendation that VA spend at least 2 to 4 percent of the value of its buildings or $1.6 billion annually on upkeep. In FY 2006 the VA budget request contained $506 million for nonrecurring maintenance. The IBVSOs believe that no less than $1.6 billion should be in the FY 2007 appropriation with continued increases in the following years until an appropriate level of funding that will forestall the continued deterioration of Department of Veterans Affairs (VA) properties is achieved.

Recommendation:

Congress should appropriate and VA should direct no less than $1.6 billion for nonrecurring maintenance in FY 2007. VA should make annual incremental increases in spending for nonrecurring maintenance in the future until the corresponding percentage of the value of its buildings is budgeted and utilized for nonrecurring maintenance.

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Inadequate Funding and Declining Capital Asset Value:

The Department of Veterans Affairs (VA) does not have adequate provisions to protect against deterioration and declining capital asset value.

The Independent Budget for fiscal years 2005 and 2006 cited the recommendations of the interim report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). That report was made final in May 2003. To underscore the importance of this issue, we again cite the recommendations of the PTF.

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only $246 million annually, a recapitalization rate of 0.64 percent of the $38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2 percent of plant replacement value for its entire facility infrastructure. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the Department of Defense adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

The PTF also recommended that "an important priority is to increase infrastructure funding for construction, maintenance, repair and renewal from current levels. The important of this initiative is that the physical infrastructure must be maintained at acceptable levels to a avoid deterioration and failure."

The PTF also indicated, "Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other life cycle components of maintenance and restoration. VA does not have a strategic facility focus but instead submits an annual top 20 facility construction list to Congress. Within the current statutory and

business rules, VA can bring new facilities online within four years. However, VA facilities are constrained by reprogramming authority, in adequate investment and lack of a strategic capital planning program."

The PTF believes that VA must accomplish three key objectives: 1) invest adequately in the necessary infrastructure to ensure safe, functional environments for health care delivery; 2) rightsize their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and 3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

The Independent Budget veterans service organizations remain supportive of the provisions contained in the PTF final report, and we concur with its conclusions therein. If construction funding continues to be inadequate, it will become increasing difficult for VA to provide high-quality services in old and inefficient patient care settings.

Recommendations:

Congress must ensure that there are adequate funds for the major and minor construction programs so the VHA can undertake all urgently needed projects.

High-Risk Buildings:

Veterans and staff continue to occupy buildings known to be at extremely high risk because of seismic deficiencies.

Seismic safety continues to be a major issue of concern with *The Independent Budget* veterans service organizations. Currently 890 of the Department of Veterans Affairs (VA) 5,300 buildings have been deemed at "significant" seismic risk and 73 Veterans Health Administration buildings are at "exceptionally high risk" (EHR) of catastrophic collapse or major damage.

VA submitted to Congress a list of 30 high-priority major construction projects to begin implementation of the Capital Asset Realignment for Enhanced Services (CARES) plan. This high priority list included seismic correction projects for seven most EHR facilities. Accordingly, this will increase VA's need for construction funding.

For efficiency, most seismic correction projects should also include patient care enhancements as part of their total scope. Also, consideration must be given to any enhanced service recommendation provided during the CARES process. Because of the lengthy and widespread disruption to ongoing hospital operations that are associated with most seismic projects, it would be prudent to make qualitative medical care upgrades at the same time. While this approach is typically both practical and cost-effective, it also results in proportionally higher projects costs and therefore it is another requirement for larger annual construction budgets.

Recommendations:

Congress should appropriate adequate construction funding to correct seismic deficiencies.

VA should schedule facility improvement projects and any CARES recommendation concurrently with seismic corrections.

Establishing a Program for Architectural Master Plans for Medical Centers:

Each Department of Veterans Affairs (VA) medical center needs to develop a detailed architectural master plan.

This year's construction budget should include $100 million to fund architectural master plans. Without these plans, the Capital Asset Realignment for Enhanced Services (CARES) medical benefits will be jeopardized by hasty and short-sighted construction planning.

Currently VA plans construction in a reactive manner—i.e., first funding the project then fitting it on the site. Furthermore, there is no planning process that addresses multiple projects; each project is planned individually. "Big picture" design is critical so that a succession of small projects don't "paint" the facility into the proverbial corner. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. The development of master plans will prevent short-sighted construction that restricts, rather than expands, future options.

Every new project is a step in achieving the long-range CARES objectives. Master plans must be developed so that each future project can be prioritized, coordinated, and phased. Medical priorities must be adjusted for construction sequencing. If infrastructure changes must precede new construction, for example, master plans will identify this requirement so that schedules and budgets can be adjusted. Careful construction phasing is necessary to avoid disrupting medical care, and this can be a substantial project expense. Architectural master planning will more cost estimates that include contingency expenses for phasing more accurate. Plans can also mitigate patient care disruptions.

Detailed master planning cost projections will either validate, or challenge, the original CARES decisions. For example, if CARES called for use of renovated space for a relocated program and a more comprehensive examination later indicates that the selected option is impractical, different options should be considered. Invalid planning assumptions should be corrected as soon as practical.

Campus planning should also address parking. Master plans will facilitate a comprehensive approach to medical center parking. Anticipated changes must be analyzed for their possible impact on parking. The construction of new facilities, for example, often displaces existing parking. This situation reduces available surface parking and also increases the demand for spaces to serve the expanded project. As more medical functions are attached to existing medical centers, parking is pushed farther and farther from the facilities it serves. Without far-sighted planning, parking structures are sometimes built on adjacent sites that are more suitable to medical programs. Master planning will also demonstrate future land deficiencies so that structured parking can be implemented early, rather than late, in medical center development.

Some CARES plans involve projects to be constructed at more than one medical center. Individual master plans must coordinate the priorities of both medical centers. For example, construction of a new spinal cord injury facility may be a high priority for the "gaining" facility, but a low priority for the "donor" facility. The best policy may be to fund the two actions together, even though activities are split between two medical centers.

Architectural master planning will also provide a mechanism to address the three critical programs that the CARES study omitted. Specifically, these are long-term care, severe mental illness, and domiciliary care. These programs should be addressed as quickly as possible.

In order to initiate architectural master planning, VA must establish formats (templates) for contracted architects to develop physical plans based on programmatic and operational decisions agreed to during CARES. Architectural master planning must begin immediately in order to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction. VA should already have developed a master planning program as recommended in the FY 2005 and FY 2006 *Independent Budget.*

Recommendations:

Congress must appropriate $100 million for medical center master plans in the FY 2007 construction budget.

The facility master plans should address the long-term care, severe mental illness, and domiciliary care programs. Architectural master plans should also address historic properties and vacant space.

VA must quickly develop a format for these master plans so there is standardization throughout the system, even though the planning work will be performed in each Veterans Integrated Service Network by local contractors. The format should be tested in pilot projects.

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Better Coordinate Planning and Design Time Frames in Order to Efficiently Manage Construction:

The Department of Veterans Affairs (VA) must develop realistic and compatible time frames for use in the Capital Asset Realignment for Enhanced Services (CARES) program, facility master planning, and individual project development.

VA's project development process, from design initiation to building occupancy, lasts from 8 to 10 years. The length of the process cannot be ignored as a factor in evaluating CARES planning initiatives. There is a fundamental incompatibility between the short, 17-year, long-range planning process and the long, 10-year implementation process. Furthermore, CARES will increase the development process's length. For example, the current timeline does not include a master planning step. In addition, many CARES projects will require more complex construction phasing. Some even involve private-sector real estate transactions.

Even if master planning were initiated immediately, the first CARES project's occupancy would follow more than a decade later. As a practical matter, one must therefore assume that the majority of CARES projects will *not* be completed by 2022, the second CARES planning target date. Only a very few projects will be completed by the first 2012 target date. Because of these long time frames, CARES implementation must be viewed realistically. For example, higher demand for veterans' services that are projected for 2012 must be addressed by *nonconstruction* alternatives. There is insufficient time to construct new facilities to meet the forecast need so the VA should address these responsibilities by means of operational adjustments.

In order to properly manage construction, VA must coordinate cycles for medical planning, architectural master plans, and project design. Statistical data gathering, for example, should be conducted every year. Now that CARES planning tools have been adopted, the same data format should be updated annually. This information will also allow VA to monitor previous projections. For example, was the CARES demand forecast for services accurate? If not, why not? This analysis will improve VA's long-range planning.

Comprehensive systemwide planning (like CARES) should be conducted on a 10-year cycle, but updated each year. Architectural master planning should be conducted on the same cycle as comprehensive medical planning, but should be adjusted every three years to reflect changes in demand for services, and philosophy of care and medical technologies. VA should reduce the length of the design and construction process so that newly completed facilities reflect the most current planning data and medical technologies and the newest models for patient care. Health-care advances and innovations occur at much too swift a pace to be compatible with a long, inflexible design-and-construction process.

Recommendations:

VA must develop nonconstruction alternatives to enable it to meet the projected increased demand for veterans' health-care services in the year 2012.

VA should conduct both medical program and architectural master planning on a regular cycle that is appropriate for each activity.

Congress must appropriate sufficient construction funding each year so that there is steady implementation of planning initiatives.

Uses for CARES Statistical Data in Facility Management and Budgeting:

The Department of Veterans Affairs (VA) and Congress should make full use of the data produced by the Capital Asset Realignment for Enhanced Services (CARES) initiative.

The CARES study has produced new data that is potentially useful to Congress and VA. The study paints a statistical picture of the system's current deficiencies in functional space. By the application of planning algorithms, current space requirements have been mathematically computed for every medical program, except long-term care, mental illness, and domiciliary. This computation establishes a benchmark that is compared to existing space inventories. The arithmetic difference between the benchmark and the inventory represents the *deficiency,* the net amount of new construction needed to provide quality medical care to today's veterans. Comparing these data, a specific medical center, for example, can be identified as the "most deficient" in the VA system. By extension, a facility is "most in need of new construction." All medical programs can also be compared and ranked on a similar basis.

CARES data also will allow prioritization of construction funding, based on different criteria, such as geographic regions or medical programs. Because these current data depend on objective measurements, they are not the product of any assumptions regarding future needs.

Data that are based on more fragile forecasts are "projected space deficiencies." These are based on various planning postulates regarding such variables as veteran eligibility, population demographics, and future military actions. Actuarial data are used to project these future demands for veterans' health-care services. Because of these conjectures, the projections are less firm than existing deficiencies. These forecasts must be carefully considered, however, because VA must plan for the system's future needs. Long-range planning is particularly critical for construction because the implementation process is so lengthy.

CARES data illustrate the scope of the system's current and future construction needs. These data can be used to establish the appropriate magnitude of construction budgets and to provide a rational basis to distribute these resources. Allocations, for example, could be made to address the greatest *current space* deficiencies. Alternatively, funding could be prioritized to offset the greatest projected space needs. Budgets could be adjusted to emphasize one medical program over another. VA should have collected this data for decades for the purposes of both system management and Congressional oversight.

Construction costs have escalated substantially during the two years since CARES data were finalized. National indexes for all types of construction show that since 2003, building costs have increased approximately 5.5 percent each year. Using the CARES data as a starting point, cost projections should be updated annually.

With the new CARES data, better systemwide facility management is now possible. CARES data should therefore be periodically updated in order to verify the accuracy of the underlying assumptions and make the necessary adjustments to facility and operational plans. Similar statistical data should be generated for the three missing programs (long-term care, mental illness, and domiciliary).

Recommendations:

VA should use CARES data to establish the magnitude of construction that is required to address current space deficiencies.

VA should use CARES data to identify future space deficiencies and initiate construction now to meet future needs.

VA should use the deficiencies data to establish current and future construction budgets and to allocate these resources among the various medical centers and medical programs.

VA should periodically update CARES data as an important tool for systemwide planning and management.

VA should generate similar statistical data for long-term care, severe mental illness, and domiciliary.

Updating and Expanding VA Design Guides:

The Department of Veterans Affairs (VA) must develop long-term care facility design guides for Spinal Cord Injury/Spinal Cord Dysfunction (SCI/D) patients.

VA owns and operates the United States' largest health-care system. An advantage of this role is the ability to develop, evaluate, and refine the design and operation of their many facilities. Every new clinic's design, for example, should benefit from lessons learned from the operation of previous clinics. VA should collect input from medical staff, engineering officers, and from users, including patients and their families. This feedback should generate improvements to future designs.

VA currently provides design guides for some facilities that support veterans' care. The guides are tools used by the designer, clinician, staff, and management during the design process. Currently, there are no design guides for long-term care facilities. The only available guide for extended-care facilities is the 1990 VA Handbook 7610 Chapter 106, "Nursing Home Care Units." This has limited data, such as square footage requirements for functional spaces. The VA has issued a new design guide for extended-care facilities. This design guide specifically addresses the needs of aging patients who require varied levels of medical care.

CARES advocates construction of several new long-term care SCI/D centers. Design guides for SCI/D long-term facilities must also be developed immediately. Currently, SCI/D long-term care facilities utilize the same design concepts as acute care facilities. This approach is not appropriate. Long-term care facilities should not provide the same patient environment as acute care centers. Although they need to meet specialized accessibility criteria, they should be less institutional in their character with a more homelike environment. Rooms and communal spaces should be designed to accommodate patients who will live in these facilities for extended periods of time. Simple ideas that would make daily living more residential should be included: Corridor lengths should be limited; they should include wide areas with windows to create tranquil places or areas to gather. Centers should have courtyards in areas where the climate is temperate and indoor solariums where it is not. A complete guideline for these facilities would also include a discussion of design philosophies as well as specific criteria for each space.

Care for the long-term SCI/D patient results from primarily physical issues, not aging or mental health. An SCI/D long-term care patient could be a 19-year-old newly injured veteran, or a 75-year-old veteran who has been a wheelchair user for decades. They may both be in a long-term facility due to a medical acuity, or they may not have the family support available to aid them. Because this type of care is unique, it is particularly important the design guidance be available to contracted architects.

Recommendation:

VA should quickly develop specialized long-term care design guides for SCI/D patients.

Preservation of VA's Historic Structures:

The Department of Veterans Affairs (VA's) extensive inventory of historic structures must be protected and preserved.

VA's historic structures illustrate America's heritage of veterans care, and they enhance our understanding of the lives of soldiers and sailors that fashioned our country. VA owns almost 2,000 historic structures. Neglected, many deteriorate further every year. These structures must be stabilized, protected, and preserved. As the first step in addressing this responsibility, VA must develop a comprehensive national program for its historic properties. Because most heritage structures are not suitable for modern patient care, the Capital Asset Realignment for Enhanced Services planning process did *not* produce a national preservation strategy. VA must undertake a separate initiative for this purpose immediately.

VA must inventory its historic structures, classify their current physical condition, and evaluate their potential for adaptive reuse by medical centers, local governments, nonprofit organizations, or private-sector businesses. To accomplish these objectives, *The Independent Budget* veterans service organizations recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. Their expertise should prove helpful in establishing this new program. VA must also expand its limited preservation staffing.

For its adaptive reuse program, VA needs to develop models and policies that will protect historic structures that are leased or sold. VA's legal responsibilities, for example, could be addressed through easements on property elements such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully helped the Department of Army to manage its historic properties.

We applaud the passage of P.L. 108-422, "Veterans Health Programs Improvement Act," which authorizes historic preservation as one of the uses of a new capital assets fund that receives funding from the sale and lease of VA property and establishes a revolving fund for costs associated with transfer, renovation, or leasing these facilities. We propose a $25 million initial appropriation to establish this fund for FY 2007.

Recommendation:

Specific funds should be included in the FY 2007 budget to develop a comprehensive program with detailed responsibilities for the preservation and protection of VA's inventory of historic properties.

Empty or Underutilized Space at Medical Centers:

The Department of Veterans Affairs (VA) should avoid the temptation to reuse empty space inappropriately.

Studies have suggested that the VA medical system has extensive empty space that can be cost effectively reused for medical services and that one medical center's unused space may help address another's deficiency. Although these space inventories are accurate, the basic assumption regarding viability of space reuse is not.

Medical design is complex because of the intricate relationships that are required between functional elements and the demanding requirements of equipment that must be accommodated. For the same reasons, medical facility space is rarely interchangeable. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a second-floor space deficiency because there is no functional adjacency. Medical space has very critical inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care. In order to preserve these relationships, departmental expansions or relocations usually trigger "domino" effects on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

A medical space's permanent features, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading, cannot be altered. Different medical functions have different requirements based on these characteristics. Laboratory or clinical space, for example, is not interchangeable with ward space because of the need for different column spacing and perimeter configuration. Patient wards require natural light and column grids that are compatible with room layouts. Laboratories should have long structural bays and function best without windows. In renovation, if the "shell" space is not suited to its purpose, plans will be larger, less efficient, and more expensive.

Renovating space rather than undertaking new construction yields only marginal cost savings, if any. Build out of a "gut" renovation for medical functions is approximately 85 percent of new construction cost. If the renovation plan is less efficient, or the domino impact costs are greater, the savings are easily lost. Remodeling projects often cost more and produce a less satisfactory result. Renovations are appropriate to achieve critical functional adjacencies, but they are rarely economical.

Early VA centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most hospitals have been consolidated into large, tall "modern" structures. Over time, these central towers have become surrounded by radiating wings with corridors leading to secondary structures. Many medical centers are built around prototypical "Bradley buildings." VA rushed to build these structures in the 1940s and 1950s for World War II veterans. Fifty years ago, these facilities were flexible and inexpensive, but today they provide a very poor chassis for a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to floor heights are very low, making it almost impossible to retrofit modern mechanical systems. The wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts. The Bradley hospital's central core has only a few small elevator shafts, and these are inadequate for vertical distribution of modern services.

Much of the space that is currently vacant is not situated in prime locations, but typically is located in outlying buildings or on upper floor levels. The permanent structural characteristics of this space often make it unsuitable for modern medical functions. VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved. Some space may be suitable for enhanced use. Some should be demolished. Each medical center should develop a plan to find suitable uses for its nonhistoric vacant properties.

Recommendation:

VA should develop a comprehensive plan for addressing excess space in nonhistoric properties that is not suitable for medical or support functions due to its permanent characteristics or location.

VBA FACILITIES

Major Construction Funding:

To achieve savings, Congress should provide major construction funding for new Veterans Benefits Administration (VBA) facilities rather than requiring the VBA to pay rent at commercial rates.

Congress last provided major construction funding for the VBA in 1992. Without major construction funding, the VBA has relied predominantly upon General Services Administration (GSA) leasing for its space needs and on enhanced use leasing (EU) for colocation with VBA facilities.

For the past six years, the VBA has been initiating colocation projects by selectively identifying facilities where there are opportunities to improve service delivery and operational efficiency. For example, the VBA used EU leasing authority for the new Milwaukee, Wisconsin, Regional Office. Though the new facilities have improved service and operations, this EU lease has not reduced the VBA's rent.

Conversely, colocation of the Hartford office to the Department of Veterans Affairs Newington campus using minor construction funds was a notable success. The new Hartford facility provides better access for veterans, improved operational efficiency, and has saved considerable rent as it is now located in a VA-owned property. VBA could well use savings such as these to provide direct services for veterans rather than being spent on rent.

The VBA leases approximately 4.3 million square feet of office space at an average rate market rate of $25 per square foot. VBA only owns four to five major regional offices. A number of smaller offices are located on VA-owned property. In the VA-owned facilities, the VBA pays an average of $10 per square foot for operating and maintenance expenses, or 60 percent less than in leased space. In FY 2005, rent payment accounted for 7.4 percent of general operating expenses.

With major construction funding, the VBA would continue its strategy of *selectively* moving out of older and lower quality GSA facilities, balancing its facilities portfolio, and prioritizing colocations when improvements in service, easier access for veterans, and enhanced operational efficiencies can be achieved. The resulting savings in general operating expense funds could then be reallocated from rent to direct services delivery activities for veterans.

Recommendation:

To allow for selective colocation and construction of VA-owned regional office facilities that provide better veteran access and improve operational efficiency while achieving savings, *The Independent Budget* veterans service organizations recommend that Congress provide major construction funding for new VBA facilities rather than requiring the VBA to rent office space.

Vocational Rehabilitation and Employment

The relationship between veterans, disabled veterans, and work is vital to public policy in today's environment. People with disabilities, including disabled veterans, often encounter barriers to their entry or re-entry 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. At present funding levels, our public eligibility and entitlement programs cannot keep pace with the resulting demand for benefits.

In recent years, there has been an increased reliance on licensing and certification as a primary form of competency recognition in many career fields. This emphasis on licensing and certification can present significant, unnecessary barriers for transitioning military personnel seeking employment in the civilian workforce. These men and women receive exceptional training in their particular fields while on active duty, yet in most cases, these learned skills and trades are not recognized by nonmilitary organizations. Efforts to enhance civilian awareness of the quality and depth of military training should be made to eliminate licensing requirements and employment barriers. We are encouraged by the emphasis now being placed on employment and not just the counseling portion of vocational rehabilitation.

In response to criticism of the Vocational Rehabilitation and Employment (VR&E) program, former Department of Veterans Affairs (VA) Secretary Anthony Principi formed the Vocational Rehabilitation and Employment Task Force. The Secretary's intent was to conduct an "unvarnished top to bottom independent examination, evaluation, and analysis." The Secretary asked the task force to recommend "effective, efficient, up-to-date methods, materials, metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment. In March 2004, the task force released its report recommending needed changes to the VR&E program. *The Independent Budget* supports the recommendations of the task force, and we look forward to seeing these recommendations implemented.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Vocational Rehabilitation & Employment Funding:

Congressional funding for the Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment services (VR&E) must keep pace with veteran demand for VR&E.

The relationship between veterans, disabled veterans, and work is vital to public policy in today's environment. People with disabilities, including disabled veterans, often encounter barriers to entry or re-entry 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. With the current global war on terrorism, large numbers of National Guardsmen and Reservists are being called to active duty and creating tens of thousands of new veterans, many facing significant challenges when they return home. At present funding levels, our public eligibility and entitlement programs cannot keep pace with the resulting demand for benefits.

Recommendation:

Congress must provide the funding level to meet veteran demand for VA VR&E programs.

VR&E Staffing Levels Inadequate:

Staffing levels of the Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) program are not sufficient to meet the needs of our nation's veterans in a timely manner.

The VR&E program of VA is charged with the responsibility to prepare disabled veterans for suitable employment and provide independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their entry into the program. However, VR&E must begin to strengthen its program due to the increasing number of service members returning from Afghanistan and Iraq with serious disabilities. These veterans require both vocational rehabilitation and employment services. There is no VA mission more important during a time of war than to enable our injured military personnel to have a seamless transition from military service to a productive life after serving their country.

In response to criticism of the VR&E program, former VA Secretary Anthony Principi formed the Vocational Rehabilitation and Employment Task Force. The Secretary's intent was to conduct a "…unvarnished top to bottom independent examination, evaluation, and analysis." The Secretary asked the task force to recommend "effective, efficient, up-to-date methods, materials, metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment. In March 2004, the task force released its report recommending needed changes to the VR&E program.

The Independent Budget veterans service organizations (IBVSOs) agree wholeheartedly with the findings of the Vocational Rehabilitation and Employment Task force which identified several changes necessary to improve many programmatic and managerial aspects of the VR&E operation. These recommendations include streamlining veteran eligibility, expanding benefit counseling, reorganizing and increasing VR&E staffing, improving information technology, and implementing an employment-driven service delivery program, which it refers to as the Five-Track Employment Process. This process would provide the following services to veterans:

- reemployment,
- access to rapid employment,
- self employment,
- long-term vocational rehabilitation, and
- independent living services.

Such improvements would allow veterans to obtain suitable employment, which is necessary for them to lead a productive life. The IBVSOs are encouraged by the progress being made by the VR&E service to implement the recommendations of the task force and look forward to seeing further improvements made. However, additional resources will be required to accomplish all these tasks.

For the past few years, VA's focus has been solely on reducing the major claims processing backlogs, which has become the dominant goal of the Veterans Benefits Administration, rather than just one of the means to assist veterans with disabilities transition to the private sector. VA must place more emphasis on returning rehabilitated disabled veterans to the workforce.

The success of transitioning disabled veterans to meaningful employment relies heavily on VA's ability to provide vocational rehabilitation and employment services in a timely and effective manner. Unfortunately, the demand and expectations being placed on the VR&E service are exceeding the organization's current capacity to effectively deliver a full continuum of comprehensive programs. The service has been experiencing a shortage of staff nationwide due to insufficient funding, which, as a result, has caused delays in providing VR&E services to disabled veterans thus reducing the veteran's opportunity to achieve a successful rehabilitation and employment. To increase emphasis on employment within VR&E, the service will require additional full time equivalent employee resources and greater sophistication, possibly only available on a contract basis. It is imperative that VA increase VR&E staffing levels to meet the increasing demand for services. The following facts further confirm these problems.

There are currently more than 65,000 veterans applying for VR&E programs (chapter 31 benefits) compared to 45,000 in FY 2000.

At present, there are more than 96,000 veterans in the various phases of VR&E compared to 70,000 in FY 2000.

There is a waiting list of more than 8,000 veterans currently awaiting access to VA Vocational Rehabilitation and Employment programs.

For many years, the IBVSOs have criticized VR&E service programs and complained that veterans were not receiving suitable vocational rehabilitation and employment services. Many of these criticisms remain of concern, including the following:

- inadequate and sometimes nonexistent case management with lack of accountability for poor decision making;
- outdated regulations, as well as policies and procedure manuals;
- long delays in processing applications due to staff shortages and large caseloads;
- failure to explore entrepreneurial opportunities for disabled veterans;
- declaring veterans rehabilitated before suitable employment is obtained and retained;
- inadequate and inconsistent tracking of electronic case management information systems; and
- need for improved collaboration between the Department of Labor and the Small Business Administration.

Recommendations:

VA needs to strengthen its Vocational Rehabilitation and Employment program to meet the demand of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq, by providing a more timely and effective transition into the workforce.

The VR&E should improve case management techniques and the use of state-of-the-art information technology.

The service needs to reduce the caseload for VR&E case managers from the current 145 cases to a more manageable level of 100 cases per counselor so they can closely follow the veteran's employment progress

and if necessary coordinate employment retraining with both the medical and benefits administration

Develop the position of employment coordinator at each regional office, working with the Department of Labor's Disabled Veterans Outreach Program representative, to assist veterans obtain and retain gainful employment.

The VR&E service must increase the success rate of their program above the current 63 percent and should also establish a much higher standard than 66 percent.

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

VA needs to streamline eligibility and entitlement to VR&E programs to provide earlier intervention and assistance to disabled veterans.

The VR&E must become an employment-driven program to successfully return disabled veterans to the workforce.

The VR&E service should rewrite its operational policies and procedures manual.

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 must develop plans and partnerships to enhance the availability of entrepreneurial opportunities for disabled veterans.

The VR&E service should follow up with rehabilitated veterans for at least two years to ensure that the rehabilitation and employment placement is successful.

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Transition Assistance Programs Inadequate:

The Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) do not adequately serve service members.

The Departments of Defense (DOD), Labor (DOL), and Veterans Affairs (VA) provide transition-assistance workshops to separating military personnel through the Transition Assistance Program and the Disabled Transition Assistance Program. These programs generally consist of a three-day briefing on employment and related subjects, as well as veterans benefits.

DTAP, however, has been largely relegated to a "stand-alone" session. Typically, a DTAP participant does not benefit from other transition services, nor does he or she automatically see a Vocational Rehabilitation and Employment Service (VR&E) representative.

The number of military members being separated annually remains high (more than 200,000 as projected by the DOD). Large numbers of separating service members are returning from the global war on terrorism. Many have been on "stop loss," prevented from leaving military service on their scheduled date, and they depart military service soon after their return. It is imperative that these soon-to-become veterans are not overlooked during their rapid transition to civilian life. Additionally, tens of thousands of National Guardsmen and Reservists have been called to active duty for the current conflict. No coherent program exists for them to receive transition services at demobilization. In some ways, they face even more difficult employment problems after being ripped from their civilian employment to serve the nation. Though protections exist, they need detailed information on both protections and information on benefits as well as other opportunities they may have. *The Independent Budget* veterans service organizations (IBVSOs) believe TAP/DTAP must continue to provide their important services as recommended by the VR&E Task Force in March 2004 and expand them to

Guardsmen and Reservists currently returning from combat.

The IBVSOs are encouraged that the VR&E service is in the process of restructuring DTAP. However, we are concerned that too little is still being done for transitioning disabled veterans, and we will continue to monitor the changes and progress in the DTAP program.

Recommendations:

Congress should pass legislation ensuring the eligibility of all disabled veterans on a priority basis for all federally funded employment and training programs.

VA should assign primary responsibility for the DTAP program within the Veterans Benefits Administration to the VR&E service and designate a specific DTAP manager.

The DOD should work closely with the DOL to ensure detailed transition services are provided at the demobilization station or other suitable site for demobilizing National Guardsmen and Reservists.

The DOD should ensure that separating service members with disabilities receive all of the services provided under TAP as well as the separate DTAP session by the VR&E service.

Whenever practical, the DOD should make preseparation counseling available for members being separated prior to completion of their first 180 days of active duty unless separation is due to a service-connected disability when these services are mandatory.

The House and Senate Veterans' Affairs Committees should conduct oversight hearings regarding the implementation of P.L. 107-288 to ensure the President's National Hire Veterans Committee fulfills the following purposes:

> Raise employer awareness of the advantages of hiring separating service members and veterans; facilitate the employment of separating service members and veterans through America's Career Kit, the National Electronic Labor Exchange; and direct and coordinate departmental, state, and local marketing initiatives.

Congress should provide the DOL adequate funding to enforce Uniformed Services Employment and Reemployment Rights Act provisions.

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Licensing and Certification:

Recent separated service members should have the opportunity to take licensing and certification examinations without a period of retraining.

In recent years there has been an increased reliance on licensing and certification as a primary form of competency recognition in many career fields. This emphasis on licensing and certification can present significant, unnecessary barriers for transitioning military personnel seeking employment in the civilian workforce. These men and women receive exceptional training and on-the-job experience in their particular fields while on active duty, yet in most cases these learned skills and trades are not recognized by nonmilitary organizations.

Recommendation:

Efforts to enhance civilian awareness of the quality and depth of military training should be made to eliminate licensing requirements and employment barriers.

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Training Institute Inadequately Funded:

The National Veterans Training Institute (NVTI) lacks adequate funding to fulfill its mission.

The NVTI was established to train federal and state veterans' employment and training service providers. Primarily, these service providers are Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) specialists. DVOP/LVER specialists are located throughout the country at various locations, such as state workforce centers; Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) program offices; VA medical centers; Native American trust territories; military installations; and other areas of known concentrations of veterans or transitioning service members.

DVOP/LVER specialists help veterans make the difficult and uncertain transition from military to civilian life. They help provide jobs and job training opportunities for disabled and other veterans by serving as intermediaries between employers and veterans. They maintain contacts with employers and provide outreach to veterans. They also develop linkages with other agencies to promote maximum employment opportunities for veterans.

The NVTI was established in 1986 and authorized in 1988 by P.L. 100-323. It is administered by the Department of Labor Veterans Employment and Training Service (VETS) through a contract with the University of Colorado at Denver. The NVTI curriculum covers an array of topics that are essential to DVOP/LVER specialists' ability to assist veterans in their quest to obtain and maintain meaningful employment. Such topics include courses to develop the following:

- core professional skills,
- media marketing skills,
- case management skills,
- investigative techniques,
- quality management skills, and
- grants management skills.

Certain DVOP/LVER specialists may be required to participate in employment programs involving other state and federal agencies. The NVTI helps prepare DVOP/LVER specialists for their roles in programs such as the VR&E program and the Transition Assistance Program (TAP). The NVTI curriculum also includes information and training on the Uniformed Services Employment and Reemployment Rights.

The NVTI offers Department of Defense employees TAP management training through reimbursable agreements under the Economy Act (at actual cost of training). The NVTI also offers a Resource and Technical Assistance Center, a support center, and repository for training and resource information related to veterans programs, projects, and activities.

The Independent Budget veterans service organizations are concerned because, after several years of level funding, appropriations for the NVTI for FY 2005 actually decreased. This reduction compromises the ability of the institute to provide quality training to those individuals serving veterans.

Recommendation:

Congress must fund the NVTI at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.

VETS Program Assessment:

Performance standards in the Veterans Employment and Training Service (VETS) system are inconsistent and inadequate.

While progress is being made to implement the "Jobs for Veterans Act" (P.L. 107-288), there are still no *clear and uniform* performance standards that can be used to compare one state to another or even one office to another office within one state. Even where such benchmarks have been produced, the VETS headquarters and regional administrators have almost no authority to reward a good job or impose sanctions for poor performance. The only real authority is the seldom-used power to recapture funds when a state has acted in a way contrary to law.

Beginning in 2002, VETS initiated performance measures that apply to all veterans served by the public labor exchange. These measures address the rates of entry to employment and the rates of retention in employment. In 2004 the same performance measures were applied to veterans served by the Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) staff members. These reforms are essential to ensuring a viable job placement service. The ultimate goal is to accomplish the Congressional intent and purpose as expressed in title 38 U.S.C. § 4102:

The Congress declares as its intent and purpose that there shall be an effective:

> (1) Job and Job Training Counseling Service Program,
>
> (2) Employment Placement Service Program, and
>
> (3) Job Training Placement Service Program for eligible veterans…so as to provide such veterans and persons the maximum of employment and training opportunities.

For several years many veterans service organizations have expressed a need for qualification standards to be put in place for both DVOP and LVER staff. In 2005 draft legislation was proposed that would require the Secretary of the Department of Labor to establish such professional qualifications for employment in the two programs. While this concept is certainly welcomed and broadly supported, the legislation did not explain exactly how VETS would implement the new qualification standards.

The heart and soul of VETS efforts is the dedicated DVOPs and LVERs tasked with facing the employment challenges of hard-to-place veterans. For decades, DVOPs and LVERs have been the cornerstone of employment services for veterans. It is important for states to continue to be required to hire veterans for these positions in part because these individuals are veterans advocating for veterans. After all, DVOP and LVER staff are the front-line providers for services to veterans. They are the individuals who provide a smooth transition of service members from the military to the civilian workforce. These people should be veterans.

Recommendations:

VETS must complete development of meaningful performance standards and reward states that exceed the standards by providing additional funding.

Public Law 107-288, the Jobs for Veterans Act, authorizes VETS, through grants to states, to provide cash and other incentives to individuals who are most effective in assisting veterans, particularly disabled veterans, find work. This recognition is only for individuals and not entities. Congress should amend this law so such entities as career one-stops who do a good job for veterans can be recognized.

Congress needs to continue work on crafting legislation that will provide meaningful DVOP and LVER qualification standards, and provide the Secretary with the authority and direction to implement the standards.

National Cemetery Administration

The Department of Veterans Affairs (VA) National Cemetery Administration (NCA) currently maintains more than 2.6 million gravesites at 121 national cemeteries in 39 states and Puerto Rico. There are approximately 14,500 acres of cemetery land within established installations in the NCA. More than half are undeveloped and have the potential to provide more than 3.6 million gravesites. Of the 121 national cemeteries, 61 are open to all interments; 22 can accommodate cremated remains and family members of those already interred; and 38 are closed to new interments.

VA estimates that about 26.6 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, and the global war on terrorism, as well as peacetime veterans. Nearly 676,000 veteran deaths are estimated to occur in 2008, with the death rate increasing annually and peaking at 690,000 by 2009. It is expected that one in every six of these veterans will request burial in a national cemetery.

Expanding cemetery capacity is coincident with projections of expanding numbers of veteran deaths and interments performed by the NCA. In the "National Cemetery Expansion Act of 2003" (P.L. 108-109), Congress authorized the establishment of six new national cemeteries in the areas of Bakersfield, California; Birmingham, Alabama; Greenville/Columbia, South Carolina; Jacksonville, Florida; Sarasota, Florida; and southeast Pennsylvania.

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the armed forces. Therefore, the purpose of these cemeteries as national shrines is one of the NCA's top priorities. Many of the individual cemeteries within the system are steeped in history and the monuments, markers, grounds, and related memorial tributes represent the very foundation of these United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

The Independent Budget veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families despite funding shortfalls, aging equipment, and the increasing workload of new cemetery activations. We again call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

NCA ACCOUNT

The National Cemetery Administration (NCA) is responsible for five primary missions: 1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; 2) to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application; 3) to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries; 4) to award a presidential certificate and furnish a United States flag to deceased veterans; and 5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

As the veterans' population ages, demand for NCA services will remain high. In recent years the NCA burial rate has averaged more than 90,000 interments per year. According to VA projections, annual individual burials will peak in 2008. Clearly, NCA resources must keep pace, meeting the growing workload and increasing demands of interments, gravesite maintenance, cemetery repairs, general upkeep, and related labor-intensive requirements of cemetery operations.

If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of the national cemeteries.

The NCA is struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many U.S. cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. It is estimated that there is a need for 938 full-scale cemetery restoration and repair improvements at existing veterans cemeteries.

In accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* recommends Congress establish a five-year, $250 million program to restore and improve the condition and character of NCA cemeteries as part of this year's operations budget. Volume 2 of the independent study provides a systemwide comprehensive review of the conditions at 119 national cemeteries. It identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery, after taking into account the cemetery's age, its burial activity, burial options and maintenance programs. The estimated cost of completing these projects is $280 million.

To fulfill a national commitment to maintain national cemeteries as national shrines, the NCA will also need to hire additional staff. *The Independent Budget* veterans service organizations (IBVSOs) recommend that the NCA be provided adequate resources and authorization to hire an additional 30 full-time employees in fiscal year 2007. It is estimated that NCA will need approximately 120 full-time employees over the next several years to staff and maintain the six cemeteries authorized by Congress in P.L. 108-109.

In addition to the management of national cemeteries, the NCA has responsibility for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries, who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries.

The Independent Budget recommends:

- Congress should provide $214 million for fiscal year 2007 to offset the higher costs related to increased workload, additional staff needs, general inflation and wage increases, and an enhanced national shrine initiative.
- Congress should include as part of the NCA appropriation, $50 million for the first stage of a $250 million five-year program to restore and improve the condition and character of existing NCA cemeteries.

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of the national cemeteries. Congress needs to immediately address the condition of the NCA cemeteries and ensure they remain respectful settings for deceased veterans and visitors.

FY 2007 Recommendation (in thousands)

Administrative Services	$162,131
Shrine Initiative	50,000
Increased Workload (30 FTEE)	1,851
Total FY 2007 Recommendation	**$213,982**

NCA ISSUES

The National Cemetery Administration (NCA) is faced with a number of serious challenges. One of the most serious of these, described previously, is the provision of adequate funding to meet increasing demands of interments, gravesite maintenance, repairs, upkeep, and related labor-intensive requirements of cemetery operations. Another major challenge is to ensure that all national cemeteries are maintained in a manner appropriate to their status as national shrines and memorials of reverence.

The State Cemeteries Grant Program faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. Moreover, Congress faces the challenge of addressing the serious erosion in the value of burial allowance benefits. *The Independent Budget* veterans service organizations have identified these issues as critical to ensuring world-class, quality service delivery from the NCA and integral to the memory of all veterans who have served this country honorably and faithfully.

State Cemetery Grants Program:

Heightened interested in the State Cemeteries Grant Program (SCGP) results in stronger state participation and increased demands on the program.

The state cemetery grants program (SCGP) complements the National Cemetery Administration (NCA) mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1973, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials.

The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the "Veterans Benefits Improvements Act of 1998," the NCA has been able to strengthen its partnership with states and increase burial service to veterans, especially those living in less densely populated areas not currently served by a national cemetery.

States remain, as before enactment of the "Veterans Benefits Improvements Act of 1998," totally responsible for operations and maintenance, including additional equipment needs following the initial federal purchase of equipment. The program allows states in concert with the NCA to plan, design, and construct top-notch, first-class, quality cemeteries to honor veterans.

To help provide reasonable access to burial options for veterans and their eligible family members, The Independent Budget recommends $37 million for the SCGP for fiscal year 2007. The availability of this funding will help states establish, expand, and improve state-owned veterans cemeteries.

Recommendations:

Congress should fund the SCGP at a level of $37 million and encourage continued state participation in the program.

Congress should recognize the increased program interest by the states and provide adequate funding to meet planning, design, construction, and equipment expenses.

The NCA should continue to effectively market the SCGP.

Veterans Burial Benefits:

Veterans' families do not receive adequate funeral benefits.

There has been serious erosion in the value of burial allowance benefits over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a small fraction of what they covered in 1973, when the federal government first started paying burial benefits for our veterans.

In 2001 the plot allowance was increased for the first time in more than 28 years, to $300 from $150, which covers approximately six percent of funeral costs. *The Independent Budget* recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

In the 108th Congress, the allowance for service-connected deaths was increased from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. Clearly, it is time this allowance was raised to make a more meaningful contribution to the costs of burial for our veterans. *The Independent Budget* recommends increasing the service-connected benefit from $2,000 to $4,100, bringing it back up to its original proportionate level of burial costs.

The nonservice-connected benefit was last adjusted in 1978, and today it also covers just six percent of funeral costs. *The Independent Budget* recommends increasing the nonservice-connected benefit from $300 to $1,270, bringing it back up to the original 22 percent level. Finally, *The Independent Budget* veterans service organizations recognize the need to adjust burial benefits for inflation annually to maintain the value of these important benefits.

Recommendations:

Congress should increase the plot allowance from $300 to $745 and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected benefit from $2,000 to $4,100.

Congress should increase the nonservice-connected benefit from $300 to $1,270.

Congress should enact legislation to adjust these burial benefits for inflation annually.

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