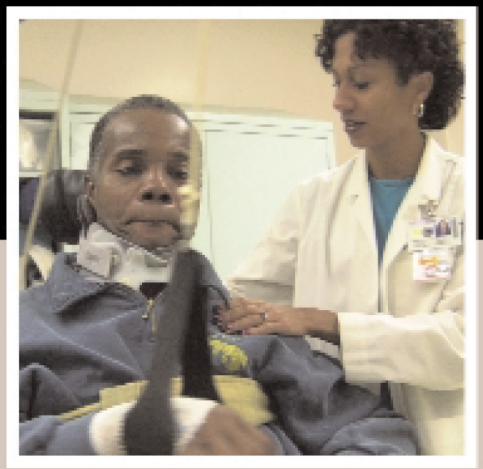
The Independent BUDGET

FISCAL YEAR 2005



A Comprehensive Budget and Policy Document Created by Veterans for Veterans

Prologue

This is the 18th year *The Independent Budget* has been developed by four veterans service organizations (VSOs): AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and 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 Independent Budget 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.

As in years past, the budget and appropriations for veterans programs for fiscal year 2005 will line up as discretionary spending in tortured competition with all other domestic discretionary programs funded by the Federal Government. *The Independent Budget* VSOs 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 2 years alone, Congress has failed to even pass a VA appropriations bill until months into the 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.

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FY 2005 *INDEPENDENT BUDGET* ENDORSERS

Administrators of Internal Medicine

Alliance for Academic Internal Medicine

AdvaMed

Alliance for Aging Research

American Federation of Government Employees, AFL-CIO (AFGE)

American Military Retirees Association, Inc.

American Osteopathic Association

American Psychiatric Association

American Thoracic Society

Association for Assessment and Accreditation of Laboratory Animal Care International (AAALAC)

Association of American Medical Colleges

Association of Professors of Medicine

Association of Program Directors in Internal Medicine

Blinded Veterans Association (BVA)

Blue Star Mothers of America, Inc.

Catholic War Veterans, USA, Inc.

Clerkship Directors in Internal Medicine

CO State Veterans Nursing Home

Jewish War Veterans of the U.S.A.

Legion of Valor of the United States of America, Inc.

Military Officers Association of America

Military Order of the Purple Heart

National Alliance for the Mentally Ill

National Association of County Veterans Service Officers

National Association of State Veterans Homes

National Association of Veterans' Research and Education Foundations

National Mental Health Association

Nurses Organization of Veterans Affairs (NOVA)

Veterans Affairs Physician Assistant Association

Veterans of the Vietnam War, Inc.

Vietnam Era Veterans Association

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 prosthetics 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

For the 18th year, *The Independent Budget* veterans service organizations (IBVSOs) and their endorsers face the task of predicting the needs of veterans in the coming fiscal year and determining the resources needed to meet those needs. The Department of Veterans Affairs (VA) and the veterans it serves are severely challenged by the skyrocketing cost of health care, surging demand for services from an aging veteran population, and eroding value of benefits. In addition, VA once again is faced with entering the second quarter of FY 2004 operating on a continuing budget resolution at the FY 2003 level.

Again this year *The Independent Budget* (IB) recommends Congress take action to enact legislation providing adequate mandatory funding for the VA health-care system. The annual budget crisis only adds to the continuing struggle veterans face in obtaining timely and quality health care. Demand on the system continues to rise; prescription drug, medical equipment, supplies, and staffing costs continue to soar, yet VA is expected to operate on last year's funding level.

The Independent Budget is a needs-based budget. This FY 2005 recommendation builds on our FY 2004 proposal, based on commonly accepted percentages for staffing and inflation adjustments for the coming fiscal year. The *IB* uses existing VA projections for health-care demand and acknowledges the importance of the VA Medical and Prosthetic Research Program with a suitable increase. This year's *IB* recommends a sizeable increase in funding for major and minor construction to help eliminate the backlog caused by a virtual moratorium on facility improvement funding and to provide a "down payment" on advance planning and construction for enhancements provided for in the Capital Asset Realignment for Enhanced Services (CARES) recommendations to be announced in the second quarter of FY 2004. With the loss of increasing numbers of our senior generation of veterans, we call for major expansion and improvements in the VA Cemetery Program.

On the benefits side, *The Independent Budget* continues to be concerned over the backlog in claims processing. VA has made determined efforts to streamline and improve the adjudication process; however, the backlog and the time it takes to process a claim remain entirely too long. The *IB* also reiterates its concern over the declining value of benefits, such as automobile adaptive equipment, specially adapted home grants, burial benefits, and insurance programs that continue to decline in value because of a lack of increases, in some cases, for years.

The Independent Budget covers the broadest possible spectrum of veterans' benefits and services with recommendations on each to make certain we keep the Nation's obligation to those who have served and sacrificed so much in its defense.

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

	FY 2004 Appropriation	FY 2005 Administration Request	FY 2005 IB Recommended Appropriation
Veterans Health Administration			
Medical Care[1]	$26,630,030	$26,939,774	$29,791,488[3]
Medical and Prosthetic Research	405,593	384,770	460,000
National Program Administration/MAMOE[2]	78,673	78,826	86,690
Subtotal, Veterans Health Administration	27,114,296	27,403,370	30,338,178
Departmental Administration			
Veterans Benefits Administration (VBA)	999,071	1,027,193	1,286,765
General Administration	276,630	297,560	330,750
General Operating Expenses Subtotal (GOE)	1,275,701	1,324,753	1,617,515
National Cemetery Administration	143,352	148,925	175,000
Office of the Inspector General	61,634	64,711	62,000
Subtotal, Departmental Administration and Miscellaneous Programs	1,480,687	1,538,389	1,854,515
Construction Programs			
Construction, Major Projects	271,081	458,800	571,000
Construction, Minor Projects	250,656	230,779	545,000
Medical Center Master Planning	—	—	100,000
CARES Facility Planning & Individual Project Development	—	–	–
Parking Revolving Fund	—	—	—
Grants for Construction of State Extended Care Facilities	101,498	105,163	150,000
Grants for Construction of State Veterans' Cemeteries	31,811	32,000	37,000
Subtotal, Construction Programs	655,046	826,742	1,403,000
Total, Discretionary Programs	**$29,250,029**	**$29,768,501**	**$33,595,693**

[1]Medical Care figures for FY 2004 and FY 2005 request include $270 million reflected as collections in the Administration's budget request.
[2]MAMOE is currently known as National Program Administration (NPA). Amounts in FY 2004 and FY 2005 Administration's budget request reflect NPA request less $8.3 million realigned from Medical Care reimbursements.
[3]Does not include third-party collections.

Benefit Programs

Ours is a nation that holds a special appreciation and high regard for those who have served in our Armed Forces. Ours is a nation that recognizes a profound indebtedness to those who have borne extraordinary burdens and made extraordinary sacrifices to defend our national interests. Through our Government, we therefore provide special assistance to veterans and their dependents to fulfill our Nation's obligation to make up for the effects of disadvantages from disabilities incurred in connection with military service and education and employment opportunities forgone or lost during service in our Armed Forces.

For budgetary classification, the benefit programs are grouped into three major categories:

(1) compensation and pensions, which also includes the appropriations for burial benefits, miscellaneous assistance, and special benefits for children of Vietnam veterans;

(2) readjustment benefits, which includes specially adapted housing grants, vocational rehabilitation programs, educational benefits, housing loans, and automobiles and adaptive equipment; and

(3) insurance programs.

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 dependency and indemnity compensation (DIC). Disability pensions provide a measure of financial relief for needy veterans of wartime service who are totally disabled by nonservice-connected causes. 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 attorney fee awards under the Equal Access to Justice Act and other special allowances for smaller select groups of veterans and dependents. 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 Department of Veterans Affairs (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.

The Post-Vietnam Era Veterans Education Program provides educational assistance to veterans who entered service between December 31, 1976, and July 1, 1985. This assistance is funded by the contributions participating veterans made during their service and matching funds from the Department of Defense (DOD).

Under its home loan program, VA guarantees home loans for veterans, certain surviving spouses of veterans who have not remarried, certain servicemembers, and eligible reservists and National Guard personnel. VA also makes direct loans to supplement specially adapted housing grants. Under a program authorized until December 31, 2005, 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 servicemembers 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 recommend the following.

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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 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.

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 recommends year after year that Congress make the round-down requirement a permanent part of the law. While rounding down compensation rates for 1 or 2 years may not seriously degrade its effectiveness, the cumulative effect over several years will substantially erode the value of compensation. Moreover, extended (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 Administration recommendations to permanently extend provisions for rounding down compensation COLAs and allow the temporary round-down provisions to expire on their statutory sunset date.

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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 8-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 servicemember 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 (IBVSOs) 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.

Concurrent Receipt of Compensation and Military Retired Pay:

All military retirees should be permitted to receive military retired pay and VA disability compensation concurrently.

Some former servicemembers 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. Although the offset is being phased out for veterans 50% or more disabled, this is especially inequitable where the military retiree is totally precluded from employment by service-connected disability and is still adversely affected during the 10-year phase-out period.

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 the 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 IBVSOs 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.

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, VA 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 IBVSOs 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.

Recovery of Taxes on Disability Benefits:

To permit veterans to recover taxes improperly withheld, Congress should enact an exception to the 3-year limitation on amendment of tax returns.

Section 104(4) of title 26 United States Code (U.S.C.) exempts from taxable income "allowance for personal injuries or sickness resulting from active service in the armed forces." Similarly, 38 U.S.C. § 5301(a) provides that benefits due or to become due under any law administered by VA "shall be exempt from taxation." In *St. Clair v. United States*, 778 F. Supp. 894 (E.D. Va. 1991), the district court affirmed that the law excludes disability severance pay from taxable income.

The Internal Revenue Service (IRS) acquiesced in the district court's ruling, and veterans may amend their tax returns to recover amounts illegally taxed. Nonetheless, taxes are still being withheld from disability severance pay, and veterans must claim a refund or file an amended return to recover these taxes. However, the 3-year statute of limitations on amending tax returns prevents veterans whose improper taxation occurred more than 3 years before the court's decision or their learning of this unlawful taxation from recovering amounts the IRS unlawfully withheld.

Additionally, where entitlement to disability compensation is established retroactively but not paid because the veteran received military retired pay during the period, the portion of the taxable retired pay that VA would have paid as nontaxable disability compensation but for the delayed award becomes nontaxable. The veteran may file an amended return to recover the excess taxes paid. Again, the 3-year limitation bars recovery of taxes for periods beyond that time.

Therefore, because of Government error, disability severance pay was improperly taxed, and this may have occurred more than 3 years previously. Additionally, retroactive compensation entitlement for more than 3 years would occur only where awards were delayed because of error reversed on appeal. In both instances, circumstances beyond the veteran's control may prevent timely amendment of tax returns. An exception to the 3-year limitation is fully justified to correct this inequity. Indeed, the IBVSOs maintain that taxes should not be withheld from disability severance pay and that necessary changes should be made to the law to discontinue this unnecessarily burdensome practice. The IBVSOs urge Congress to enact legislation to remedy this problem.

Recommendation:

Congress should amend the law to provide for an exception to the 3-year limitation on amendment of tax returns in the case of erroneous taxation of disability severance pay or in the case of retroactive exemption of more than 3 years and should change the law to discontinue the withholding of taxes from disability severance pay.

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Exclusion of Compensation as Countable Income for Federal Programs:

Disability compensation should not be counted as income for purposes of eligibility for assisted housing through the Department of Housing and Urban Development and other means-tested Federal programs.

Current policy at the Department of Housing and Urban Development (HUD) considers nontaxable service-connected disability compensation provided by VA to be countable income when determining a veteran's eligibility for HUD's Assisted Senior Housing Program. In some cases, particularly when income is limited to Social Security and VA disability compensation, our aging veterans are being denied access to this program because their VA compensation places them above an established income threshold. This compassionate program must be available to those veterans who have severely limited incomes. The principle that disability compensation should not be counted as income should extend to all Federal programs.

Recommendation:

Congress should enact legislation to exempt VA disability compensation from countable income for purposes eligibility for federally funded programs.

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Service-Connection for Smoking-Related Disabilities:

Congress should reverse its action that took money from veterans' disability compensation to pay for over-budget spending on transportation programs.

In 1998, Congress changed the law to prohibit service-connection for disabilities related to smoking. Under the pretext of making an appropriate change in law for genuine public policy purposes, Congress enacted, in a transportation bill, a provision concocted to generate savings from the veterans' disability compensation program to pay for over-budget spending on politically popular transportation programs. This unprecedented raid on veterans' programs for the ignoble purpose of paying the cost of massive pork-barrel spending was a shameful injustice against veterans. At a cost of $217 billion, this transportation bill contained nearly 1,500 pork projects and exceeded by $26 billion the spending caps set in the balanced budget bill of the year before.

Compensation for smoking-related disabilities provided a convenient target for those with the motive of finding money to satisfy their appetite for big spending. The target was convenient because it was easy to get similarly inclined members to subscribe to the superficial arguments that veterans should not be compensated for disabilities that result from their personal choice to use an injurious product. It was made an attractive target for those who coveted the money for their own use by exaggeration of the costs of smoking-related compensation for the calculated purpose of artificially increasing the amount of spoils it would yield to those who would capture it as their prize. As a result, they obtained $15.5 billion to pay for increased spending of massive proportions on transportation programs.

It is easy to subscribe to the notion that veterans should not be compensated for illnesses that result from their personal choice to smoke cigarettes. However, the argument that this is merely a matter of personal choice or responsibility is more than a deceptive oversimplification: It is a misrepresentation. The question of whether these are disabilities that should be compensated cannot be answered so simply. Indeed, when the question is considered in the depth required to arrive at a fair, judicious conclusion, the injustice of the prohibition against service-connection is easily seen.

Cigarettes have been one of our country's major mass-marketed products since the 1920s. Citizens across all socioeconomic levels have used tobacco for pleasure or have been enticed by its glamorization and romanticization in books, motion pictures, advertising, and in our society in general. Only recently has there been a serious shift in public attitude about smoking and serious proposals to regulate tobacco for public health reasons.

Smoking has traditionally been even more prevalent among members of our Armed Forces. The DOD has been perhaps our Nation's largest distributor of cigarettes. The DOD has long been in the business of discounting tobacco products and subsidizing smoking among servicemembers. In past years, many of the images of soldiers included cigarettes dangling from their mouths. Cigarettes were an integral part of military life. Survey data compiled in connection with a study for VA showed that more than 70% of veterans, as compared to about 50% of the U.S. adult population, had a history of smoking. Findings from that study indicate that a significant proportion of veterans started smoking while on active duty. The higher incidence of smoking among veterans can be explained by a military environment and culture that encouraged and facilitated smoking.

Smoking was much more of a social activity in the military setting than it was in civilian life. Part of that was due to the inherent nature of the military environment, and part was due to the military's own use of tobacco as a small and relatively inexpensive but effective way to help servicemembers cope with that difficult environment.

During rigorous training and combat operations, smoking often provided the only opportunity for a brief distraction or escape from the stresses or drudgery of the moment. Smoking provided the only coping tool immediately accessible. Drill instructors and others in control of military units used smoking as the activity for occupying servicemembers during breaks. Servicemembers looked forward to those breaks as their only respite and pause from combat and the rigors of military training and duties. Smoking was also an ever-present part of

the restricted social activities available to servicemembers in isolated military settings.

Perhaps it was for these reasons that the military establishment became a partner with the tobacco companies in distributing cigarettes and promoting tobacco use among members of the military services. It is well established that the Armed Forces, under various legal authorities, provided rations of tobacco to servicemembers. Free cigarettes were provided to them during combat tours. Free cigarettes were included in C-rations, and, as noted, cigarettes were provided at substantially discounted prices in military exchanges. Thus, we can accurately state that smoking was not only fully approved of by the Armed Services, it was encouraged and facilitated by the military on a level probably unparalleled anywhere else in our society.

Like the recent groundswell of anti-tobacco sentiments, the Government's opposition to tobacco-related benefits for veterans is of recent advent and, within VA, represents an abrupt—and convenient—reversal of policy. Given the Government's complicity in tobacco use among veterans, VA's self-righteous hypocrisy and the Government's ulterior motive for enacting this legislation become all the more reprehensible.

Under the law, service-connection is awarded for any disability incident to service. Disabilities due to willful misconduct are an exception to that rule, however. "Willful misconduct" is "an act involving conscious wrongdoing or known prohibited action." It means a deliberate or intentional act with "knowledge of or wanton and reckless disregard" of its probable consequences. Tobacco use has never been a prohibited action. On the contrary, as noted previously, tobacco use was fully authorized and approved by the military. VA has held expressly that tobacco use is not willful misconduct. In 1964, Administrator's Decision No. 988 pointed out that smoking is not deemed willful misconduct by VA. The Omnibus Reconciliation Act of 1990 amended sections 105(a), 1110, and 1131 of title 38, United States Code, to include "abuse of alcohol or drugs" as disabilities for which service-connection is barred. However, smoking did not fall within the definition of drug abuse for VA purposes. In that application, "drug abuse" means use of illegal drugs, use of illegally or illicitly obtained prescription drugs, intentional use of prescription or nonprescription drugs for purposes other than their medically intended use, and use of substances to enjoy their intoxicating effects.

It would be the height of hypocrisy for Congress or VA to declare smoking misconduct when VA provided free tobacco to hospitalized veterans under authority of a statute enacted by Congress, a law that has not been repealed. To do so would suggest the Government abetted misconduct.

Congress's action to prohibit service-connection for smoking-related illnesses was inequitable and inconsistent with the Government's position on who is responsible for the adverse health effects of smoking. During decades of litigation, the cigarette manufacturers paid not even a single dollar in damages for the injurious effects of smoking. They successfully invoked the defense that smokers were personally responsible for the consequences of smoking because they "assumed the risk" by knowingly using a potentially harmful product. Those suing the tobacco companies persisted, nonetheless, and that defense is no longer recognized as viable because it has come to light that the tobacco companies concealed from consumers much about the injurious and addictive effects of tobacco use.

It is on the premise that the cigarette manufacturers, and not smokers, are responsible for the effects of smoking that the state governments and the Federal Government are recouping from the tobacco industry billions of dollars for costs of tobacco-related health care provided to government beneficiaries. Yet the Clinton Administration disingenuously invoked the very defense the Government rejected as an excuse for depriving veterans of compensation. Congress, seeing that this was the way to fund its own pork-barrel spending, seized upon the President's proposal.

While the Government's position in the litigation against tobacco companies rested on the premise that these consumers could not themselves be held responsible for their own tobacco use inasmuch as they were not undertaking a potentially harmful activity with full knowledge of its risks and probable consequences, the President's proposal to prohibit compensation for veterans rested on a contrary premise. The contrary premise was that veterans were somehow in a position of knowledge and understanding superior to that of all other consumers and thereby voluntarily exposed themselves to a known danger of which they appreciated the nature and

extent and thus must be held personally responsible and not entitled to compensation.

There was no proposal to prohibit other Government benefits on this basis. For example, disability and health-care benefits continue under other Federal programs even though smoking may have played a role in causing the illness and disability.

Accordingly, considering that smoking was encouraged by the Armed Forces with the result of a higher incidence of smoking among veterans, considering that veterans were no more aware of the inherent risks of smoking than the general public, and considering that no other Federal programs prohibit disability or medical benefits for conditions related to smoking, no rational basis exists for holding veterans to a different standard and singling them out for disparate and punitive treatment.

In its quest to get veterans' benefits to fund increased spending on transportation, Congress paid little attention to the merits of a prohibition against service-connection. The manner in which the provision was enacted demonstrates that it was the money and not the merits that provided the momentum behind this legislation.

Certainly it is arguable that anyone entering military service today should be deemed to have full knowledge of the risks of smoking. We would not oppose a prohibition of service-connection for disabilities shown by clear and convincing evidence to have been caused by smoking alone if the law applied to persons who enter military service on or after the date of enactment of the law. The current prohibition should be repealed, however.

Recommendation:

Congress should repeal its prohibition on service-connection for smoking-related disabilities.

Compensable Disability Rating for Hearing Loss Necessitating Hearing Aid:

VA's disability rating schedule should provide a minimum 10% 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%, 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% disability evaluation for any hearing loss for which a hearing aid is medically indicated.

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 1 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.

While the effective date of the temporary total disability rating corresponds to the beginning date of hospitalization or treatment, under 38 U.S.C. § 5111 the effective date for payment purposes is delayed 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 IBVSOs 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.

READJUSTMENT BENEFITS

Montgomery GI Bill

Expansion of Montgomery GI Bill Eligibility:

Servicemembers who in every respect are at least equally entitled to participate in the Montgomery GI Bill as servicemembers 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 servicemember 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 servicemember 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, servicemembers 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.

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, servicemembers 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 IBVSOs 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.

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.

VA 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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Adequate Fees for Compliance Inspectors:

The current limitation on fees for compliance inspectors makes it difficult to obtain the services of qualified inspectors in some instances.

VA assumes the responsibility to ensure that specially adapted housing is properly constructed in compliance with the construction contract and according to the needs of the disabled veteran. To ensure that specially adapted housing conforms to the pertinent specifications and standards, VA uses contract inspectors. Currently, VA pays a maximum of $65 for compliance inspections. This amount is not sufficient to allow for geographic differentials and the variety of technical backgrounds of inspectors to ensure that competent inspections are performed.

Recommendation:

Congress should amend chapter 21 of title 38, United States Code, to authorize payment of reasonable fees, including travel reimbursements, for compliance inspections on housing being constructed or adapted under the specially adapted housing program.

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.

VA provides certain severely disabled veterans and servicemembers 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% of the average cost of a new automobile, and later 80%. 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% 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% of the 1946 cost, but the automobile allowance of $5,500 was only 343% of the 1946 award. Currently, the $11,000 automobile allowance represents only about 42% of the average cost of a new automobile, which is $26,163. To restore the comparability between the cost of an automobile and the allowance, the allowance, based on 80% of the average new vehicle cost, would be $20,930.

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% of the average cost of a new automobile in 2003. 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% of the average cost of a new automobile and provide for automatic annual adjustments in the future.

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Home Loans

Increase in Amount of VA Guaranty:

Average housing costs in some areas have risen to amounts that make the maximum VA guaranty insufficient to allow veterans to purchase homes with VA-guaranteed mortgages.

To make home ownership easier for eligible veterans and others, the VA home loan guaranty program creates conditions in which private lenders extend credit under more favorable terms than would generally be extended in the commercial mortgage market. By guaranty of repayment, the VA protects lenders against loss. This VA obligation to ensure repayment allows lenders to make loans without borrower down payments and other safeguards that would generally be necessary under conventional lending practices. However, when the maximum amount of the VA guaranty does not keep pace with rising home costs, veterans who must rely on VA guaranties are frozen out of the home market or are limited in their ability to acquire suitable homes.

The maximum amount of the VA guaranty effectively limits the maximum loan that can be made without a down payment. When the total guaranty does not at least equal what the lender would require as a down payment on a loan not guaranteed (e.g., 25% of the total loan), the lender will not provide a VA-guaranteed loan unless the borrower can make up the difference with a down payment. With the current maximum guaranty of $60,000, and the general requirement that 25% of the loan be covered by the guaranty, persons wishing to purchase homes with VA-guaranteed mortgages are in effect limited to homes costing a maximum of $240,000.

Until 1999, the VA loan limit was always significantly higher than the Federal Housing Administration (FHA) home loan limit. Since 1999, when FHA loans were indexed to the Federal National Mortgage Association ("Fannie Mae") and Federal Home Loan Mortgage Corporation ("Freddie Mac") conforming mortgage loan limit—which is adjusted annually to reflect increases in housing costs—FHA loan ceilings have risen substantially higher than the maximum loans for veterans. The FHA limit is 87% of the conforming loan limit. Starting January 1, 2004, the new Fannie Mae–Freddie Mac single-family loan limit will increase from $322,700 to $333,700, and the FHA limit will therefore increase to $290,319.

Home loans for veterans should be more generous than those available to other citizens under the FHA. The IBVSOs recommend that the VA home loan guaranty be set to allow maximum loans at 90% of the Fannie Mae–Freddie Mac conforming loan limit, with automatic annual indexing to the conforming limit. For 2004 the amount of the maximum VA loan under

that formula would be $300,330, which would require an increase in the maximum VA guaranty to $75,082.50. The IBVSOs recommend that the maximum VA guaranty be increased to $75,085 for 2004.

Recommendation:

To keep pace with the rising costs of housing, Congress should increase the maximum VA home loan guaranty to $75,085 for 2004 and provide for automatic annual indexing to 90% of the Fannie Mae–Freddie Mac loan ceiling thereafter.

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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 VA 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, VA life insurance policies from consideration in determining entitlement under other Federal programs.

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Service-Disabled Veterans' Insurance (SDVI)

Lower Premium Schedule to Reflect Improved Life Expectancy:

VA should be authorized to charge lower premiums for 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. VA therefore offers disabled veterans life insurance at standard rates under the SDVI program. 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. However, VA continues to base its rates on mortality tables from 1941. 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 SDVI Coverage:

The current $10,000 maximum for life insurance under SDVI 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 servicemembers 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, some 87 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 (VMLI)

Increase in VMLI Maximum Coverage:

The maximum amount of mortgage protection under 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

The Department of Veterans Affairs (VA) administers veterans' benefit programs through its central office in Washington, DC, and a nationwide system of regional and benefit offices. 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 IBSVOs make the following recommendations for improving VA performance and service to veterans.

General Operating Expense Issues

VETERANS BENEFITS ADMINISTRATION
VBA Management

Line Authority over Field Offices:

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.

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 VBA's problems to unclear lines of accountability. NAPA found that a sense of powerlessness to take action 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 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.

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.

Departmental Policy for Veterans' Programs

Improvements in Rulemaking:

Today's Department of Veterans Affairs is misusing its rulemaking authority for self-serving purposes and to orchestrate an insidious erosion of veterans' rights.

From America's beginnings, our citizens recognized that our Nation's very existence and future depended on a strong army and navy. They appreciated the fundamental necessity and exceptional value of military service. On the principle that those who devote part of their youth and risk their lives and health to defend their Country deserve special treatment and advantages over those who do not, our people have, through Congress, accorded veterans special honors and provided for generous benefits. Consistent with our indebtedness to veterans and our deep appreciation for their contributions and sacrifices, our citizens have charged VA with providing veterans seeking benefits with the highest level of personal service and assistance in obtaining those benefits. Every effort is to be made to help veterans apply for, and establish entitlement to, the benefits they claim; within the law, VA must endeavor to grant them the benefits they seek. For VA to create procedural impediments or substantive rules to limit veterans' rights offends the very essence and spirit of benefits for veterans and is antithetical to the intent of our grateful nation as expressed in the laws of Congress.

Congress has repeatedly stated its intent that the ultimate goal of VA's unique process is to ensure veterans receive every benefit to which they are entitled. That goal overrides agency convenience and expedience, and toward that end, the VA system must afford veterans advantages not afforded to claimants in other agencies. When enacting legislation to improve the process, Congress has frequently sought to preempt any misinterpretation of its intent that would formalize or make VA claims procedures burdensome for veterans. On these occasions, Congress has gone to great lengths to emphasize and reaffirm its intent to preserve the "pro-claimant bias," informality, and helpful nature of the process. Congress expressly stated it intends that no changes be made to the existing system except to further the goals, informality, accuracy, and fairness.

The Federal Courts have reaffirmed on many occasions the principle that laws governing veterans' benefits are to be liberally construed in favor of veterans. It is a well-settled rule of statutory construction that ambiguities in such statutes are to be resolved in favor of veterans.

Historically, VA's regulations were drafted to reflect these benevolent goals and the special treatment and considerations to be accorded veterans seeking benefits. For example, a longstanding VA regulation begins with this declaration: "It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation." 38 C.F.R § 3.102 (2003). In another regulation, the essence of VA policy is articulated with this statement: "Proceedings before VA are ex parte in nature, and it is the obligation of VA to assist a claimant in developing the facts pertinent to the claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government." 38 C.F.R. § 3.103 (2003).

Regrettably, with its decisions immune to judicial review and VA operating in what has been described as a state of "splendid isolation" for most of the 20th century, VA adjudicators often ignored the liberal provisions of VA regulations. With the advent of judicial review, the courts began enforcing the letter and spirit of the law and these regulations. In reaction, VA began to construe the statutes as narrowly as possible to limit veterans' entitlements, and it began to rewrite its rules in ways designed to diminish veterans' rights, to make the process more burdensome and formal, and to serve for VA's own advantage, convenience, and purposes rather than to serve the interests of veterans.

Although VA's Special Regulations Rewrite Task Force has initially shown signs of adhering to VA's pro-veteran mission in its rewrite of part 3 of title 38 C.F.R.—and we hope the final product will reveal good intentions—generally, when VA writes new regulations, they no longer have the traditional pro-veteran tone. They often have a negative, restrictive focus. They appear calculated to give VA the upper hand against claimants and to impair veterans' due process

rights or access to an open claims process and benefits. Today's VA regulations are too often self-serving: They are designed for VA expedience and to incorporate VA's resistance to liberalizing legislation. Sometimes, their apparent aim is to inhibit what VA cannot prohibit. VA exploits opportunities to reinterpret statutory provisions to remove from its longstanding regulations provisions that are favorable to veterans. With aloofness, VA pays little real attention to public comments and offers flimsy rationales for brushing them aside. VA's justifications in response to public comments sometimes suggest pretext and are tenuous, specious, shallow, or as arbitrary as the text of the rules themselves. VA vigorously defends narrow or restrictive judicial interpretations of its regulations that are adverse to veterans but actively seeks to overturn judicial constructions that are more favorable to veterans than VA desires.

Outraged veterans' organizations have begun to challenge more frequently VA's regulations, but, consistent with courts' tendency to indulge Federal agencies, the results have been mixed, despite special canons of statutory construction intended to favor veterans. While veterans' organizations have had some successes in getting the most objectionable regulations invalidated, the courts have sometimes strained to defer to VA rules, and veterans' organizations have sometimes not prevailed even in exceptionally meritorious challenges. As one court noted, this practice of judicial deference "all too often is taken to mean simply that administrative agencies win any dispute involving statutory construction." *Mid-America Care Foundation v. National Labor Relations Board*, 148 F.3d 638, 642 (6th Cir. 1998). VA's awareness of these circumstances appears to embolden it in its arbitrary rulemaking.

In matters of veterans' rights, this type of agency behavior must not be tolerated. If the Secretary of Veterans Affairs is unwilling to rein in those who write his regulations and if the courts continue to permit such behavior, Congress should act to impose special constraints and requirements upon VA's rulemaking to ensure VA carries out the will of the people to treat veterans as a special class; to ensure that VA does not deal with veterans grudgingly, indifferently, or at arm's length as if they were ordinary litigants or claimants for Federal benefits; and certainly to ensure that VA does not treat veterans like adversaries.

As has often been observed, veterans have unique needs, the nation has an extraordinary obligation to meet those needs, and the VA system is therefore a unique system with an extraordinary mission. The procedures, rules, and remedies of other forums or agencies are frequently improperly suited or inadequate for the administration of veterans' programs. In view of the hardening of VA's regulations and its departure from the benevolent role assigned to it by Congress, specially tailored laws may become necessary to bring VA's rulemaking back in line with its unique mission as the nation's patron and benefactor for veterans.

Recommendations:

The Secretary of Veterans Affairs should act decisively to put an end to VA's self-serving rulemaking; if the Secretary does not, Congress should

(1) scrutinize VA's rulemaking more closely as part of its oversight role,

(2) intervene to override VA rules that run counter to Congressional intent, and

(3) enact special provisions to control VA rulemaking if the Secretary of Veterans Affairs fails to bring VA's rulemaking back in line with Congressional intent and VA's benevolent mission.

Compensation and Pension Service

Improvements in Claims Processing Accuracy:

To reduce the error rate and to avoid unacceptably large case backlogs and protracted processing times in veterans' compensation and pension claims, the Veterans Benefits Administration (VBA) must address the root causes of its quality problems.

The inability of the VBA to process and decide veterans' compensation and pension (C&P) claims accurately and timely is widely recognized as one of the most serious and persisting problems affecting VA and veterans. This problem has seriously degraded VA's ability to fulfill its mission of assistance to veterans and its corresponding responsibilities to them under the law. It has prevented disabled veterans from receiving, within a reasonable time, the compensation or pension they often urgently need to relieve the economic effects of disability. Although this problem plagued VA for several years, VA's various initiatives and plans have failed to solve the problem. Rather, while the number of C&P claims decreased substantially over the past decade, the claims backlog continued to grow larger because production declined and because high error rates necessitated rework of large numbers of cases, thereby adding to the workload of an already overburdened system.

The historical dynamics of this intolerable situation include flawed policies. In a climate of immunity from outside review over several decades, a culture and mind-set developed within VA whereby adjudicators began making decisions based on their own personal beliefs, attitudes, and predilections. Unwritten rules evolved, and arbitrary practices became ingrained. The decisions were based more on these unwritten rules and practices than the law. As a result, angry veterans demanded, and eventually received, the right to have judicial review of VA decisions.

The courts found fundamental departure from the law in numerous areas. For a while VA attempted to resist the precedents of courts. Then VA found that its adjudicators were poorly equipped to interpret and apply case law. Other factors, such as budget reductions and inadequate resources, intervened to compound the predicament. Rather than address the problems directly, VA management went through a period of denial and blamed its problems on judicial review.

The claims backlog grew. VA management began to press for increased production. VA further compromised quality for quantity. Alarming claims backlogs, and consequent pressure from Congress and the veterans community, eventually forced VA to devote more meaningful attention to this serious problem. By that time, poor quality pervaded the claims processing system and the backlog was enormous. VA's own internal study revealed poor quality as the major cause of its inefficiency, but the poor quality was rooted in other factors, such as inadequate training and resources. Poor quality was a precipitating cause of the backlog and then, with the focus on production, also became an effect of the backlog.

To break this vicious cycle, VA needed a technically sound strategy and effective implementation. In its business process reengineering (BPR) plan, it had a well-designed and technically sound strategy to address the root causes, but VA management failed to take the decisive action necessary to implement the plan. In addition, while the BPR plan correctly identified the root causes in process and set out appropriate remedies, it did not address the paramount need to change the negative institutional culture and strengthen management within VA. These flaws seriously hindered progress in implementing the plan's reforms. Today, VA still struggles with the same enormous problem.

Studies by various panels, commissions, and other bodies have failed to produce effective solutions because they have either recommended reducing veterans' rights and benefits to reduce VA's workload and thus accommodate its inefficiency or they have lost focus and strayed away from the root causes to various incidental and contributing factors. Reducing veterans' rights and benefits to allow VA to remain inefficient is indefensible, and any viable and effective solution will necessarily require that VA first address the root causes.

In its October 2001 report, the VA Claims Processing Task Force made beneficial recommendations, but implementation of these recommendations has not resulted in the kind of systemwide and sustained improvements necessary to overcome the problem. Although VA has gained ground in reducing its large backlog of pending claims for disability benefits, these gains appear more the result of targeting of resources and stop-gap measures than systematic improvements in quality and accountability for accuracy. Indeed, in 2001, despite large numbers of inexperienced adjudicators and complex new procedural requirements in the Veterans Claims Assistance Act of 2000, which would be expected to both slow claims dispositions and result in increased errors, VA shifted its emphasis to increased production to meet goals of reducing the claims backlog. Under this emphasis on production, VA regional office directors became accountable for production targets; some were required to develop plans to increase production but not quality; and performance awards were based primarily on production. VA awarded bonuses for production to some regional offices that had not met VA accuracy standards. Quality again took a back seat to quantity. During fiscal year 2002, VA increased its number of claims decisions by two-thirds. Thus, there were three factors that each would be expected to have a negative effect on accuracy: increased production with a corresponding lack of emphasis on quality, inexperienced staff, and new complex procedural requirements. Together, these three factors could be expected to have a compounding effect. According to the United States General Accounting Office (GAO) in its September 2003 report, *Veterans' Benefits: Improvements Needed in the Reporting and Use of Data on the Accuracy of Disability Claims Decisions*, GAO-03-1045, VA's accuracy in compensation and pension claims decisions declined from 89% to 81% during fiscal years 2001 to 2002. The GAO also found that VA has not made the best use of the accuracy data it collects to evaluate regional office performance, to correct errors, to identify needed training, and to hold regional offices accountable for accuracy.

At the end of fiscal year 2003, VA had reduced its pending caseload to 253,000 claims, coming close to meeting its goal of reducing pending disability claims to 250,000. VA reported that it had increased its monthly claims decisions by more than 70% above its 2001 level, despite an inexperienced workforce and increased procedural burdens on VA. VA also surprisingly reported that its accuracy improved to 85% in fiscal year 2003. With its continued net decline in accuracy over the past 3 years, the number of claims needing additional work to correct errors is likely to rise. Accordingly, while the unmanageable claims backlog would appear on the surface to have been largely overcome for the present, the true amount of claims work awaiting VA may be greater than indicated by the inventory of currently pending claims. The backlog of pending claims may very well again begin to quickly grow, repeating the familiar vicious cycle in which poor quality necessitates rework and results in increased workloads, increased backlogs, decline in timeliness, and greater pressure to increase production at the expense of quality. Gains on the claims backlog through increased production at the expense of quality are merely cosmetic and temporary. The only way to break this vicious cycle is quality first. This requires management discipline and dogged persistence in improving quality even if timeliness and VA's pending claims statistics suffer in the short term. VA must focus primarily on the root cause of this problem to overcome it.

Clearly, VA's adjudicators make erroneous decisions because they are poorly trained in the law, they operate in a culture of indifference to the law, and they are not accountable for their poor proficiency and performance. Accordingly, in conjunction with the deployment of better training, VA must take bold steps to change its institutional culture, and it must make its decisionmakers and managers accountable. With its primary focus on these fundamental defects, VA should intensify its efforts to make other essential process improvements, such as better disability examinations and data exchange between the VBA and its health-care facilities. With well-informed, well-reasoned claims decisions will come fairness and efficiency. Stable reductions in claims backlogs and consistent timeliness will eventually follow.

Recommendations:

To improve quality in VA claims decisions and stabilize the inventory of pending claims to avoid the return of an enormous claims backlog and consequent long delays in the delivery of compensation and pension benefits, VA must address the root causes of the problem by:

1) improving the substance, implementation, and measurement of the effectiveness of its training for compensation and pension adjudicators;

(2) taking decisive and immediate steps to change its negative institutional culture to instill in its decisionmakers and line management more positive attitudes and fidelity to the law; and

(3) imposing from top to bottom real accountability for proficiency and a quality product.

In addition to these root causes of inefficiency, VA must address other substantial contributing problems, such as the inadequacy of VA disability examinations and its technology for information exchange between the VBA and its medical facilities.

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Sufficient Staffing Levels:

To process and decide additional claims not anticipated and not considered in previous plans to reduce staffing, VA must maintain its staffing in FY 2005 at FY 2003 levels.

VA had projected that its workload would allow it to draw down its full-time employees (FTE) in FY 2005 by approximately 268 below its staffing of 7,757 FTE at the end of FY 2003. However, those projections did not take into account an additional 391,000 claims and an additional 52,869 appellate case load over the next 5 years, which VA now expects incident to legislation expanding eligibility for combat-related special compensation. Neither did it take into account workload incident to authorizing concurrent receipt of military retired pay and disability compensation for veterans with service-connected disabilities rated 50% or higher in degree. In addition, VA projects that it will have to rework approximately 48,000 claims to meet the requirements of the decision of the Court of Appeals for the Federal Circuit in *PVA v. Secretary of Veterans Affairs*. While most of that work will be done during FY 2004, it will likely delay work of some of C&P's inventory and carry some extra caseload over into FY 2005. This additional workload requires that VA maintain its staffing levels of 7,757 FTE for C&P Service in FY 2005.

Recommendation:

Congress should authorize 7,757 FTE for C&P service in FY 2005.

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Improved Claims Processing with Information Technology:

To meet its workload demands, VA must develop integrated systems to electronically transfer veterans' medical records from their source to the claims processing database and to aid adjudicators in evaluating that evidence according to the pertinent law and regulations.

To meet its workload demands, VA must take full advantage of automated information systems. These systems can facilitate case management, claims processing, and decision making in ways that increase accuracy and efficiency. To determine and implement its optimum performance in record development, disability examinations, and claims disposition, VA is undertaking a review of its claims process with the goal of developing an integrated electronic format to aid in uniform and correct application of procedures and substantive rules and to allow for the electronic transmission of data from its source into the claims database. Known as the C&P Evaluation Redesign (CAPER) initiative, this project is being undertaken by a CAPER team, working with outside experts.

VA began work on this initiative in 2001 with a goal of nationwide deployment by April 2005. VA now hopes to have this system fully in place by September 2006. To achieve that goal, VA needs approximately $3.5 million in FY 2005 to continue development of this system.

Recommendation:

Congress should provide $3.5 million to fund VA's Compensation and Pension Evaluation Redesign initiative.

Improved Claims Processing with Electronic Files:

To improve its business processes through reliance on more efficient modern information technology, VA needs to acquire, store, and process claims data in electronic files.

VA is moving toward more modern and efficient methods of compensation and pension claims processing by replacing its paper-based claims system with electronic imaging. VA's project, known as "Virtual VA," has been deployed at VA's pension maintenance centers and is undergoing evaluation and assessment based on experience at these three sites. With eventual full implementation, all VBA regional offices will have document-imaging capabilities, and VA medical centers will have electronic access to veterans' claims folders for review in connection with disability examinations. VA expects better timeliness and accuracy in claims decisions once the system is fully deployed.

To continue document preparation and scanning at the pension maintenance centers and development of the system for use nationwide, VA needs $8 million in FY 2005.

Recommendation:

Congress should provide $8 million to support continuing use of VA's Virtual VA electronic file system at its pension maintenance centers and to continue developing the system for eventual installation in all VBA regional offices.

Education Service

Adequate Staffing:

To sustain services at current levels and meet added workload demands consequent to liberalizations in education programs, the Education Service needs to retain its FY 2003 staffing.

As it is with its other benefit programs, VA is striving to provide more timely and efficient service to its claimants for education benefits. The Education Service has made gains in these areas during FY 2003. To continue on that course and to meet the added workload demands expected from recent expansion of training to qualify for educational benefits, VA must at least maintain its FY 2003 direct program staffing of 708 FTE (excludes information technology and management and support FTE) in its Education Service.

Recommendation:

Congress should authorize 708 direct program FTE for VA's Education Service.

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Vocational Rehabilitation and Employment

Adequate Staffing Levels:

To meet its ongoing workload demands and to implement new initiatives recommended by the Secretary's VR&E Task Team, VR&E needs to increase its staffing.

At the end of FY 2003, VR&E had 931 direct program FTE (excludes information technology and management and support FTE). To sustain current levels of performance with its projected workload, VR&E needs to maintain that level of staffing. In addition, the Secretary's VR&E Task Team has made a number of recommendations to improve vocational rehabilitation and employment services for veterans. It is projected that approximately 200 additional FTE will be needed to implement these substantial reforms in the VR&E program, its organization, and its work processes.

Recommendation:

Congress should authorize 1,131 direct program FTE for the Vocational Rehabilitation and Employment Service for FY 2005.

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GENERAL ADMINISTRATION
Board of Veterans' Appeals

Amendment of 38 C.F.R. § 19.5:

VA has declined to amend 38 C.F.R. § 19.5 to remove its erroneous provision that the BVA is not bound by VA manuals, circulars, and other VA directives.

In a 1995 study titled *Veterans Benefits: Effective Interaction Needed Within VA to Address Appeals Backlog*, the GAO cited as a factor contributing to the backlog of appeals the lack of uniformity between the BVA and VA's field offices in the interpretation and application of the law. The GAO noted that while both are bound by the same laws and regulations, they issue independent policy and procedural guidance and sometimes interpret legal requirements differently. Observing that "hundreds of individuals within these organizations interpret and apply laws, regulations, and guidance in adjudicating claims," the GAO said: "This legal and organizational structure makes consistent interpretation of VA's responsibilities essential to fair and efficient adjudication but difficult to achieve." The GAO noted that although "at least four studies have made recommendations" that VA coordinate its decision making to avoid these types of problems, "we found evidence that existing mechanisms do not always identify or are slow to resolve" such problems with adjudication. Assessing the effect of the lack of uniformity in interpretation and application of the law, the GAO said: "These types of differences not only contribute to inefficient adjudication, but also inhibit VA's ability to clearly define its responsibilities and the resources necessary to carry them out."

Despite good reason to do so, VA has inexplicably declined to correct § 19.5, which erroneously provides: "The Board is not bound by Department manuals, circulars, or administrative issues." Section 19.5 thus provides that the BVA will not operate under the same rules as VA field offices and therefore subjects claims decisions to different interpretations and applications of law. This provision is contrary to statute and a well-established line of case law, which holds that VA, like other Government agencies, is bound by its own internal procedures and rules.

In 38 U.S.C. § 501, Congress delegated to the Secretary the authority to prescribe rules and regulations, and issue "guidelines, or other published interpretation[s] or order[s]" on the nature, extent, and methods of submission of proof; application forms; methods of medical examinations; and manner and form of adjudication and awards. VA manuals are official Department instructions, which are binding on adjudicators under 38 C.F.R. § 3.100 and under provisions of the manuals themselves. Many of VA's actions, such as claims decisions and other official acts, are performed by the Secretary's subordinates and do not carry the Secretary's personal signature. They are nonetheless the Secretary's acts for purposes of law. Under 38 U.S.C. § 512, Congress authorized the Secretary to subdelegate the authority it delegated to him. Under that section, the Secretary may assign functions and duties to officers and employees, and "all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Secretary." The issuance of manuals as binding instructions must be an authorized and proper act and must be deemed instructions of the Secretary. Otherwise, they would not be legal and valid. Under 38 U.S.C. § 7104(c), the Board "shall be bound in its decisions by the regulations of the Department, instructions of the Secretary, and the precedent opinions of the chief legal officer of the Department."

Another point makes it clear that the BVA is bound by law to follow VA manuals and circulars. Regulations and instructions of the Secretary have the force and effect of law. Because VA field offices are clearly bound by VA manuals and circulars, the failure of a field office adjudicator to follow them would constitute an error in law. Under 38 U.S.C. § 7104(a), the BVA is charged with, and legally obligated to, correct errors in law. When the BVA refuses to follow, enforce, or apply a manual provision to correct its omission by a field office, it commits legal error. This has required veterans to appeal to the Court of Appeals for Veterans Claims to obtain enforcement of rules in manuals in some cases.

VA's refusal to amend § 19.5 to require the BVA to follow and enforce VA manuals and other departmental instructions is indefensible.

Recommendation:

VA should amend 38 C.F.R. § 19.5 to remove its unlawful provision exempting the BVA from VA manuals, circulars, and other Department directives, and absent timely action by VA, Congress should intervene to ensure this counterproductive problem is corrected.

Judicial Review in Veterans' Benefits

Although the Department of Veterans Affairs (VA) has the sole authority to adjudicate claims for veterans' benefits, 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 what is now the United States Court of Appeals for Veterans Claims (CAVC or the court) to review appeals from VA's Board of Veterans' Appeals (BVA), 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.

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 in *The Independent Budget*, Congress made some important adjustments to correct some of the unintended effects of the judicial review process. In its initial decisions construing these changes, the CAVC has not given 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. Here again, changes are needed to bring the positive effects of judicial review to all of VA's 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's scope of review.

The Court upholds VA's 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 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 rendered 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 court's 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 court will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

Recommendation:

Congress should amend section 7261 of title 38 United States Code to provide that the court will hold unlawful and set aside any finding of material fact that is not reasonably supported by a preponderance of the evidence.

Preservation of Informalities of VA Claims Process

"Exhaustion" Requirement Has No Place in Veterans Benefits Claims:

By refusing to consider points not specifically argued to BVA, the CAVC has, contrary to Congressional intent and the law, imposed formal pleading requirements upon VA's informal administrative claims process.

When Congress authorized judicial review of veterans' claims, one of its foremost concerns and intents was preservation of the informality of VA's administrative claims process under conditions in which the BVA's decisions would be subject to review by a court. Congress was very much aware of the dangers that the courts might attempt to impose their own formal rules of adversarial proceedings upon VA's informal claims process and therefore sought to prevent this adverse consequence. By imposing an exhaustion requirement upon veterans, the CAVC has, for its own expedience, largely ignored Congressional intent, the law, and the unique nature and purposes of veterans' programs by doing the very thing Congress so carefully and clearly acted to forestall.

In its broader sense, the purpose of the doctrine of exhaustion of administrative remedies is to prevent parties from bypassing the available administrative processes to take their claims directly to the courts. It has been recognized that the exhaustion doctrine has four primary goals:

(1) discourage flouting of the administrative processes created by Congress;

(2) allow the administrative agency to apply its expertise, to exercise its discretion, and to correct its own errors;

(3) aid judicial review by allowing the parties and the agency to develop the facts of the case in the administrative proceeding; and

(4) promote judicial economy by avoiding needless duplication of actions and perhaps by avoiding the necessity for any judicial involvement.

Clearly, the law does not allow a veteran to bypass the BVA and appeal an agency of original jurisdiction decision directly to the CAVC. As provided in 38 U.S.C. § 7261, under an appeal properly before it, the court "shall," "to the extent necessary to its decision and when presented," "decide all relevant questions of law, interpret constitutional, statutory, and regulatory provisions, and determine the meaning or applicability of the terms of an action by the Secretary"; "hold unlawful and set aside decisions, findings…conclusions, rules, and regulations issued or adopted by the Secretary, the Board of Veterans' Appeals, or the Chairman of the Board." Contrary to this statutory provision, the CAVC refuses to address "all" relevant questions of law, etc., "presented" to it unless the veteran expressly raised and argued these points to the BVA. In requiring that the veteran have first raised a precise legal point or argument to the BVA, the court is not only violating § 7261, it is ignoring Congressional intent and improperly shifting VA's obligations under the law to veterans.

Unlike judicial or more formal administrative proceedings where it is the responsibility of the parties to raise and plead all legal arguments and discover and present all material evidence, veterans are not expected to know and plead the legal technicalities of veterans' benefits. Veterans file simple claims forms with basic information, not detailed legal pleadings. Congress repeatedly stated its intent to preserve and maintain this informal process throughout the legislative history of its legislation to authorize judicial review. It is VA's legal obligation to assist the veteran in filing the claim and developing the evidence and to consider all relevant legal authorities and potential bases of entitlement regardless of whether they are expressly raised by the veteran. When a veteran appeals to the BVA and receives an unfavorable decision, the veteran has exhausted his or her administrative remedies. Any failure to fully develop the record, to fully explore all avenues of entitlement, or to apply all pertinent law is an error of omission by the BVA that the CAVC should address in its appellate review, irrespective of whether the veteran knew of or raised the specific point before the BVA. Yet, for its own purposes, the CAVC refuses to consider points of argument that were not specifically raised before the BVA. By requiring veterans to know and expressly raise and argue all the complex legal points relevant to a claim, the CAVC shifts the Government's obligations to veterans, imposes unnecessary formalities upon VA's administra-

tive claims process, and fundamentally alters the nonadversarial, pro-veteran nature of VA proceedings. The court seems unable or unwilling to grasp the simple fact that in considering veterans' appeals it reviews a claims record, not a litigation record.

Congressional intervention is necessary to restore veterans' basic rights under the VA claims process. Congress should amend 38 U.S.C. § 7261. The phrase "without regard to any theory of issue preclusion or exhaustion" should be added between the words "presented," and "shall" at the end of section (a). This change would not disfavor VA because the CAVC provides the agency an opportunity to respond to any legal argument presented by a claimant before it rules.

Recommendation:

Congress should amend 38 U.S.C. § 7261 to preclude judicial imposition of formal pleading requirements upon the VA claims process.

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Court Facilities

Courthouse and Adjunct Offices:

The court 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 15 years since the court 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 court 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, court practicing attorneys, and veterans service organization representatives to the court in one place. The court 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 VA Schedule for Rating Disabilities:

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

Under 38 U.S.C. § 502, the Federal Circuit may directly review 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 coauthors of *The Independent Budget* have become 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 only be compensated as 10% disabled. VA should not be empowered to issue rules that are clearly arbitrary and capricious. Therefore, the Court of Appeals for the Federal Circuit (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.

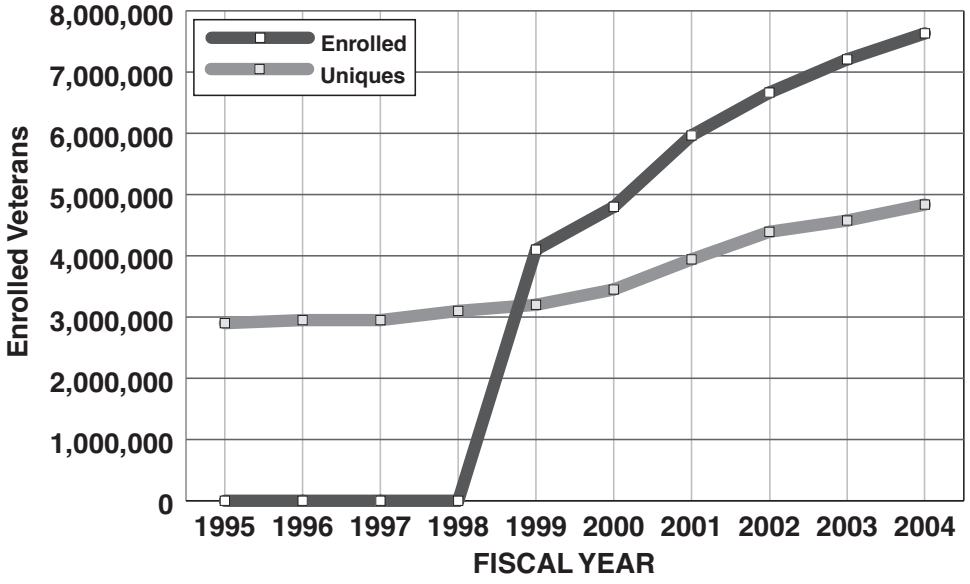
Medical Care

Medical Programs

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

Of the 7.2 million enrolled veterans in fiscal year 2003, the VHA provided health care to more than 4.5 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 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. The VHA was a recipient of the 2002 Pinnacle Award, in recognition by the American Pharmaceutical Association Foundation for its leading-edge technology in bar coding of pharmaceuticals, thereby dramatically reducing errors.

CHART 1. UNIQUE VHA PATIENTS & ENROLLED VETERANS



Even though the Secretary of Veterans Affairs placed a moratorium on the enrollment of priority 8 veterans during FY 2003, chart 1 shows the trend toward increasing numbers of patients treated in VHA facilities and the dramatic increase of veterans enrolled for care. ***NOTE:*** *Figures for FY 2004 are projections based on VHA data.*

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 behavioral 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 year, the IBVSOs are concerned about the methodology used in producing statistics reflecting this reduction in the backlog. As stated above, the Secretary placed a moratorium on the enrollment of priority 8 veterans in FY 2003. Additionally, the IBVSOs are receiving reports that VA hospital directors are no longer advertising VA services to veterans and in many cases openly discourage veterans from enrolling.

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 the safety net hospitals. In any case, society pays more while the veteran suffers. A method to ensure VA receives adequate funding annually to continue providing timely, quality health care to all enrolled veterans must be put in place.

During the 5-year period between 1996 and 2000, the VA Medical Care appropriation was virtually flatlined with an overall net increase over the 5 years of slightly more than 2%.

During the 4-year period between 2000 and 2003, the number of veterans enrolled and served by VA has increased significantly. However, the VA-appropriated budget has not kept pace. The number of enrolled veterans in the VA system increased approximately 50% over the 4-year period with the number of unique veterans increasing about 33%. Although the VA-appropriated medical care budget has increased approximately 24%, the buying power over the 4-year period has increased only 7%.

As U.S. military involvement in Iraq and Afghanistan continue, the number of veterans eligible for VA health care will continue to escalate. As of December 2003, more than 9,700 new veterans due to injuries received in Iraq or Afghanistan were being treated by VA. As of January 2004 there are almost one-quarter million Reserve and National Guard members on active duty. Within the year, all of these Reserve and National Guard members will be eligible for veteran status having served more than 180 days on active duty. At the very least, they will be eligible for VA benefits during the 2-year window following release from active duty. This is in addition to the many new regular veterans that will be rotating out of regular active duty ranks, currently staffed at approximately 1.5 million.

VA is the second biggest financial supporter of education for medical professionals, after Medicare, and the Nation's most extensive training environment for health professionals. As academic medical centers are under increasing financial pressures to reduce health-care professional training, VA has mitigated this gap by maintaining existing programs that train for VA and the Nation. VA has academic affiliations with 107 medical schools, 55 dental schools, and more than 1,200 other schools across the country. Each year, more than 81,000 health professionals are trained in VA medical centers. In addition to their value in developing the Nation's health-care workforce, the affiliations bring first-rate health-care providers to the service of America's veterans. The opportunity to teach attracts the best practitioners from academic medicine and brings state-of-the-art medical science to VA. Veterans get excellent care, society gets doctors and nurses, and the taxpayer pays a fraction of the market value for the expertise the academic affiliates bring to VA.

Programs initiated at VA have led to the development of new medical specialties, such as geriatrics, which focuses on care of the elderly. VA-based training, along with psychiatry, pain management, and spinal cord injury medicine, are addressing the needs of the Nation as well as the needs of our veterans. VA is developing new programs using teams of health-care providers that provide specialized services to veterans, such as palliative care teams that provide care to patients at the end of life. VA trains health-care professionals in the total care of the patient because VA health care provides total care to eligible veterans.

The largest integrated medical care system in the world has a unique capability to translate progress in medical science to improvements in clinical care and the health of the population. VA research is clinically focused: 80% of VA researchers see patients. The patient focus keeps VA research relevant and provides the incentive to translate research findings into evidence-based medical practice. More effectively than any other Federal research funding sector, the VHA provides a mechanism for the clinical application of research findings.

VA leverages the taxpayers' investment via a nationwide array of synergistic partnerships with the National Institutes of Health, other Federal research funding entities, the for-profit sector, and academic affiliates. This extraordinarily productive enterprise demonstrates the best in public-private cooperation.

VA medical and prosthetic research is a national asset that is a magnet for attracting high-caliber clinicians to practice medicine in VA health-care facilities. The resulting atmosphere of medical excellence and ingenuity, developed in conjunction with collaborating medical schools and universities, benefits every veteran receiving care at VA and ultimately benefits all Americans.

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MEDICAL CARE ACCOUNT

The VA medical care account supports VHA medical facilities, including hospitals, nursing homes, outpatient clinics, and VA-financed contract and state home care. *The Independent Budget (IB)* recommends a "current services" budget of $28.2 billion for VA medical care in FY 2005. The FY 2005 *Independent Budget* current services recommendation is based on the FY 2004 *Independent Budget* recommended appropriation with commonly accepted assumptions about staffing and inflation. With increased staffing and services recommended by the *IB,* the IBVSOs recommend that Congress fund the Medical Care Account at the level of $29.8 billion for FY 2005.

Recommended FY 2005 Independent Budget Medical Care Account Initiatives:

	MILLIONS
Funding the Fourth Mission	$383.0
Increased workload, including priority 8	$400.0
Fully meet prosthetics needs for all veterans	$160.7
Fully fund long-term care	$600.0

MEDICAL CARE ISSUES
Financing Issues

Mandatory Health-Care Funding for VA Health Care

Congress should make funding for VA health-care mandatory to ensure service-connected disabled veterans, and all other enrolled veterans, have timely access to VA health care.

The Independent Budget Veterans Service Organizations (IBVSOs) are especially concerned about maintaining a stable and viable health-care system to meet the unique medical needs of our Nation's sick and disabled veterans. The effectiveness of all veterans' programs, including VA health-care services, is dependent upon sufficient funding for available benefits, services, and resources adequate to allow for their timely delivery.

We have often stated that through their extraordinary sacrifices and contributions, veterans have *earned* the right to free health care as a continuing cost of national defense. Yet veterans' health care remains a discretionary program, and each year funding levels must be determined through an annual appropriations bill. This creates an inherent conflict between open enrollment and constrained resources—a problem neither Congress nor the Administration has been willing to resolve. Year after year, the IBVSOs have fought for sufficient funding for VA health care and a budget that is reflective of the rising cost of health-care and increasing need for medical services. Despite our continued efforts, the cumulative effects of insufficient health-care funding have now resulted in the rationing of medical care. We believe mandatory funding for VA health care is a reasonable long-term solution to VA's funding crisis.

In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF). The task force was charged to identify ways to improve health-care delivery to VA and Department of Defense (DOD) beneficiaries. Most important to the IBVSOs is the PTF's recognition of a "growing dilemma" concerning VA health care. The PTF noted in its *Final Report*, "…it became clear that there is a significant mismatch in VA between demand and available funding—an imbalance that not only impedes collaboration efforts with DOD but, if unresolved, will delay veterans' access to care and could threaten the quality of VA health care." As a solution to this complex problem, the PTF recommended the Government provide full funding for VA health care for priority groups 1–7 by using a mandatory funding mechanism, or by some other changes in the process that would achieve the desired goal of ensuring enrolled veterans are provided the current comprehensive benefits package, in accordance with VA's established access standards. The PTF also suggested the Government address the present uncertain access status and funding of priority group 8 veterans.

The PTF's final report noted that the discretionary appropriations process has been a major contributor to the historic mismatch between available funding and demand for health-care services. We agree that to improve timely access to health care for our nation's sick and disabled veterans, the Federal budget and appropriations process must be modified to ensure full funding for the veterans' health-care system. The long-term solution must factor in how much it will cost to care for each veteran enrolled in the system and guarantee that the full amount determined will be available to VA to meet that need. Including priority group 8 veterans under a guaranteed funding mechanism is essential to ensuring viability of the system for its core users, preserving VA's specialized programs, and maintaining cost effectiveness.

Even though over the past two budget cycles Congress has increased discretionary appropriations for veterans' health care, the funding levels have simply not kept pace with inflation or the significant increase in demand for services. Additionally, VA began the last two budget cycles without having the benefit of an enacted increased spending level. Although VA requested an increase for veterans' health care for fiscal year 2003, it fell far short of what VA's Under Secretary for Health testified would be necessary—a 13%–14% increase—just to maintain current services. We believe VA has an obligation to provide veterans timely top quality health care and that Congress has an obligation to ensure that VA is provided sufficient funding to carry out that mission. We agree that the real problem, as the PTF aptly states in its report, is that "the Federal government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions."

During the 108th Congress, mandatory funding bills have been introduced in both chambers. The Assured Funding for Veterans Health Care Act of 2003 has been introduced in the House of Representatives as H.R. 2318 by House Veterans' Affairs Committee Ranking Member Lane Evans (D-IL) and in the Senate as S. 50 by Senator Tim Johnson (D-SD). This mandatory health-care funding measure aims to guarantee adequate annual funding for health care for all sick and disabled veterans eligible to receive medical care from the VA. If veterans' health care were a mandatory program, sufficient funding to treat all veterans who fell under its mandatory provisions would be guaranteed for as long as the authorizing law remained in effect. Veterans would not have to fight for sufficient funding in the budget process every year as they now do.

Making veterans' health-care funding mandatory would also eliminate the year-to-year uncertainty about funding levels that have prevented VA from being able to adequately plan for and meet the constantly growing number of veterans seeking treatment. For several months in fiscal year 2004, VA had to operate under a continuing resolution funded at the fiscal year 2003 level. This further complicates VA's budget problems and prevents VA from being able to provide the health-care services veterans need. Mandatory funding would prevent the adverse consequences resulting from such action when an appropriations bill is not enacted. It is disingenuous for our Government to promise health care to veterans, especially service-connected disabled veterans and then make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who have so honorably served our Nation and who continue to carry the physical and mental scars of that service.

Mandatory health-care funding would not create an individual entitlement to health care nor change VA's current mission. We do not propose to change the existing eligibility criteria for priority groups 1–8 or the medical benefits package defined in current regulations, only the way the funds are provided for VA health care. Having a sufficient number of veterans in the health-care system is critical to maintaining the viability of the system and sustaining it. By including all veterans currently eligible and enrolled for care, we protect the system and the specialized programs VA has developed to improve the health and well-being of our Nation's sick and disabled veterans.

Providing timely quality health-care services for veterans disabled as a result of military service should be a top priority for this Congress, this Administration, and the American people. In a time when more veterans are turning to VA for care, it is unconscionable that VA is forced to reduce services, close enrollment, and severely ration care due to insufficient funding. But the discretionary appropriations process continues to unfairly subject disabled veterans to the annual funding competition for limited discretionary resources. Now is the perfect opportunity for this Administration and Congress to move forward on the recommendations of the PTF, charged with improving health-care delivery for our Nation's veterans, and to support solutions that will permanently resolve this untenable situation.

A young American wounded in Afghanistan, Iraq, or in the war on terror today will still need the VA health-care system in the year 2060. He or she will still need VA disability compensation and other benefits. Congress and the Administration have an obligation to ensure that these veterans have access to a stable, thriving health-care system, dedicated to their needs, now and in the future. Equally important is Congress's support for those who have previously served this Nation. Too many elderly veterans who have sacrificed their health, their limbs, and mental well-being on our Nation's behalf are being told they must wait—in some cases years—for care. Something must be done now to ensure VA is guaranteed sufficient resources to deliver the specialized high-quality health care to those who need it most.

The IBVSOs believe mandatory funding for VA health care provides a comprehensive solution to the current funding problem. This would ensure the viability of the veterans' health-care system and meet the needs of current and future users of the system. Therefore, it is imperative that funding for the veterans' health-care system be made mandatory to ensure access to and timely delivery of high-quality health services for veterans.

Recommendation:

Congress should make funding for VA health care mandatory so that all enrolled veterans have access to high-quality health-care services.

Homeland Security/Funding for the Fourth Mission:

The VHA is playing a major role in homeland security and bioterrorism prevention without additional funding to support this vital statutory fourth mission.

VA has four critical health-care missions. The primary mission is the provision of health care to veterans. The Department's second mission is to provide education and training for health-care personnel. Indeed, VA:

> …manages the largest medical education and health professions training program in the United States, training 85,000 health professionals annually in its medical facilities that are affiliated with almost 1,400 medical and other schools.[1]

The third mission of VA is to conduct medical research, while its fourth is:

> During 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, the Secretary may furnish hospital care, nursing home care, and medical services to members of the armed forces on active duty. The Secretary may give a higher priority to the furnishing of care and services under this section than to the furnishing of care and services to any other group of persons eligible for care and services in medical facilities of the Department with the exception of veterans with service-connected disabilities.[2]

The National Disaster Medical System (NDMS) consists of, among others, the Departments of Defense (DOD), Health and Human Services (HHS), and VA, along with the Federal Emergency Management Agency (FEMA).[3] This mission would require that the Secretary of Homeland Defense, when necessary, activate the NDMS to:

> provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of a public health emergency… (and) be present at locations, and for limited periods of time, specified by the Secretary (of Homeland Security) on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified.[4]

Public Law 107-188 also provides that the NDMS carry out needed ongoing preparedness functions.

The Independent Budget is concerned that VA not only lacks the resources to meet its responsibilities under 38 USC 8811A and PL 107-188 but will actually lose resources before undertaking its fourth mission.

The fourth mission, as previously described, does not require, but allows the Secretary of Veterans Affairs to furnish medical care to active duty military personnel. However, there is a caveat: The Secretary may not allow the military to receive a higher priority for medical treatment than that of service-connected disabled veterans. Unfortunately, if the fourth mission must be utilized, a large number of VHA medical professionals will not be available as they will, quite probably, have been mobilized as members of the reserve components, including the National Guard, of the Armed Forces. These may include 482 physicians, 172 dentists, 2,209 RNs, 3,259 in other medical fields, and 7,144 men and women in support roles.[5] If these 13,266 VHA employees are, in fact, called up with reserve forces, how does VHA support its fourth mission?

> The Secretary of Veterans Affairs shall take appropriate actions to enhance the readiness of Department of Veterans Affairs medical centers to protect the patients and staff of such centers from chemical or biological attack or otherwise to respond to such an attack and so as to enable such centers to fulfill their obligations as part of the Federal response to public health emergencies… (To) include (A) the

[1]Homeland Security: Need to Consider VA's Role in Strengthening Federal Preparedness, GAO-02-145T, October 15, 2001.
[2]38 U.S.C. § 8111A(a)(1).
[3]Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107–188; 116 Stat. 594, 632.
[4]*Ibid.*, 116 Stat. 594, 600.
[5]E-mail from Under Secretary Roswell dated 27 October 2003.

> provision of decontamination equipment and personal protection equipment at Department medical centers; and (B) the provision of training in the use of such equipment to staff of such centers.[6]

The Secretary of Veterans Affairs must also ensure that not only the staff, but the patients, are protected in event of an emergency, to include chemical or biological attack or another type of terrorist attack. Additionally, there are security and pharmacology issues addressed by P.L. 107-188, as well as training issues under the cognizance of the Public Health Service Act (title 42 United States Code), that need to be addressed. Although P.L. 107-188 authorized the appropriation of a total of $133 million for VA to fulfill the added responsibilities in FY 2002, for the next four fiscal years VA has been authorized to have appropriated *"…such sums as may be necessary."*[7]

Additionally, the successful implementation and performance of the fourth mission requires the VA to have the proper facilities.

In 1986 the Assistant Secretary of Defense for Health Affairs testified before the House Committee on Armed Services that *"VA was directed to serve as the primary backup to the DOD in the event of a war or national emergency. The two Departments have made great strides in designing a VA backup system to our contingency system at DOD. Today the system stands ready to provide* ***32,506 contingency beds*** *for use by DOD in the event of a war or a national crisis."*

However, the Congressional General Accounting Office (GAO) reported on October 15, 2001, that:

> VA has plans for the allocation of up to 5,500 of its staffed operating beds for DOD casualties within 72 hours of notification…VA's plans would provide up to 7,574 beds within 30 days of notification.[8]

This is a decrease of 77% of available beds in the intervening 15 years. Looking through the Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan submitted by the VA Under Secretary for Health, it appears that the VHA may be giving up an additional 4,441 beds, of which 666 would come out of the DOD Contingency Plan; thus, we have a total loss, since 1986, of an estimated 79% of the DOD contingency beds.

It is readily apparent that the VHA:

- has had a decrease of approximately 25,680 contingency beds;
- has 13,266 VHA employees serving in the Ready Reserve and the National Guard;
- has had an increase in service-connected and nonservice-connected patient workload; and
- has insufficient funding for veterans' health care.

The IBVSOs are deeply concerned that the VHA is ill-equipped and ill-prepared to adequately perform its role in the fourth mission.

Recommendations:

Congress should appropriate $250 million in the VHA's FY 2005 appropriation to fund the VHA's fourth mission. (We have included this in the Medical Care appropriation.)

Congress should include the funding the fourth mission as separate line item in the Medical Care Account.

Congress should appropriate $133 million to fund the four emergency preparedness centers created by P.L. 107-287. (We have included this in the Medical Care appropriation.)

Congress should, with the assistance of the Secretaries of Defense and Veterans Affairs and the Director of the Selective Service Administration, incorporate methodology in title 10 U.S.C. to preclude a major active duty call of reservists employed by the VHA or modify title 50 U.S.C. to authorize compulsory service for medical professionals in VA, the DOD, and HHS.

Congress should relocate portions of PL 107-188, pertaining to Veterans Affairs, to title 38 U.S.C.

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[6]*Supra,* 116 Stat. 594, 631.
[7]*Ibid.*, 116 Stat. 594, 632.
[8]GAO Report, *supra.*

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 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 to both 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 VBA 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 information about service-connected conditions that exceed the six stored in the C&PBDN. According to VA, difficulties in the development and implementation of the first two steps have delayed the action plan for improving VBA/VHA sharing of information about veterans' service-connected conditions. Furthermore, VA acknowledges that not all these cases with more than 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&PBDN master record.

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Appropriations, not MCCF:

Third-party payments should augment, not offset, the VA medical care appropriation.

The FY 2005 *Independent Budget* calls for an adequate medical care budget fully funded by appropriations. Therefore, we strongly oppose the budget maneuver that Congress and the Administration have used since 1997 to offset appropriations by the estimated amount that VA might collect from veterans and their third-party insurers. Many VA beneficiaries, especially priority 7 and 8 veterans, are Medicare-eligible. However, the Centers for Medicare and Medicaid Services (CMS) is prohibited by law from reimbursing VA.

VA is pursuing additional revenue sources and improved collections, and more revenue from these sources could improve access to care within VA. Potential sources of increased VA revenue are:

(1) improved collections from first-and third-party payers;

(2) enhanced sharing with appropriate civilian community providers;

(3) enhance-use leases (for buildings or land where Federal-civilian partnering can occur); and

(4) reimbursement from other agencies when veterans are eligible for services from such agencies.

Developing additional revenue sources, whether from TRICARE reimbursements or Medicare subvention, will not help VA's overall funding situation if the additional revenues are simply applied as an offset to the Department's budget request. VA could have a strong incentive to earn and collect additional revenues if it could retain these additional revenues without an offset to its appropriated budget.

The IBVSOs believe it is the responsibility of the Federal Government to fund the cost of veterans' care. Therefore, we have not included any cost projections for the Medical Cost Collection Fund (MCCF) in our budget development. VA's historical inability to meet its collection goals has eroded our confidence in VHA estimates. We also object to funding the absurdly high cost of collections out of the veterans' medical care account. The IBVSOs believe the cost of implementing effective billing practices and systems will absorb any net income generated by MCCF.

Recommendation:

The Administration and Congress must base the VA medical care budget on the principle that third-party collections are to supplement, not substitute for, appropriations.

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Copayments:

Veterans should not be charged copayments for health-care services and medications.

Through extraordinary sacrifices and contributions, veterans have earned the rights to certain benefits. As the beneficiaries of veterans' service and sacrifice, the citizens of a grateful nation want our Government to fully honor our moral obligation to care for veterans and generously provide benefits and health care free of charge. Asking veterans to pay for part of the benefit is fundamentally contrary to the spirit and principles underlying the provision of benefits to veterans. Copayments are a feature of health-care systems in which some costs are shared by the insurer in a commercial relationship between the patient and the for-profit company or of Government health care programs in which the beneficiary has not earned the right to have the costs of health care fully borne by the taxpayers.

Copayments were only imposed upon veterans under urgent circumstances and as a temporary necessity to contribute to reduction of the Federal budget deficit. In an effort to help our nation get its fiscal house in order, veterans acquiesced in the imposition of copayments as a "temporary" deficit-reduction measure, even though the concept fully contradicts the spirit and purpose of veterans' benefits.

Unfortunately, Congress has not only made copayments a regular feature of some veterans' health-care services by extending the sunset date of this "temporary" measure, but also has introduced legislation encroaching down the "slippery slope" toward higher copayments and annual enrollment fees. With such brazen attempts to capitalize on the generous and selfless nature of veterans to serve their country when in need, Congress has forgotten its traditional philosophy of providing free benefits to veterans as repayment for protecting our freedoms.

The Administration and Congress seem unwilling to restore veterans to their prior status once either has impaired, reduced, or eliminated a benefit purportedly on a temporary basis. *The Independent Budget* strongly objects to such insidious erosion of veterans' benefits.

In the past, copayments were targeted as a source of funding for other veterans' benefits. Such schemes, in effect, require one group of veterans to pay for the benefits of another group of veterans. For example, if copayments were used to pay for increases in the Montgomery GI bill, this would mean requiring sick and disabled veterans to pay for a cost of national defense.

That is unconscionable. Copayments and user fees are actually taxes on veterans' benefits. The IBVSOs urge Congress to eliminate the copayment measure.

Recommendation:

Congress should eliminate copayments charged to veterans for medication or health-care services.

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Access Issues

While the VHA has made commendable improvements in quality and efficiency, veterans' access to their health-care system is severely limited. Excessive waits 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.

Access is the primary problem in veterans' health care. The significant backlog of delayed appointments, which is caused by severe funding shortfalls, is the immediate cause of veterans' limited access. Many VA facilities and clinics have reached capacity and have had to limit enrollment. Due to perennially inadequate health-care budgets, the VA health-care system can no longer meet the needs of our Nation's sick and disabled veterans. Without funding for increased clinical staff, veterans' demand for health care will continue to outpace the VHA's ability to supply timely health-care services.

A July 2002 survey by the VHA revealed more than 310,000 veterans waiting for medical appointments, half of whom must wait 6 months or more for care and the other half having no scheduled appointment. As of October 15, 2003, the VHA reported the national total of veterans who will likely wait 6 months or more for nonemergent clinic visit has been reduced to 43,217, of which 17,496 veterans are waiting for their first clinic appointment to be scheduled. VA also reported 25,775 veterans waiting for a follow-up appointment. Even veterans with appointments are waiting more than 6 months.

Last year the situation became so critical that the Secretary of Veterans Affairs instituted regulations 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, this does not provide timely access to quality heath care for all eligible veterans authorized access to VA health care under the provisions of the Health Care Eligibility Reform Act of 1996. To ensure that all service-connected disabled veterans, and all other enrolled veterans, have access to the system in a timely manner, it is imperative that our Government provide an adequate health-care budget to enable VA to serve the needs of disabled veterans nationwide.

The Advanced Clinic Access Initiative, a program designed to eliminate waiting times and reject the supply constraint theory of managing health-care demand, has shown promise in addressing the issue of wait times. The goal is to build a system in which veterans can see their health-care providers when they need to. Through the work of a few leaders, this program reduced waiting times and significantly improved veterans' access to their health-care system.

Under the Advanced Clinic Access Initiative, the average waiting time measurement at primary care clinics was reduced from 28.2 days for the next available appointment in FY 2002 to 23.7 days in FY 2003. The average waiting time at specialty clinics was reduced from 36.3 days to the next available appointment in FY 2002 to 29.02 days in FY 2003.

Despite improvements in wait times for needed appointments, continued disparities exist in the implementation of the Advanced Clinic Access Initiative nationwide. Currently, only one dedicated full-time employee and two volunteer employees manage the Advanced Clinic Access Initiative. With a dedicated staff of six, VA could fully implement this initiative across the country to improve the health-care experiences of millions of veterans. A fully staffed and supported Advanced Clinic Access initiative could develop better ways to measure real waiting times, link performance measures to improvements in waiting times, and compare VHA patients' waiting times with those of private sector patients.

Both increased medical care appropriations and VA's Advanced Clinical Access Initiative are needed to improve veterans' access to VA health-care services.

Recommendations:

The VHA should fully develop the Advanced Clinic Access Initiative to measurably improve waiting times.

The VHA should include improvements in waiting times as part of an administrator's performance measures.

The Administration should establish a physician-led program within VHA National Headquarters and provide six full-time staff to the Advanced Clinic Access Initiative.

Community-Based Outpatient Clinics:

Many community-based outpatient clinics do not comply with the Americans with Disabilities Act and lack staff and equipment to serve the specialized needs of veterans.

As of August 2003, the VHA operated 677 community-based outpatient clinics (CBOCs).

Proposed under the currently ongoing CARES process is establishment of 262 additional CBOCs. The IBVSOs commend the VHA's efforts to expand access to needed primary care services. The presence of CBOCs reduces the travel required of many veterans who live long distances from VA medical centers (VAMCs) and for those whose medical conditions make travel to VAMCs difficult. 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.

While the IBVSOs support establishment of CBOCs, we are 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 the general veteran population or those with service-connected mental illness. Too often CBOC staff lack the requisite knowledge to properly diagnose and treat conditions commonly secondary to spinal cord dysfunction, such as pressure ulcers and autonomic dysreflexia. Indeed, VSOs caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care program.

Inadequately trained providers are less likely to render appropriate primary or preventive care and accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with section 504 of the Rehabilitation Act regarding physical accessibility to medical facilities. Veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

CBOCs must contribute to the accomplishment of the VHA's mission of providing health services to veterans with specialized needs. These 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.

To ensure the integrity of the VA medical system, it is essential that Congress and the Administration appreciate the indispensable role of VAMCs in providing both acute and primary care. Valuable resources must not be siphoned away from the infrastructure of VA hospitals as more CBOCs are established. Unless the VHA is adequately funded and properly managed, the proliferation of CBOCs could ultimately reduce the comprehensive scope of VHA care.

Recommendations:

The VHA must ensure that 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 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 exists.

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

VHA-DOD Sharing:

The Independent Budget *encourages collaboration of VA-DOD health systems and recommends careful oversight of sharing initiatives to ensure beneficiaries are assured timely access to partnering facilities.*

The President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF) delivered its final report in May 2003. The PTF was charged with three tasks:

(1) 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;

(2) review barriers and challenges that impede VA-DOD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement; and

(3) identify opportunities for partnership between VA and the DOD to maximize the use of resources and infrastructure.

Interest in VA-DOD health systems' collaboration is supported by enactment of sharing initiatives in the FY 2003 National Defense Authorization Act and other legislation.

The Independent Budget VSOs continue to support the careful expansion of VHA/DOD sharing agreements. We agree, however, with PTF Cochairman Dr. Gail Wilensky's testimony before the House Veterans' Affairs Committee (June 2003) that true sharing will not be possible until Congress addresses the underlying mismatch between demand for VA services and appropriated resources. Further, we do not believe that joint activities demonstrate the need to integrate the management of the two systems. Complementary business systems can offer benefits to users of both systems, but these benefits do not mean that a total integration of the two systems is practical or necessary.

Leadership and Reporting

The recently authorized VA-DOD Joint Executive Council should report annually to the Armed Services and Veterans' Affairs Committees on collaborative activities, including development of tools to measure the "health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing, and desired outcomes." *The Independent Budget* VSOs believe there has been insufficient transparency in the work of various VA-DOD executive planning forums—stakeholders need information on the likely impact of sharing initiatives on veterans.

Seamless Transition

The IBVSOs note that some veterans returning from Iraq and Afghanistan are not seamlessly referred or transferred between the DOD and VA health-care systems. We strongly support early development of servicemember medical records that are "interoperable, bi-directional, and standards-based."

Joint Venture Sites

The DOD and VA have identified 60 sharing initiatives at the facility level, and the DOD has labeled 20 of these as "priority" initiatives. In addition, VA and the DOD announced in October 2003 a series of demonstrations required by the fiscal year 2003 National Defense Authorization Act to test improving business collaboration between VA and DOD health facilities. The two departments will use the demonstration projects at eight sites to test initiatives in joint budget and financial management, staffing, and medical information and information technology systems. The *IB* does not object to these joint ventures in themselves, but we have serious concerns about their interaction with the VA CARES and DOD health facilities planning processes.

VA and DOD Access Standards

VA has had access standards since 1995 but has not been required to meet them. Conversely, the DOD has mandatory access standards and is required by law to meet them. The DOD's access standards drive funding levels to meet demand in the military health-care system, TRICARE. In examining the "mismatch between demand and funding," the PTF report concluded that the VA health-care system should be funded "in accordance with VA's established access standards."

Fully Fund Enrolled Veterans

The PTF recommended that the Government should provide "full funding" for all veterans enrolled in VA health care in priority groups 1–7. The PTF suggested that this objective could be achieved either by a "mandatory funding mechanism," through "modification to the current budget and appropriations process," or by some other method. It is clear that the PTF recommended that the gap between demand and resources must be closed by increasing and sustaining VA health-care funding. As outlined elsewhere in *The Independent Budget*, we strongly recommend mandatory funding for all enrolled veterans VA has agreed to care for. 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 necessary resources to accelerate the creation of a single separation physical and "one-stop shopping" to enable veterans' benefits decisions.

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

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

Enrollment Priority 4 Not Fully Activated:

Many catastrophically disabled veterans are incorrectly classified as enrollment priorities 5, 6, 7, and 8.

Six years ago Congress enacted Public Law 104-262, which specifies that veterans who are receiving 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.

Prior to VA curtailing enrollment of priority group 8 veterans, all enrolled veterans that were entitled to be but were not classified as enrollment priority 4 have been denied VA health care. In the future it is possible that inadequate appropriations may force the Secretary to change enrollment policy with regard to priority 7 veterans. If that were the case, thousands of misclassified veterans could be affected.

The VHA has not developed a consistent and effective mechanism for identifying eligible veterans and properly classifying them as priority group 4. Reports from national service officers attempting to help veterans obtain appropriate reclassification to priority group 4 indicate that many times they are met with resistance and at times refusal from VA hospital staff.

There is no logical reason for the VHA to delay implementation of this law. Appropriate classification of eligible veterans to priority group 4 must be accomplished without further delay.

Recommendations:

The VHA should expedite the proper identification and classification of enrollment priority 4 veterans.

Congress should require the VHA to report on numbers of enrolled priority 4 veterans.

Emergency Services:

Many enrolled veterans may be excluded from non-VA emergency medical services.

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 not only must be enrolled in the VA health-care system, they also 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 IBVSOs object to eligibility limitations on enrolled veterans. We believe 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 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. It is ludicrous to penalize a veteran for seeking emergency care when he or she is 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.

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Prosthetics and Sensory Aids

Continuation of Centralized Prosthetics Funding:

Despite significant improvement in many areas, problems in the VA prosthetics and sensory aids arena continue to exist. As a result, veterans who require prosthetic and sensory aids continue to encounter obstacles in receiving timely and appropriate services and equipment. The program enhancements developed to eliminate or minimize these obstacles have not been fully implemented throughout the VA health-care system.

The IBVSOs are pleased to report that on a national level veterans have continued to benefit significantly through the continuation of the centralized prosthetics budget. The protection of these funds from being used for unintended purposes has had a major positive impact on disabled veterans. The IBVSOs applaud VHA's 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 prosthetic needs of veterans with disabilities.

The IBVSOs also commend the decision to distribute FY 2004 prosthetic funds to the VISNs based on prosthetics fund expenditures and utilization reporting. This decision has greatly improved the budget reporting process. For example, prior to implementing FY 2002 prosthetics budget, the VISN network directors were informed, in no uncertain terms, that the variance between obligations for prosthetics budget object codes and the National Prosthetics Patients Database (NPPD) would be no greater than 5%. In FY 2001, a total of $634.7 million was obligated against prosthetics, yet VHA field stations only documented $492.2 million through the NPPD, resulting in a variance of 22.4% at the national level. Among the 22 networks, the variance ranged from a best of 13.2% to a worst of 52.6%. Additionally, the network directors were instructed to ensure that VA purchase cards (credit cards) will be utilized to purchase at least 90% of all prosthetics devices at the facility level. It was believed this requirement would increase accountability for the funds obligated and expended and facilitate NPPD entry. Of the VISNs, 5 of the 22 failed to comply with this method of accounting. This resulted in VHA senior officials withholding a total of $12 million (combined) from the five VISNs. After each of the VISNs complied with the required accounting procedures to demonstrate the actual need for their budget, an appropriate portion of the $12 million reserve was disbursed to the five VISNs. The end result of VISN compliance was increased communication and documentation between prosthetics and fiscal officers. As a result, for FY 2003 all 21 VISNs fell within the 5% variance between expenditures versus obligations.

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 the general operating funds. Many facility and fiscal managers who manage the general operating funds believe that because they are responsible for the general operating funds, they should also control the prosthetic funds. But 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, the historical evidence also shows that centralization and protection of prosthetic 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 prosthetic 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 prosthetic budget expenditures at all levels, primarily utilizing data generated from the NPPD. As a result, many are now aware that proper accounting procedures will result in a better distribution of funds.

The IBVSOs applaud the 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 2004. The allocated budget for prosthetics was approximately $846 million, up from $752.7 million in FY 2003. Funding allocations for FY 2004 were primarily based on FY 2003 NPPD expenditure data, coupled with Denver Distribution Center billings and an overall 12.5% increase. 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 2004 budget allocations at their requested levels. However, prosthetics requested approximately $917 million to cover the actual anticipated FY 2004 prosthetics budget. The $71 million that was not funded is needed to cover the Home Oxygen Program, which currently is not reflected in the prosthetics budget, in addition to recent enhancements in the prosthetics package, including technological advancements, and service dogs. 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 $30,000, a single IBOT wheelchair $25,000, and a single service dog $20,000.

In FY 2005, the IBVSOs anticipate that the prosthetics budget will need to be increased to approximately $951.7 million. If the prosthetics budget were to reflect the Home Oxygen Program, for which prosthetics is responsible, an additional $55 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.

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 prosthetic 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 prosthetic expenditures and trends.

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

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

Consistent Application of National VHA Prosthetic Policies and Procedures:

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 VA care and treatment.

It is clear that senior leadership in the VHA recognizes that this problem exists. For example, Prosthetics and Sensory Aids receives repeated requests to clarify instructions to its VISN prosthetics representatives concerning the uniform application of the provisions on the issuance of medically needed automotive adaptive equipment (ingress/egress items). This had to be done even though 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 be diligent to ensure that national prosthetic policies are properly followed as this handbook is translated in VISN and facility-level operating guidelines.

As we 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 prosthetic policies and procedures are followed uniformly at all VHA facilities.

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

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Assessment and Development of "Best Practices" to Improve Quality and Accuracy of Prosthetic Prescriptions:

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

In the past, the IBVSOs cautiously supported VHA efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetic prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Our continued concern with the PCMP is that this program could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

The IBVSOs are concerned with the procedures that are being used, as part of the PCMP process, to award single-source national contracts for specific prosthetic devices. Mainly, our concern lies with the high rates that are contained in the national contracts. The typical compliance rate, or performance goals, in the national contracts awarded so far as a result of the PCMP have been 95%. This means that for every 100 of the devices purchased by the VHA, 95 of the devices are expected to be of the make and model covered by the national contract. The remaining 5% 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 counter productive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe that national contract awards should be multiple-source. 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 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.

The following is a synopsis of a statement made by a paralyzed veteran who is active on a PCMP workgroup:

> We do not live in a one-size-fits-all world, and when you spend 15-plus hours a day sitting down, the manner in which you do it is very personal and intimate. I would be a fool to think that, as a wheelchair user, I fully understand the factors that other wheelers need to consider in their selection of specific types or models of wheelchair. Disabled veterans who require a wheelchair for ambulating must be able to participate in the selection process and maintain their freedom of choice to help maximize their independence and facilitate their lifestyles. I understand that new users, or those with changing medical needs, require a lot of help in selecting the right chair from specialists. Experienced users have a better feel for their needs and limits and play a larger role or even a solo role in the selection process.
>
> I cringe at the thought that someone may point to the work of this workgroup and say, "Sorry, but you can't have that wheelchair. A VA workgroup has already decided what is best for you." I'm working hard to prevent a scenario like this from occurring. And I see from your thoughts that you understand my concerns, and I appreciate your efforts as a clinician and those of the other workgroup members, to address those concerns for the benefit of all disabled veterans who depend on these wonderful devices. Saving dollars at the expense of the disabled veteran would be a tragedy, not a victory.

Significant advances in prosthetics technology will continue to dramatically enhance the lives of disabled veterans. In our view, standardization of the prosthetic devices that VA will routinely purchase threatens future advances. 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. 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 concerns surgical implants. While funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device (LVAD), coronary stents, cochlear implants), the surgical costs associated with implanting the devices come from the local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule the implant surgeries or are "limiting the number of surgeries" due to the costs involved. If true, the consequences to those veterans would be devastating and possibly 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 need—not cost—and 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.

Restructuring of Prosthetic Programs:

Not all VISNs have taken necessary action to ensure that their respective prosthetic programs have been appropriately restructured, despite the passing of nearly 5 years.

The IBVSOs continue to support the restructuring efforts that are occurring at the VISN level as a result of the prosthetics program reinvention project completed in March 1999. To ensure an acceptable degree of consistency nationwide, the IBVSOs believe that VHA headquarters must provide more specific information to the VISNs on the restructuring of their prosthetics programs, as it is now obvious that some VISNs will not commit to restructuring on their own initiative. As we have stated for the past 4 years, VHA headquarters *must* direct VISN directors to:

- Designate a qualified VISN prosthetics representative to whom the prosthetics service at each VA facility is accountable (the position should be graded at the approved GS-14 or GS-15 level).
- Ensure that VISN prosthetic representatives have line authority over 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 a prosthetics representative for a local VA facility within their VISN.
- Hold each VISN prosthetic representative responsible for ensuring implementation and compliance with national prosthetic 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 the consistent operational parameters and authorities for reorganizing prosthetics services and hold individual VISN directors responsible for failing to do so.

Failure to Develop Future Prosthetic Managers:

There continues to be a serious shortage in the number of qualified prosthetic representatives who are available to fill current or future vacant positions.

The VHA has developed and requested 12 training billets for the National Prosthetics Representative Training Program. VHA's National Leadership Board has approved the re-implementation of this vital program. This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. Because of the lack of this training program, there continues to be a serious shortage in the number of qualified prosthetic representatives who are available to fill current or future vacant positions. This has led to many inappropriate prosthetic personnel selections around the country.

On a positive note, the IBVSOs are aware that prosthetics has been allocated 12 billets for trainees in the Prosthetics Representative Training Program for fiscal years 2003, 2004, and 2005. However, additional trainee billets may be necessary based on the future anticipated vacancy rates.

As we have reported previously, some VISNs have selected individuals who do not have the requisite training and experience to fill the critical VISN prosthetics representative positions. The IBVSOs believe that 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.

Continuing education and certification for field prosthetic staff, especially VISN prosthetics representatives who are responsible for ensuring compliance with national policy, is also essential to improving the prosthetics program. The IBVSOs strongly encourage the VHA to continue to conduct quarterly VISN prosthetics representative training meetings and its prosthetics chiefs national training conferences, which are held normally in conjunction with other rehabilitation services (e.g., blind rehabilitation, spinal cord injury, traumatic brain injuries, etc.).

In addition, appropriate prosthetic 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 FTEE 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.

Mental Health Services:

Congress must ensure that mental health care becomes a greater programmatic and funding priority for VA.

Congress and the Administration must make VA mental health care a much greater priority; must improve access to specialized services for veterans with mental illness, post-traumatic stress disorder (PTSD), and substance abuse disorders commensurate with their needs; and must make recovery from mental illness a guiding component of VA health-care programming. For too long, mental health care has *not* been a priority for VA, as evidenced again only last year by the VHA's development of a CARES plan, which employed a badly flawed planning model that underestimated veterans' future needs for mental health services.

Despite very substantial current and future veteran need for mental health care, recent years have seen erosion in VA mental health service capacity. Virtually every entity with oversight of VA mental health-care programs, including Congressional oversight committees, the GAO, VA's Committee on Care of Veterans with Serious Mental Illness, and *The Independent Budget,* have documented both the extensive closures of specialized inpatient mental health programs and VA's failure in many locations to replace those services with community-based programs. The resultant dearth of specialized inpatient care capacity and the failure of many networks to establish or provide appropriate specialized programs effectively deny many veterans access to needed care. These glaring gaps highlight VA's ongoing failure to meet a statutory requirement to maintain a benchmark capacity to provide needed care and rehabilitation through distinct specialized treatment programs.

In all, during the transformation of its health-care system beginning in 1996, VA has allowed mental health spending to decline by 25%. That spending reduction cannot be attributed to "efficiencies gained in shifting from inpatient to outpatient care" as has been suggested. To the contrary, as documented by VA's statutorily mandated Committee on Care of Veterans with Serious Mental Illness, the Department has not adequately developed, nationwide, the community-based services needed to replace lost inpatient and other services. Although the *IB* has long called for the VHA to maintain equitable access to a full continuum of mental health services, veterans' access to mental health services is highly variable, without a common commitment among VA's networks to making mental health and substance use services a priority.

In reinforcing and strengthening the capacity law through the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135), Congress has unmistakably directed VA to substantially expand the number and scope of specialized mental health and substance abuse programs so as to improve veterans' access to needed specialized care and services. The law now makes clear that VA's obligation is not simply to report to Congress, but to make systemic changes network by network to reverse the erosion of that specialized capacity. To ensure that real change occurs, Congress has made very clear that the criteria by which the "maintain capacity" obligation is to be met are not vague "outcome" data, but hard, measurable indicators that apply not only nationally but to each of VA's veterans integrated service networks.

With wide disparity in the availability of needed services across the system, the *IB* continues to find that *veterans with mental illnesses can have no assurance that any given VA facility, or network of facilities, will meet their mental health needs.* To appreciate the profound implications of this failure, one must consider the impact of mental illness on our veterans and the magnitude of the obligation this Country owes them:

- More than 460,000 veterans are service-connected for mental disorders.
- Nearly 117,000 of these veterans are service-connected for psychosis.
- More than 180,000 are service-connected for PTSD, a disorder most often directly related to combat duty.
- During fiscal year 2002, more than 750,000 veterans, or 17%, received mental health services from VA; during that same period, VA provided care to more than 206,000 veterans with psychoses, 97% of whom were high priority patients due to service-connection or low-income status.

The prevalence of mental illness and substance-use problems among our veterans, and the significant need for mental health services among VA's patients—particularly among those with the highest priority for care—is at odds with the still relatively limited specialized programming available to them. Even veterans residing in reasonable proximity to VA health-care facilities often do not have access to a needed continuum of mental health services. Resources freed up in prior years by hospital ward closures were not retained in and dedicated to mental health programming. Rather than reinvesting dollars to meet veterans' mental health needs, these savings were used to establish and operate an array of new community-based outpatient clinics (CBOCs), which to this day still do not have mental health staffing in most locations. Efforts to provide such staffing, moreover, are still no substitute for the specialized services needed to support veterans with serious mental illness.

The problem of unmet need is not one that faces only veterans with a chronic, serious mental illness. As VA's special committee on PTSD has reported, there are not enough specialized PTSD programs to meet veterans' needs, and access is a problem in many areas. Veterans with substance-use disorders may be even more underserved. The dramatic decline in VA substance-abuse beds has robbed clinicians of the means of providing veterans a full continuum of care, often needed for those with chronic, severe problems. Funding for programs targeted to homeless veterans who have mental illness or co-occurring substance-use problems is also markedly short of the needs in that population. Despite the needs of an aging veteran population, relatively few VA facilities have specialized geropsychiatric programs.

Given the high proportion of VA patients who need treatment for mental health problems and the long-documented need to restore VA's specialized mental health service capacity, it is very troubling that VA mental health-care spending has declined by 8% over the past 7 years, and by 25% when adjusted for inflation. The *IB* estimates that simply to restore lost funding support, VA should be devoting an additional $478 million to mental health-care spending. This projection would still fall short, however, of what is needed to fully fund a comprehensive continuum of care for veterans with serious mental illness, PTSD, and substance-use disorders, an altogether reasonable target identified at a 2002 Senate Veterans' Affairs Committee hearing. Meeting that very compelling need would exceed $4 billion annually, almost double VA's current mental health budget.

In addition to the gaps attributable to an erosion in services for mental health care since 1996, the *IB* is concerned that VA mental health service delivery needed to provide veterans state-of-the-art care has not kept pace with advances in the field. The 2003 report of the President's New Freedom Commission on Mental Health Care has particular relevance in this regard in highlighting that recovery is a realizable goal for people with mental illness. VA can, and should be, a model for recovery-based mental health care. Such care requires an array of services that include intensive case management, access to substance abuse treatment, peer support and psychosocial rehabilitation, pharmacologic treatment, housing, employment services, independent living and social skills training, and psychological support to help veterans recover from a mental illness. VA's Committee on Care of Veterans with Serious Mental Illness has recognized that this continuum should be available through VA. But it is not. At most, it can be said that some VA facilities have the capability to provide some limited number of these services to a fraction of those who need them. *But what is clear is that the professionally recognized standard of care that should be available to any person suffering from serious mental illness is not available through VA, even to the many veterans who are service-connected for a serious mental illness.*

As the *IB* noted last year, VA's compensated work therapy (CWT) program illustrates the extent to which VA mental health care has failed many of those most in need. This rehabilitation program helps veterans learn social and work skills as part of a recovery process and has successfully placed many participating patients in competitive employment. Yet only minute numbers of veterans who have a severe mental illness and who have been found to be employable with sufficient supports have participated in this program. The *IB* commends Congress for passing legislation to enable VA to provide supported employment services to these veterans and thereby taking an important first step toward moving VA from simply managing the symptoms of mental illness to providing the needed supports to make possible recovery from mental illness and return to productive life in the community. VA can

go much further, however, and should follow the call of the Committee on Care of Veterans with Serious Mental Illness to expand the arsenal of support that can help veterans on a path toward recovery. The *IB* strongly urges VA to utilize peer-support services, which have been shown to have both clinical and cost effectiveness in building independence, self-esteem, and skills that foster recovery.

The *IB* has identified a broad array of mental health funding needs, covering such areas as intensive community case management programs, psychosocial rehabilitation services and other recovery supports, geriatric psychiatry, increases in supported housing and residential treatment capacity, additional mental health services available through more community-based outpatient clinics, and additional inpatient beds. Compelling considerations, including the outright needs of veterans who rely on VA, professional state-of-the-art treatment standards, and Congressional mandates, dictate that FY 2005 funding provide for restoring both lost program capacity in, and increased support for, veterans' mental health care and recovery.

The *IB* recognizes that the development of these needed programs must be approached with deliberation and care and recommends that funding be augmented steadily over a 5-year period.

Recommendations:

Congress must incrementally augment funding for specialized treatment and support for veterans who have mental illness, PTSD, or substance-use disorders by $500 million each year from FY 2005 through FY 2009.

The VHA 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 disorder, housing alternatives, work therapy and supported employment, and other support services for veterans with serious mental illnesses.

In light of the flawed methodology regarding veterans' mental health needs used in the CARES process, VA (and Congress in its oversight capacity) must give priority to ensuring that the Department's strategic planning relating to mental health care and support is based exclusively on data and assumptions that have been validated by VA mental health experts. Accordingly, the Under Secretary for Health must ensure that erroneous CARES mental health projections are expunged from VA planning databases.

With the failure of many VA networks to maintain specialized mental health and substance abuse treatment capacity, and restore such lost capacity, and with the resultant lack of access to needed mental health and substance abuse care, VA must institute a mechanism to "fence" funding of monies for these programs for those networks whose mental health or substance use funding levels are markedly out of line with inflation-adjusted 1996 funding.

The VHA, its networks, and facilities should partner with mental-health advocacy organizations, such as the National Mental Health Association, the National Alliance for the Mentally Ill, and veterans service organizations to provide support services, such as outreach, educational programs, peer and family support services, and self-help resources.

Specialized Services Issues

Blinded Veterans:

The VHA needs provide a full continuum of vision rehabilitation services.

The VA Blind Rehabilitation Service (BRS) is known worldwide for its excellence in delivering comprehensive blind rehabilitation to our Nation's blinded and severely visually impaired veterans. VA currently operates 10 comprehensive residential Blind Rehabilitation Centers (BRCs) across the Country. Historically, the residential BRC program has been the only option for severely visually impaired and blinded veterans to receive services.

As the VHA made the transition to a managed primary care system of health-care delivery, the BRS failed to make the same transition for rehabilitation services for blinded veterans. *The Independent Budget* believes it is imperative that the VA BRS expand its capacity to provide blind rehabilitation services on an outpatient basis when appropriate. More than 2,600 blinded veterans are waiting entrance into 1 of the 10 VA BRCs. Many of these blinded veterans do not require a residential program. If a veteran cannot or will not attend a residential BRC, he or she does not receive any type of rehabilitation.

The Independent Budget encourages funding for additional research into alternative models of service delivery to identify more cost-efficient methods of providing essential blind rehabilitation services. Alternative methods of delivering rehabilitative services must be identified, tested, refined, and validated before the existing comprehensive residential BRC programs are dismantled. Innovative programs like the outpatient 9-day rehabilitation program called Visual Impairment Services Outpatient Rehabilitation Program (VISOR) at the VAMC Lebanon, Pennsylvania, must be encouraged and replicated. VISOR offers skills training, orientation and mobility, and low-vision therapy. 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 FTEEs, compromising its capacity to provide comprehensive residential blind rehabilitation services. Many 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 and blind rehabilitation outpatient specialists (BROS), have been frozen, postponed indefinitely, or eliminated. Currently, there are only 22 BROS positions. 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 P.L. 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 appropriate staffing levels for blind rehabilitation specialists.

The VHA must increase the number of blind rehabilitation outpatient specialist (BROS) positions.

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.

Spinal Cord Dysfunction:

VA continues to have a shortage of bedside nursing staff, which adversely affects the quality of care for spinal cord dysfunction patients.

A system of classifying patients according to the amount of bedside nursing care needed has been established by VA. Five categories of patients were developed, which took into account significant differences in nursing care hours for each category, on each shift, and in determined segments of time such as a 24-hour period, shift by shift, and the number of FTEEs needed for continuous coverage. This could be converted in nursing needs over a week, quarter, or even a year. It was also adjusted for net hours of work for annual, sick, holiday, and administrative leave.

The emphasis of this acuity system is on *bedside care nursing* and does not include administrative nursing or light-duty nurses who either do not or are not able to provide full-time, labor-intensive bedside care for the spinal cord injured/dysfunctional (SCI/D) patient. According to the *California Nurses Association's Safe Staffing Law* about California registered nurse (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 was delineated in VHA Handbook 1176.1 and VHA Directive 2000-022. It was derived on 71 FTEEs per 50 staffed beds based on the average of category III patients. Currently nurse staffing numbers do not reflect an accurate picture of bedside care being provided because administrative nurses and light-duty nurses were counted in with bedside nurses as the total number of nurses caring for SCI/D patients.

VHA Directive 2000-022 requires 1,347.6 bedside nurses to provide minimal nursing care for 85% of the available beds at 23 SCI centers. Bedside nurses are comprised of RNs, licensed vocational/practical nurses, nursing assistants, and health technicians. The regulation is that the nursing staff mix should approximate 50% RNs. Not all SCI centers are in full compliance with this regulation. At the end of fiscal year 2003, nurse staffing was 1,266.4. Of the 1,266.4, 79 nurses were administrative and 45 were light-duty nurses. This left only 1,142.4 nurses for bedside care, which is 205.2 below the required 1,347.6. This represents a *15% decrease* of available bedside nursing care.

SCI facilities are using minimal staffing levels as their maximum recruiting levels. And, as shown above, when the minimal staffing levels contain numbers of administrative nurses and light-duty nurses, nursing care is severely compromised. It is well documented in professional medical publications that patient morbidity and mortality following complications are affected by nurse staffing. For every additional patient in the average nurse's workload, the odds of death increase by 7%.

The IBVSOs continue to believe that basic salaries of bedside nurses is too low to be competitive with community hospital nurses, causing many of the nursing staff to leave VA or accept a job at one of the community hospitals.

Recruitment and retention bonuses have been instituted at several VA SCI Centers to assist in increasing morale and to comply with staffing requirements. However, these efforts have been variable and inconsistent systemwide. SCI center staff find themselves with a complete lack of flexibility in their work schedules and in many cases have to work mandatory overtime. This has also contributed to low morale.

Recommendations:

The VHA needs to count only those nurses who provide direct bedside care and use those numbers for assessing compliance with VHA Directive 2000-022 and VHA Handbook 1176.1.

The VHA needs to hire more nurses.

The VHA needs to centralize their policies systemwide for recruitment and retention bonuses.

Salaries as well as recruitment and retention bonuses need to be set at an amount that is competitive with community health-care facilities.

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

Gulf War Veterans:

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

Heightened controversy over "Gulf War Syndrome" still exists more than a decade after the start of the Gulf War. 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 veterans suffer from real illnesses, there is no single disease or medical condition affecting them.

In the 12 years since the Persian Gulf War (PGW), both the DOD and VA have had many service members and veterans with concerns regarding undiagnosed illnesses and Gulf War Syndrome. Although some headway has been made in diagnosis, treatment, and payment of disability compensation, further research by both Departments is needed. Moreover, we are now confronted by an additional issue. The international War on terrorism has put our troops on the ground in Iraq and Afghanistan. Many of these young men and women have fought, are fighting, and are living in the same areas as did our PGW veterans. The IBVSOs, therefore, expect to see additional health-care issues and disability claims related to some of the same undiagnosed illnesses from which the veterans of the PGW have suffered.

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. 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. P.L. 105-277 requires that VA and the National Academy of Sciences (NAS) determine which hazardous toxins members of the Armed Forces may have been exposed to while serving in the Persian Gulf. Upon identification of those toxins, NAS will identify the illnesses likely to result from such exposure, for which a presumption of service-connection is or will be authorized. Accordingly, the IBVSOs urge that Congress extend the provision of Public Law 107-135, thus prolonging eligibility for VA health care of veterans who served in Southwest Asia during the Persian Gulf Wars. 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 (CPGs) 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 their 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.

On a more positive note, recently enacted legislation includes poorly defined illnesses, such as fibromyalgia and chronic fatigue syndrome, under the "undiagnosed illness" provision. Previously, many Gulf War veterans received diagnoses of these conditions, yet were denied compensation simply because they were diagnosed. Because of passage of Public Law 107-103, which became effective March 1, 2002, Gulf War veterans diagnosed with chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome now qualify for VA compensation for those conditions. Additionally, the Secretary has granted presumption for service-connection to those Gulf War veterans diagnosed with ALS

(Lou Gehrig's Disease). The Secretary should reexamine VA regulations for disabilities due to undiagnosed illnesses, with a focus on the intent of Congress in Public Law 106-446 to ensure Gulf War veterans are fairly and properly compensated for their disabilities.

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 the Federal Government and private entities.

Recommendations:

VA should continue to foster and maintain a close working relationship with the NAS in the effort to ascertain which toxins Gulf War veterans were exposed to and what illnesses may be associated with such exposure.

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

Congress must reject the recommendation of the Commission on Service Members and Veterans Transition Assistance to declare February 28, 1993, as the ending date of the 1991 Persian Gulf War.

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Women Veterans:

VA should evaluate which health-care delivery model demonstrates the best clinical outcomes for women veterans to ensure quality health care is provided at all VA facilities.

According to the United States Census 2000, in contrast to the overall declining veteran population, the female veteran population of the United States is increasing. Of the 26.4 million veterans, 1.6 million are women.

Today more than 212,000 women serve on active military duty and represent nearly 15% of the active force. Another 149,000 women serve in the National Guard and Reserve. As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health-care services.

Enrollment of women veterans into the VA health-care system increased 10.8% from 275,316 in FY 2001 to 304,989 in FY 2002. The projection for FY 2003 for women veteran enrollees is 378,559, representing an estimated 24.1% increase between FY 2002 and FY 2003. Between FY 2000 and FY 2002, the number of women veteran patients receiving VA health-care services increased from 154,256 to 182,434 with a projected increase of 14.9% between FY 2002 and FY 2003. Women veterans make up approximately 5% of all users of VA health-care services, and within the next decade this figure is expected to double. With increased numbers of women veterans seeking VA health care following military service, it is essential that VA is equipped to meet their specific health-care needs.

VA is obligated to deliver health-care services to female veterans that are equal to those provided to male veterans.

According to the VA Veterans Health Administration (VHA) Handbook 1330.1, *VHA Services for Women Veterans:*

> It is a VHA mandate that each facility, independent clinic, mobile 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 is concerned that although VA has markedly improved the way health care is being provided to women veterans, privacy and other deficiencies still exist at some facilities. VA needs to enforce, at the 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 levels. VA needs to evaluate 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. More than 50% of women seeking VA care are younger than 45, compared to only 15% of men. VA must be responsive to the unique demographics of this veterans' population and adjust programs and services as needed to meet their changing health-care needs.

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. VA has a very limited number of comprehensive or full-service women's health clinics dedicated to both the delivery of primary and gender-specific health care to women veterans. Most facilities provide care to women in integrated primary care settings 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 to an outpatient preventative medicine health-care delivery model. The *IB* is seriously 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% of a primary care practitioner's clientele, women veterans comprise less than 5% 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 under this scenario, 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.

The IBVSOs are also concerned about the availability of quality mental health services for women veterans, especially women veterans who have experienced sexual trauma during military service. Only 43% of VAMCs have one or more designated women's health providers in outpatient mental health clinics to accommodate women veterans' special needs.

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, "… 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."

Women Veterans Program Managers (WVPMs) are another key component to addressing the specialized health-care needs of women veterans. These program directors are instrumental to the development, management, and coordination of women's health 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 *IB* is concerned about the actual amount of time WVPMs are able to dedicate to women veterans' issues. VA staff members assigned to these positions frequently complain that their duties as coordinators are collateral or "secondary" to their overall responsibilities, and that they generally do not have sufficient time to devote to women veterans' issues. 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 women veterans is necessary because female veterans 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 women veterans' programs, are endangered. 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 increase the priority given to women veterans' programs to ensure that quality health care is provided in all VA facilities and that specialized services are equally available to women veterans as men 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. The health-care environment directly affects the quality of care provided to women veterans and significantly impacts the patient's comfort and feeling of safety and sense of welcome. Finally, the *IB* recommends VA focus its women's health research on finding which health-care delivery model demonstrates the best clinical outcomes for women veterans to ensure they have equal access to high-quality health care at all VA facilities.

Recommendations:

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

VA needs to increase the priority given to women veterans' programs and evaluate which health-care delivery model demonstrates the best clinical outcomes for women.

VA needs to increase its outreach efforts to women veterans because female 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 in such areas as post traumatic stress disorder, spinal cord injury, prosthetics, and homelessness are equally available to female veterans as male veterans.

Long-Term Care Issues

VA Long-Term Care

VA has failed to meet its statutory obligation to maintain its capacity to provide extended (long-term) care services to America's aging veterans as mandated by 38 U.S.C. § 1710B.

Since 1998, VA's average daily census (ADC) for VA nursing homes has continued to decline and VA has failed to provide comprehensive coverage for its noninstitutional long-term care services.

VA Nursing Home Care:
VA's Veteran Population (VetPop) data adjusted to the Census of 2000 reveals aging trends that will certainly increase veteran demand for both VA's institutional and noninstitutional (home and community-based) long-term care services. For example, the number of veterans in the 85–89 age groups is expected to rise from 547,735 as of September 30, 2002, to 966,669 (almost double) by September 30, 2010. Additionally, the number of veterans in the 90–94 age groups is expected to increase from 107,695 in 2002 to 314,167 (almost triple) in 2010. These aging demographics will place a tremendous strain on existing VA long-term care resources within the next 10 years.

Despite an aging veteran population VA's ADC for VA nursing homes continues to decline from the 1998 baseline number of 13,391 as required by the Veterans Millennium Health Care and Benefits Act, P.L. 106-117 of 1999 (Mill Bill). According to VA's workload data, included in its 2004 budget submission the ADC for VA nursing homes, was 11,969 in 2002, 9,900 in 2003, and is projected to be 8,500 for 2004. Also, VA's ADC for Community Nursing Homes showed 3,834 in 2002, 4,929 in 2003, and a projected drop to 3,072 in 2004.

Yet despite this clear picture of increasing long-term care demand, VA has failed to meet its statutory obligations as mandated in 38 U.S.C. § 1710B to maintain its nursing home capacity at 1998 levels. Section 1710B states, "The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during fiscal year 1998."

VA Noninstitutional Care (Home and Community-Based Services):
In addition to a decline in VA nursing home capacity, VA has done a poor job of correcting service gaps and facility restrictions that limit veterans' access to noninstitutional long-term care services provided under the Mill Bill.

In May of 2003, the GAO issued a report (GAO-03-487) titled *Service Gaps and Facility Restrictions Limit Veterans' Access to Non-institutional Care*. The report addresses service gaps for six noninstitutional VA services mandated by the Mill Bill. The GAO found that of the 139 VA facilities it reviewed, 126 do not offer all six of these services. The services were adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care. Of these six services, veterans have least access to respite care.

The GAO also reported that veterans' access to noninstitutional services is even more limited than the numbers suggest because even when facilities offer these services they often do so in only part of the geographic area they serve. The report also states that at least nine facilities limit veterans' eligibility to receive these services based on their level of disability related to military service, which conflicts with VA's own eligibility standards. These restrictions have resulted in waiting lists at 57 of VA's 139 facilities.

The GAO said that "VA's lack of emphasis on increasing access to noninstitutional long-term care services has contributed to service gaps and individual facility restrictions that limit access to care." The GAO went on to say, "Without emphasis from VA headquarters on the provision of noninstitutional services, field officials faced with competing priorities have chosen to use available resources to address other priorities."

The GAO issued two recommendations to correct VA's access barriers to noninstitutional care:

- VA should ensure that facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services.
- VA should refine current performance measures to help ensure that all facilities provide veterans with access to required noninstitutional services.

VA Long-Term Care Workload:

The following data is taken from VA's FY 2004 budget submission and is expressed in Average Daily Census (ADC) numbers.

INSTITUTIONAL CARE:	2002	2003	2004	INCREASE/ DECREASE
VA Domiciliary	5,484	5,577	5,672	+ 95
State Home Domiciliary	3,772	4,323	4,389	+ 66
VA Nursing	11,969	9,900	8,500	- 1400
Community Nursing Home	3,384	4,929	3,072	- 1,857
State Home Nursing	15,833	17,600	18,409	+ 809
Subacute Care	1,122	956	860	- 96
Psychiatric				
Residential Rehabilitation	1,349	1,429	1,508	+ 79
Institutional Total	43,363	44,714	42,410	- 2,304

NONINSTITUTIONAL CARE	2002	2003	2004	INCREASE/ DECREASE
Home-Based Primary Care	8,081	10,024	13,024	+ 3,000
Contract Home Health Care	3,845	3,959	4,070	+ 111
VA Adult Day Care	427	442	458	+ 16
Contract Adult Day Care	932	1,352	1,962	+ 610
Homemaker/Home Health Aide	4,180	4,247	4,315	+ 68
Community Residential Care	6,661	6,821	6,821	0
Home Respite	0	1,284	1,552	+ 268
Home Hospice	0	0	492	+ 492
Noninstitutional Care Total	24,126	28,129	32,694	+ 4,565
Long-Term Care Total	67,489	72,843	75,104	+ 2,261

These VA workload numbers show a clear decline in VA nursing home care and contract community nursing home care and an overall decline in capacity for VA institutional care services. While VA noninstitutional care reflects a modest increase in ADC, the projected increase in 2004 services remains to be seen.

Over the next 10 years an aging veteran population will have an increased demand for VA long-term care services. Despite mandating legislation, VA has failed to meet legislative requirements requiring it to maintain long-term care capacity at 1998 levels and provide noninstitutional long-term care services systemwide. VA's capacity to provide VA nursing home care continues to decline despite increased appropriations from Congress. In 2003 the GAO reported that VA has failed to provide these noninstitutional long-term care services in a comprehensive manner. It is clear that VA must do more to meet the increasing demand for VA long-term care services.

VA has attempted to amend Congressional language mandating VA long-term care capacity at 1998 levels by allowing VA to count nursing home care furnished by private providers and state veterans' nursing homes. The IBVSOs are adamantly opposed to this suggestion and continue to believe the only true measure of VA capacity is one that counts only the services provided directly by VA.

Sadly, it appears that VA would prefer to off-load America's aging veterans who require nursing home care to the private sector or other Federal payers. It also appears that VA is allowing its facilities to provide noninstitutional long-term care as they see fit instead of providing these services as mandated by Congress. Noninstitutional long-term care services can be a great benefit to America's veterans and in some cases can reduce the timing and need for nursing home care. But the availability of these services must be nationwide and unrestricted by the manipulation of eligibility standards.

The IBVSOs believe VA must move to embrace its aging veteran population by improving its mind-set and current culture, which seems to see this veteran population as a financial burden rather than a national treasure.

Recommendations:

Congress must provide the necessary resources to enable VA to meet its legislative mandate to maintain its long-term care services at the 1998 levels and meet increasing demand for these services. VA requires up to $600 million dollars to correct this long-term care bed deficit and provide required increased number of home- and community-based services.

VA must meet its statutory obligation to provide long-term care services in its facilities.

VA must work to identify and incorporate additional noninstitutional services and programs that can improve and bolster VA's ability to meet increasing demand as required by law.

VA must ensure that its facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services.

VA must refine current performance measures to help ensure that all facilities provide veterans with access to required noninstitutional services.

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Assisted Living:

Assisted living can be a cost-effective alternative to nursing home care for many of America's veterans. The IB *also believes that an expansion of the assisted living pilot project to additional VISNs will benefit veterans and provide useful information to VA regarding other assisted living markets.*

Assisted living (AL) is a special combination of individualized services, which include housing, meals, health care, recreation, and personal assistance, designed to respond to the individual needs of those who require assistance, with the activities of daily living (ADLs) or the instrumental activities of daily living (IADLs). A key feature is the delivery of services in a home-like setting. Assisted living can range from renovated homes serving 10 to 15 individuals or high-rise apartment complexes accommodating 100 people or more. The philosophy of AL emphasizes independence, dignity, and individual rights.

Therefore, AL can be a viable alternative to nursing home care for many of America's aging veterans who require ADL or IADL assistance and can no longer live at home. However, there are some AL regulatory barriers that must be overcome before AL will be open to many disabled veterans. Currently, AL is an industry that is regulated by state law, and many states have regulations that are not friendly to disabled veterans or other people with disabilities. Before VA becomes an AL provider or establishes relationships with private AL providers, solutions to these regulatory barriers

must be found to enable full participation in any VA or private AL program.

VA has argued that it should not become an AL provider because it is not in the business of providing housing to its veterans. However, VA has long been in the business of providing housing for veterans who use VA domiciliary programs, VA nursing homes, and VA contract nursing homes. VA could easily harness its vast long-term care expertise and building resources to become an efficient provider of AL services. AL could be provided through an expanded VA domiciliary care program if modifications were made to serve this population.

VA medical centers have already looked into public-private partnerships to provide AL on VA property through VA's enhanced-use leasing authority. Under this program, VA leases unused land to private AL providers in exchange for services to veterans at a negotiated rate. Additionally, VA's CARES initiative has called for the broad use of AL in its Draft National CARES Plan.

Public Law 106-117, "The Veterans Millennium Health Care and Benefits Act," authorized VA to establish a pilot program to determine the "feasibility and practicability of enabling eligible veterans to secure needed assisted living services as an alternative to nursing home care." VA's Northwest Veterans Integrated Service Network, VISN 20, is implementing the Assisted Living Pilot Program (ALPP) in seven medical centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Oregon, and Roseburg, Oregon; and Spokane, Washington, and the Puget Sound Health-Care System (serving the Seattle and American Lake, Washington, and White City, Oregon).

Following are highlights that reflect a preliminary review of the implementation of the program and the first year of program operation through December 2002. The final report, as mandated by law, will be provided to Congress in October of 2004. VA findings thus far include:

- The implementation of the ALPP has been successful: Despite significant challenges, the ALPP has negotiated contracts with a total of 89 vendors. All sites are actively recruiting and enrolling veterans for the program. From January 29, 2002, through December 31, 2002, a total of 181 veterans were placed in ALPP facilities.
- A new computerized database is allowing efficient recruitment, processing of payments, high-quality data collection, and data analysis for ongoing management feedback and evaluation.
- The average ALPP veteran is a 69-year-old unmarried white male who is not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.
- ALPP veterans show significant functional impairment and a wide variety of physical and mental health conditions.
- 36 adult family homes, 39 assisted-living facilities, and 14 residential care facilities have been contracted with to date. The average vendor has 25 rooms/apartments, ranging from 2 to 208.
- Preliminary data on the cost of ALPP placements are available. Initial findings suggest the mean cost per day for the first 160 enrolled veterans (not including bed hold days) is $75.10.
- The ALPP's implementation will allow VA to obtain an accurate picture of the feasibility of these services in VA based on high-quality managerial and clinical staff with commitment to the goals of evaluation, the new data base, and a wide variety of important issues arising from a multisite demonstration.

Recommendations:

VA must expand and broaden the ALPP authorized by P.L. 106-117.

VA must investigate and eliminate state regulatory barriers that prevent disabled veterans from enrollment and full participation in any VA ALPP, VA AL program, or any other AL arrangement or contract for private AL services utilizing VA property.

VA should aggressively pursue development of AL capacity within existing VA programs that are adaptable to AL and through enhanced-use lease opportunities with private-sector providers and partnerships.

Congress must pass permanent legislation and provide funding to allow VA to provide AL.

Veterans' Access to Noninstitutional Long-Term Care Services:

Veterans' access to noninstitutional long-term care programs is limited by the lack of services available through VA and restrictions imposed by local VA facilities.

Changes in VA eligibility have resulted in an increase in the number of veterans eligible for VA health care, including noninstitutional, long-term care services. The demand for these services is likely to increase significantly during the next decade due to the increasing age of our Korean- and Vietnam-era veteran population. VA estimates the number of veterans age 85 and older—those most in need of long-term care—will more than double by year 2012.

In response to this demand, Congress passed the Veterans Millennium Health Care and Benefits Act of 1999, P.L. 106-117, requiring VA to provide enrolled veterans equal access to three noninstitutional, long-term programs: adult day health care, geriatric evaluations, and respite care. VA is also required to provide home-based primary care, skilled home health care, and homemaker/home health aide as part of its standard benefits package.

Unfortunately, veterans' access to these six noninstitutional long-term care programs is limited by the lack of services available through VA and restrictions imposed by local VA facilities. Many facilities restrict access to a small portion of the respective geographic areas for which they are responsible; impose their own eligibility requirements, e.g., service-connected veterans only; or limit the number of veterans allowed to participate in the various programs, resulting in veterans being placed on waiting lists for noninstitutional services they need now. These restrictions conflict with VA eligibility standards and cause an inequity in access for all enrolled veterans.

Recommendations:

The IBVSOs recommend that VA specify in Department policy (and enforce) the requirement that all eligible veterans be afforded equal and timely access to noninstitutional, long-term care programs.

VA should promulgate performance standards and provide adequate program guidance to ensure nationwide compliance with this policy.

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VA MEDICAL AND PROSTHETICS RESEARCH

Funding for Medical and Prosthetic Research:

Funding for VA medical and prosthetics research is inadequate to support the full costs of the VA research portfolio and fails to provide the resources needed to maintain, upgrade, and replace aging research facilities.

The Department of Veterans Affairs (VA) medical and prosthetic research is a national asset that helps to attract high-caliber clinicians to practice medicine and conduct research in 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: 60% of VA researchers treat veterans. As a result, the VHA, which is the largest integrated medical care system in the world, has a unique ability to translate progress in medical science 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 Prosthetics Research Program, which makes this leverage and synergy possible, relies on an outdated funding system. A thorough review of VHA research funding methodology is needed to ensure adequate funds for both the direct and indirect costs 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. As demands on medical center resources increase, physicians have difficulty finding time to fulfill their clinical, administrative, and training responsibilities **and** to conduct research. Also, funds to staff the necessary oversight committees—Research and Development, Institutional Review Boards, Animal Safety, Biosafety, etc.—are scarce.

VA-funded programs are barely one-third (37%) of the total VA research enterprise, yet VA has failed to secure equitable reimbursement for its indirect costs from all of its research partners, particularly other Federal agencies. VA investigators are to be applauded for their success in obtaining extramural grants, but the medical care appropriation should not bear the entire cost of the necessary infrastructure.

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 construction funding amounting to more than $4 million and $29 million for major construction. 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 the backlog is addressed.

VA medical and prosthetics research is highly productive and has a direct impact on the quality of care provided to veterans.

Medical and Prosthetic Research Account:

VA cannot continue to achieve break-through applications in health-care delivery without adequate growth in the annual R&D appropriation.

Recent VA research achievements include findings that flu shots may also protect the elderly from pneumonia, heart attacks, and strokes; a combination of drugs results in decreased suffering and shorter hospital stays for schizophrenia patients; and believing that tumors spread when exposed to air, African Americans are more likely to decline lifesaving surgery to treat lung cancer. These and many more VA research breakthroughs have direct applications to health-care delivery for veterans as well as the Nation as a whole. However, a commitment to steady and sustainable growth in the annual R&D appropriation is necessary for VA to continue its long record of achievement.

Recommendation:

The IBVSOs recommend an FY 2005 appropriation of $460 million to offset the higher costs of research resulting from biomedical inflation and wage increases as well as opportunities for new breakthroughs.

Medical and Prosthetic Research Issues

A New Vision for VA Research

The VA research program is in need of a thorough review and long-term planning involving external stakeholders.

During 2003, significant changes in the VA research program were implemented without prior public debate or input from stakeholders. Despite the resulting turmoil, VA researchers added to their remarkable record of achievement, and the IBVSOs are confident that VA research has much to offer in advancing diagnosis and treatment of disease and disability. However, there is a need to build a new foundation of broad consensus about the purpose and scope of the VA research program.

Recommendation:

VA should convene a consensus committee involving VA personnel and external stakeholders to conduct a thorough review of the VA research program. The committee should propose to the Secretary and Congress a clear vision for the future with recommendations on complex policy matters in need of resolution.

Restructuring the Research Funding Methodology

More study is needed before deciding whether to assign to the Office of Research and Development (ORD) responsibility for administering the Veterans Equitable Resource Allocation (VERA) research support funds.

Ensuring adequate, accountable funding for both the direct and indirect costs of research is an essential factor in the success of any research enterprise. Currently, ORD allocates R&D funding for the direct costs of projects, while the indirect costs, and physicians' and nurses' salaries are covered by the medical care appropriation. As a result, there is no centralized means to ensure that each facility's research program receives adequate support. At the same time, the flexibility of the current methodology at the local level is essential to meet the variable needs of research, academic, and clinical cycles.

Recommendations:

The IBVSOs do not support assigning to ORD administration of the FY 2005 VERA research support dollars. Prior to consideration of this possibility, VA must demonstrate that it has a workable plan for implementation that provides accountability while preserving the local flexibility of the current methodology. At a minimum, such a plan should be pilot-tested at three sites before contemplating national implementation.

Congress must ensure adequate resources for both the direct and indirect costs of advancing medical diagnosis and treatment.

Research Infrastructure:

VA research infrastructure is in need of repair and improvement.

The IBVSOs applaud Congress and VA for beginning to address in the FY 2004 budget the critical need for minor construction funding to maintain, upgrade, and replace VA's aging research facilities. However, a backlog of high priority research sites in need of minor construction funding amounting to more than $45 million still remains. Additionally, some research facilities are beyond repair, and $290 million is needed for construction to begin replacing outdated buildings.

Recommendation:

Congress and VA must work together to ensure sufficient funding for research facility maintenance and improvements as well as at least one major research construction project per year until the backlog is addressed.

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

Congress and VA should support the Christopher Reeve Paralysis Act of 2003, 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 of 2003 (S. 1010, H.R. 1998), 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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Administrative Issues

Critical Need for a Strong Nursing Workforce:

VA needs a committed, satisfied, and well-educated nursing workforce to sustain the high-quality care our veterans deserve.

VA has the largest nursing workforce in the country, with more than 55,000 registered nurses, licensed practical nurses, and other nursing personnel. The Country and VA are facing an unprecedented nursing shortage, a shortage that could potentially have a profound impact on the care given to our Nation's veterans. VA nurses are an essential component in delivering high-quality, compassionate care to veterans, and VA must be able to retain and recruit well-qualified nurses in order to continue that care.

VA is facing serious challenges in providing consistently *high* quality care. Compensation, benefits, and workplace issues affect VA's ability to retain and recruit nurses in today's highly competitive labor market. The average age of a VA registered nurse is 47.4 years, and only 17% are under 40 years of age. By the end of 2003, 35% of VA's registered nurses were eligible to retire.

The October 23/30, 2002, issue of the *Journal of the American Medical Association* reported job dissatisfaction among hospital nurses nationwide is four times greater than the average for all U.S. workers, and one in five hospital nurses reported an intention to leave his or her current job within a year. Overall, many VA nurses report wage scales and benefits are inadequate and are a major factor in their decision to maintain employment with VA.

An article in the September 24/30, 2003, issue of the *Journal of the American Medical Association* examined whether the proportion of hospital RNs educated at the baccalaureate level or higher is associated with mortality and failure to rescue (deaths in surgical patients with serious complications). The documentation revealed significantly better patient outcomes in hospitals with more highly educated RNs at the bedside. This article reinforces VA's commitment to the VA Nurse Qualification Standard and the expectation of a bachelor's of science degree in nursing for advancement beyond the entry level, as well as a commitment of economic support for associate degree nurses to pursue an advanced degree.

In the current nursing shortage, public policy discussion has centered on how to increase the supply of RNs. VA invests in two major educational pathways into nursing: practice-associate or bachelor's degree programs. However, little attention has been paid to considering how investments of VA funds in these programs will best serve the good of our veteran patients. The documentation of significantly better patient outcomes in hospitals with more highly educated RNs at the bedside underscores the importance of placing greater emphasis on policies to alter the educational composition of the future nurse workforce. VA funding should aim at shaping a workforce best prepared to meet the needs of our aging veteran

population and enhancing the quality of care they receive.

Unfortunately, the VA health-care budget has not kept up with rising health-care costs, and the situation grows more critical each fiscal year. Adequate funds must be appropriated for recruitment and retention programs for the nursing workforce.

VA staffing levels are frequently so marginal that any loss of staff 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.

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 nonnursing duties due to shortages of ward secretaries, building management, and other support personnel. These staffing deficiencies have an impact on both patient programs and VA's ability to retain an adequate nursing workforce.

VA nurses are a national treasure and are dedicated to the mission of caring for America's heroes. Establishing and support of the following recommendations as well as the structures that support the work of nursing will foster the environment necessary for a successful future. Our veterans deserve it.

Recommendations:

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

To meet this goal VA should:

- Establish recruitment programs that enable VA to remain competitive with private-sector marketing strategies;
- Reestablish the VA Professional Scholarship Program;
- Continue the Employee Debt Reduction Program to include all VA nursing personnel;
- Continue funding for the National Nursing Education Initiative;
- Implement youth outreach programs to foster selection of nursing as a career choice;
- Develop special programs between local VA facilities and community colleges/universities with a focus on preparing all levels of future VA nursing personnel;
- Increase support of career path development within nurses' qualification standards; and
- Ensure adequate nursing support personnel to achieve excellence in patient care and outcomes.

Volunteer Programs:

VHA's 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 534 million hours of volunteer service to America's veterans in 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 63 major veteran, civic, and service organizations, which reports 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 2003, VAVS volunteers contributed a total of 12,983,728 hours to VA health-care facilities. This represents 6,221 FTEE positions. These volunteer hours represent more than $215 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 in gifts and donations. 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 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.

Recommendations:

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.

The VHA should develop volunteer opportunities in community-based and home-health settings and recruit local volunteers.

The VHA should develop partnerships with local businesses and corporations for volunteer and program support.

The VHA should include VAVS volunteer productivity data in VHA facility productivity measurement systems and facility management performance standards to create incentives for facilities and managers to utilize VAVS volunteers effectively.

The VHA should initiate volunteer recruitment strategies for age groups 20–40 within each VISN.

VA should encourage all national cemeteries to expand volunteer programs.

Contract Care Coordination

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.

To ensure a full continuum of health-care services, VA spends approximately $1 billion a year for medical care outside the VA health-care system when privately contracted medical services are needed. Current legislation allows VA to contract for non-VA health care (fee basis) 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. Unfortunately, no consistent process exists in VA for veterans receiving contracted care services to ensure that:

(1) veterans are getting the appropriate, most cost-effective care delivered by certified or credentialed providers;

(2) continuity of care is properly monitored by VA and that veteran patients are directed back to the VA health-care system for follow-up care when possible;

(3) veterans' medical records are properly updated with any non-VA medical and pharmaceutical information;

(4) the process is part of a seamless continuum of care/services to facilitate improved health-care delivery and access to care.

Currently, the Preferred Pricing Program allows VA to reap savings when veterans who need contracted care select a physician within the established Preferred Provider Organization (PPO) network. Preferred pricing allows contracted VA medical facilities to save money when veterans need non-VA health-care services by using network discounts. However, VA's program for contracted care is *passive* and only allows for cost savings when veterans coincidentally *choose* to receive care from the contractor's provider network. VA currently has no system in place to direct veteran patients to the participating PPO providers so that VA can:

(1) receive a discounted rate for services rendered;

(2) use a mechanism to refer to credentialed, quality providers; and

(3) exchange clinical information with non-VA providers.

Although preferred pricing is available to all VA medical centers (VAMCs), not all facilities take advantage of these cost savings. Therefore, in many cases VA is paying more for contracted medical care than necessary. Though preferred pricing was a significant improvement in purchasing care for the best value when it was introduced in 1999, and despite the significant savings achieved (more than $19 million), there are several major improvements that can be made to improve the access, quality, and cost of non-VA care.

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 would include:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks would address timeliness, access, and cost-effectiveness. Additionally, the care coordination contractor would require providers to meet specific requirements, such as the timely communication of clinical information to VA, electronic claims submission, meeting VA established access standards, and complying with directors' performance measures.
- 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 for the veteran is an integrated episode of care.
- Improved veteran satisfaction through integrated, efficient, and appropriate health-care delivery across VA and non-VA components of the continuum of care.
- Best value health-care purchasing.

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. A care coordination contractor could be used to temporarily fill a gap or deal with unexpected backlogs. 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 VA's health care and economic objectives. Doing so will improve patient care delivery, optimize the use of VA's limited resources, and prevent overpayment when utilizing community contracted care.

Recommendations:

VA should establish a phased-in contracted care coordination program that is based on principles of medical management.

Whenever possible, veterans who receive care outside VA, at VA expense, should be required to do so in the care coordination model.

VA should engage an experienced contractor willing to go at risk to implement and manage a care coordination program that will deliver improvements in medical management, access, timeliness, and cost efficiencies. VA and the contractor would jointly develop identifiable and achievable metrics to assess program results and will report these results to stakeholders.

Components of a care coordination program should include claims processing, centralized appointment scheduling, and a call center or advice line for veterans who receive care outside the VA health-care system—and should be implemented at VA's expense.

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MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE)

The Medical Administration and Miscellaneous Operating Expenses (MAMOE) appropriation enables supervision and administration in support of the goals and objective of the VHA's comprehensive and integrated health-care system. MAMOE functions include development and implementation of policies, plans, and broad program activities; assistance to the networks in attaining their objectives; and follow-up actions necessary to ensure complete accomplishment of goals. The Facilities Management Service Delivery Office, funded on a reimbursable basis by other VA components, supports project management; architectural engineering; real property acquisition; and disposition, construction, and renovation of facilities under the jurisdiction of, or used by, VA.

MAMOE Account

The Independent Budget VSOs recommend the MAMOE account be funded by the Congress at $86.7 million for FY 2005. The recommended amount is the minimum funding consistent with maintenance of current operations through all MAMOE departments.

MAMOE Recommended Budget Appropriation
(Dollars in Thousands)

FY 2005 IB RECOMMENDATION BY TYPE OF SERVICE	
Personnel Compensation	$71,408
Travel and Transportation of Persons	1,319
Rental Payments to GSA	6,160
Communications, Utilities, and Miscellaneous Charges	1,522
Other Services	3,698
Supplies and Materials	1,353
Equipment	1,229
IB Recommended FY 2005 Appropriation	$86,689

MAMOE Issues

Quality Assurance and Policy Guidance:

Funding shortfalls in the MAMOE account have left VA unable to implement adequate quality assurance efforts or to provide adequate policy guidance within the 21 VISNs.

Despite VHA headquarters' enormous oversight responsibility, large reductions in VHA National Headquarters' staff have caused serious degradation of VA's ability to manage quality of care, provide effective policy guidance, or ensure collection and management of essential information. MAMOE reductions have also adversely impacted VA's critical oversight function and made it difficult to gauge VA's compliance with Congressional mandates.

The work of VHA's Office of Quality and Performance is of the utmost importance, not only to the patient, but also to the Administration and to the Congress who are ultimately responsible for veterans' health policy. What data are available certainly support the contention that VA care is as good as or better than care rendered outside of the VA. However, a quality program must have adequate staff to successfully perform all its necessary functions and be fully accountable to its various constituencies. Additional quality management staff in VA headquarters would translate to more thorough collection, analysis, and reporting of information about health-care quality by network and across the system.

VHA National Headquarters has the critical role of ensuring VA fulfills its Congressional mandate to maintain the capacity for provision of specialized services. Although the VHA takes great pride in its efforts to aggregate patient data within the system, the agency must be equally capable of providing in-depth analyses of its collection in order to understand who is providing the highest quality care and how those analyses can be shared systemwide. The VHA is charged with establishing national policies and priorities, a responsibility whose successful execution further reductions to MAMOE will seriously jeopardize.

VA is the Federal Government's largest employer of physician assistants (PAs), with more than 1,290 FTEE positions. The Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed that the VHA establish a physician assistant advisor position to the Office of the Under Secretary for Health. Congress strongly encouraged that the VHA ensure the PA advisor position is full-time and located in the VA Central Office or in a VA medical center in close proximity to Washington, DC; further, that sufficient funding be provided to support the

administrative and travel requirements associated with the position. Congress directed that VA report by March 3, 2003, on the progress made in this regard. As of this writing, the PA advisor position has not been established as full-time. Moreover, the minimal travel funds made available to the part-time incumbent in FY 2004 have been significantly decreased in the FY 2005 allocation. Indeed, the position is not assigned to the Office of the Under Secretary for Health, does not reside in or near the VA Central Office, and does not appear on the VHA organizational chart.

Health-care delivery and its management are extremely dynamic. Advances in information management/information technology (IM/IT) are even more so, and of ever-increasing importance. New technologies and concepts are both prerequisites to and great opportunities for health-care improvement. IM/IT is the key to many process improvements, evidence-based medicine, population-based research, and other health-care quality enhancements.

The Principi Commission recommended, and the IBVSOs endorse, joint acquisition of a clinical information system to replace the VA's legacy systems. In this connection, the GAO recommended strengthening the Government Computer-Based Patient Record (GCPR), since renamed the Federal Health Information Exchange (FHIE), because of the importance of VA/DOD interoperability.

Recommendations:

Congress and the Administration must provide adequate funding to the MAMOE account to support VHA National Headquarters' role relative to quality management; policy guidance; and information collection, analysis, and dissemination.

VHA National Headquarters must maintain hands-on oversight to meet Congressional mandates to monitor and maintain the capacity for specialized programs.

VHA must staff the PA advisor with one Congressionally approved FTEE position.

Congress should fund, and the VA should implement, new FHIE capability.

Construction Programs

The Department of Veterans Affairs construction budget includes major construction, minor construction, grants for construction of state extended care facilities, grants for state veterans' cemeteries, and the parking garage revolving fund.

The Historical Appropriations for VA Major and Minor Construction chart listed on the next page clearly shows that since 1993 VA's construction budget and annual appropriations for both major and minor projects continue to drop sharply to the current low level. The FY 1993 combined total was $600 million; however, by FY 2003, the total had decreased to only about $300 million. VA's history of low construction budgets the last 12 years is an explicit indication of poor stewardship of the system's facility capital assets.

In a study completed in 1998, Price Waterhouse was asked to determine the spending level required to ensure that VHA's investment in facility assets would be adequately protected against adverse deterioration and to keep the average condition of facilities at an appropriate level. Price Waterhouse concluded that the VHA was significantly underfunding its construction spending, and based on their observations across the industry, appropriate annual spending should be between 2% and 4% of the plant replacement value (PRV) on reinvestment to replace aging facilities. Price Waterhouse considered reinvestment to be improvements funded from the major and minor construction appropriations. PRV for the VHA is approximately $35 billion. The 2%–4% range would therefore equate to annual funding of $700 million to $1.4 billion

There continues to be major political resistance to fund an adequate construction budget before the Capital Asset Realignment for Enhanced Services (CARES) process has been completed. We have been supportive of the CARES process from the beginning, as long as the primary emphasis is on the "ES"—enhanced services; however, we believe that it is poor policy to defer all VA construction needs until CARES is complete.

Currently, most VA medical centers, with an average age of 54 years, are in critical need of repair. Sadly, the prospect of systemwide capital asset realignment through the CARES process has been used as an excuse to hold all construction projects hostage. These projects are essential to patient safety; moreover, they will eventually pay for themselves through future savings as a result of modernization. The ongoing reconfiguration of the system through CARES must not distract VA from its obligation to protect its current assets by postponing needed funding for the construction, maintenance, and renovations of VA facilities.

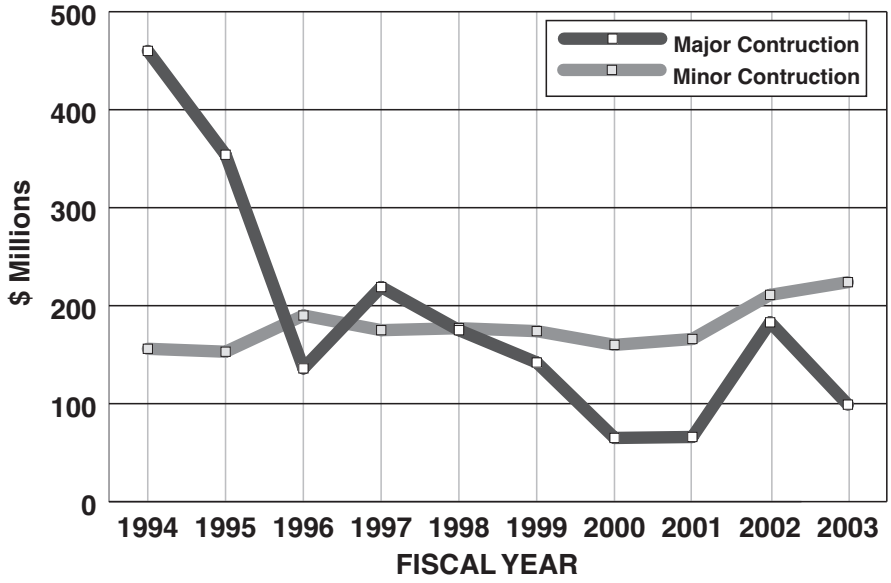
While we still believe the CARES process should proceed, we perceive a need for further data to support various recommendations that would close or change missions of certain VA long-

term care and small size facilities. These data should include such items as a cost analysis associated with these changes to include the costs of transferring patients and staff; the cost associated with contracting for care in the community; the cost related to shutting down and disposing of property to include asbestos removal; the cost to build or lease new facilities like community-based clinics and patient bed towers to include associated site elements to make the building functional, such as equipment, relocation, and activation costs; and updating facility infrastructures to handle additional patient workloads while maintaining privacy and safety requirements.

We acknowledge that the VA Office of Facilities Management has assembled construction cost data for various functional building types; however, the inclusion of the aforementioned cost could provide the rationale for reconsidering some decisions.

In additional, the assumption that Congress will adequately fund all CARES proposed changes must be questioned. The IBVSOs are concerned that when CARES implementation costs are factored into the appropriations process, Congress will not fully fund the VA system, further exacerbating the current obstacles impeding veterans' access to quality health care in a timely manner. It is our opinion that VA should not proceed with CARES changes until sufficient funding is appropriated for the construction of new facilities and renovation of existing hospitals is approved.

CHART 2. HISTORICAL APPROPRIATIONS FOR VA MAJOR AND MINOR CONSTRUCTION



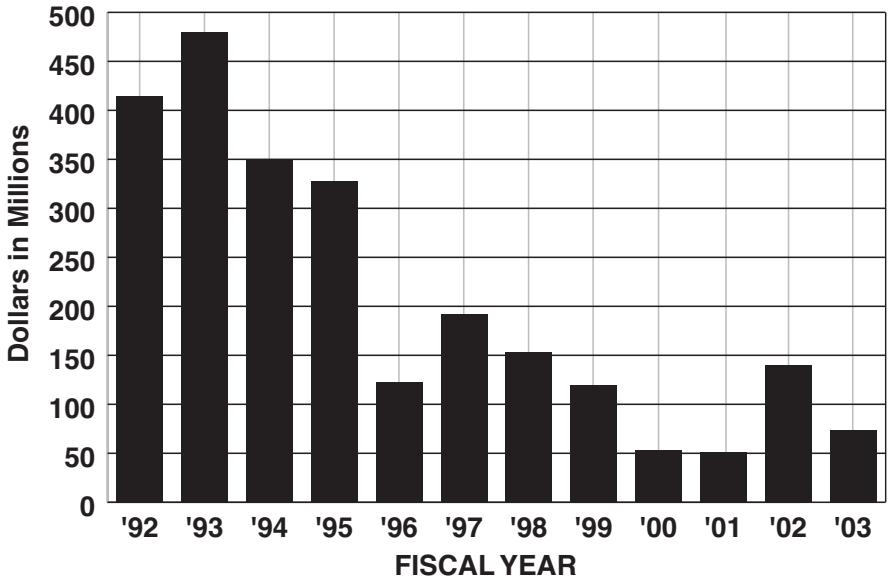
MAJOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate **$571 million** to the Major Construction Account for FY 2005. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition, and claims.

Construction, Major Projects Recommended Appropriation
FY 2005 IB Recommendation by Type of Service
Medical Program (VHA)

Seismic Improvements	$285,000
Clinical Improvements	25,000
Patient Environment	10,000
Research Infrastructure Upgrade and Replacement	50,000
Advance Planning Fund	60,000
Asbestos Abatement	60,000
National Cemetery Administration	81,000
IB Recommended FY 2005 Appropriation	$571,000

CHART 3. MAJOR CONSTRUCTION BUYING POWER ADJUSTED FOR INFLATION



MINOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate **$545 million** to the Minor Construction Account for FY 2005. 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, a staff office account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects.

Construction, Minor Projects Recommended Appropriation
FY 2005 Recommended by Type of Service
Medical Program (VHA)

Inpatient Care Support	$130,000
Outpatient Care and Support	100,000
Infrastructure and Physical Plant	150,000
Historic Preservation Grant Program	25,000
Other	25,000
VBA Regional Office Program	35,000
National Cemetery Program	35,000
VA Research Facility Improvement and Renovation	45,000
IB Recommendation FY 2005 Appropriation	$545,000

CONSTRUCTION ISSUES

CORRECT SEISMIC DEFICIENCIES:

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

Annually, the VHA submits a list of Top 20 Priority Major Medical Construction Projects to Congress, which identifies the major medical construction projects that have the highest priority within VA. This list includes buildings that have been deemed at "significant" seismic risk and buildings that are at "exceptionally high risk" of catastrophic collapse or major damage. Currently, 890 of VA's 5,300 buildings have been classified as significant seismic risk, and 73 VHA buildings are at exceptionally high risk.

Four exceptionally high-risk seismic correction projects—Palo Alto, San Francisco, West Los Angeles, and Long Beach—were included in VA's recent budget submission; however, none of these seismic projects were funded. These four facilities have been classified as the most exceptionally high risk for catastrophic collapse or major damage.

The IBVSOs believe, as we have indicated in the past, that there is political resistance to fund any major construction projects before the CARES process has been completed, and this includes correcting seismic deficiencies in VHA facilities. Regardless of the recommendations of the CARES program on facility realignments, it is our contention that VA must maintain and improve its existing facilities to support the delivery of health-care services in a risk-free environment for veterans and VA employees alike.

Most seismic correction projects should include patient-care enhancements as part of their total scope.

Also, consideration must be given to enhanced service recommendations provided for CARES. Due to 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.

Recommendations:

Congress should appropriate $285 million to correct seismic deficiencies.

VA should schedule facility improvements projects and CARES recommendations concurrently with seismic corrections.

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Inadequate Funding/Declining Capital Asset Value:

VA's health-care facility infrastructure is grossly undercapitalized.

Good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs, such as seismic correction, compliance with the Americans with Disabilities Act (ADA) and Joint Commission of Accreditation of Healthcare Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES, VA's construction budget continues to be inadequate.

In *The Independent Budget for Fiscal Year 2004*, we 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 will cite the recommendation of the PTF again this year.

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% 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% of plant replacement value for its entire facility infrastructure. A minimum of 5% to 8% investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the DOD adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

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

The PTF also indicated that "Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus, but instead submits an annual top 20 facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within 4 years. However, VA facilities are constrained by reprogramming authority, inadequate 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) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and

(3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

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

The IBVSOs concur with the provisions contained in the PTF final report. If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high-quality services in old and inefficient patient care settings.

Recommendation:

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

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Increase Spending on Nonrecurring Maintenance:

The deterioration of many VA properties calls for increased spending on nonrecurring maintenance.

The IBVSOs support the Price Waterhouse recommendation that VA spend at least 2% of the value of its buildings or $700 million annually on upkeep. The IBVSOs believe that $400 million should be appropriated in FY 2005 with continued increases in the following years until an appropriate level of funding that will forestall the continued deterioration of VA properties is achieved.

Recommendations:

Congress should appropriate no less than $400 million for nonrecurring maintenance in FY 2005 to provide for adequate building maintenance.

VA should direct no less than $400 million for nonrecurring maintenance in FY 2005. VA should also make annual increments in nonrecurring maintenance in the future until 2% of the value of its buildings is budgeted and utilized for nonrecurring maintenance.

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Empty or Underutilized Space at Medical Centers:

VA should avoid the temptation to reuse empty space inappropriately.

The suggestion has been made that the VA medical system has vast quantities of empty space that can be cost effectively reused for medical services. Furthermore, it has been suggested that unused space at one medical center may help address a deficiency that exists at another. Although the space inventories may be accurate, the basic assumption regarding viability of space reuse is not.

Medical facility planning is a complex task because of the intricate relationships that must be provided between functional elements and the demanding technical requirements of the sophisticated equipment that must be accommodated. For these reasons, space in medical facilities is rarely interchangeable—except at a prohibitive cost. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a

space deficiency in a second floor surgery because there is no functional adjacency. Medical space has very critical inter- and intra-departmental adjacencies that must be maintained for efficient and hygienic patient care. In order to maintain these adjacencies, departmental expansions or relocations usually trigger extensive "domino" impacts on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Some permanent features of medical space, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading, cannot be altered. Different medical functions have different technical requirements based on these permanent characteristics. Laboratory or clinical space, for example, is not interchangeable with patient ward space because of the need for different column spacing and perimeter configuration. Patient rooms need natural light and column locations that are compatible with patient room layouts. Laboratories should have long structural bays and function best without windows. If the "shell" space is not appropriate for its purpose, renovation plans will be larger and more inefficient and therefore cost more.

Using renovated space rather than new construction yields only marginal cost savings. Build out of a "gut" renovation to accommodate medical functions usually costs approximately 85% of the cost of similar new construction. If the renovation plan is less efficient, or the "domino" impact costs are greater, the small potential savings are easily lost. Renovation projects often cost more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve desirable functional adjacencies, but they are rarely economical.

Early VA medical centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most main hospitals have been consolidated into large, tall "modern" structures. Over time, these central medical towers have become surrounded by radiating wings and connecting corridors leading to secondary structures. Many current VA medical centers are built around prototypical "Bradley buildings." These structures were rapidly constructed in the 1940s and 1950s for returning World War II veterans. Fifty years ago, these brick facilities were easily site-adapted and inexpensive to build, 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. This makes it almost impossible to retrofit modern mechanical systems. The older hospital's wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts by contemporary standards. The Bradley hospital's central service core with a few small elevator shafts is inadequate for the vertical distribution of modern medical services.

In addition, much of the currently vacant space is not situated in prime locations. If the space were, it would have been previously renovated or demolished to clear the way for new additions. Unused space is typically located in outlying buildings or on upper floor levels. Its permanent characteristics 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 and protected. Some space may be appropriate for enhanced use. Some may be appropriate for demolition. While it is tempting to focus on unused space, it should not be a major determinant in CARES realignments. Each medical center should develop a plan to find appropriate 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.

Preservation of VA's Historic Structures:

VA's extensive inventory of historic structures must be protected and preserved.

VA's historic structures provide direct physical evidence of America's proud heritage of veterans' care, and they enhance our understanding of the lives and sacrifices of the soldiers and sailors that fashioned our country. VA owns almost 2,000 historic structures. Many are suffering from neglect and deteriorate further every year. These structures must be stabilized, preserved, and protected. The first step in addressing this important legal and moral responsibility is for VA to develop a comprehensive national program for its historic properties. Because the majority of these structures are not suitable for modern patient care, the current CARES planning process will *not* produce a national strategy for the preservation of historic properties. A separate initiative must be undertaken immediately.

VA must inventory its historic structures and establish broad classifications regarding their current physical condition and their potential for adaptive reuse. This reuse may be either by VA medical centers or by local governments, nonprofit organizations, or private-sector businesses. In order to accomplish these initial objectives, we 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. This expertise should prove helpful in establishing this program. In addition, VA must expand its current staffing for this new task.

In conjunction with an adaptive reuse program, VA needs to develop legal models and strict administrative policies for protecting those historic structures that are leased or sold. VA's responsibilities, for example, could be addressed through legal easements on appropriate property elements, such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully completed a cooperative agreement assisting the Department of Army with the management of its historic properties.

We propose a $25 million budget for FY 2005 in order to stabilize, preserve, and reuse the thousands of historic VA properties. The funds should also be used to maintain VA's artifacts and collections and to provide grants to local organizations for preservation activities related to veterans facilities. We support the proposed language in Section 8171 for the establishment of a fund and for its purpose.

The protection and preservation of VA's historic structures is an important responsibility that the Department has ignored for too long. Faced with scarce funding and competing patient care demands, VA management has delayed addressing this issue for decades. We therefore recommend that specific funding and detailed responsibilities are included in the FY 2004 budget for this purpose.

Recommendation:

Specific funds should be included in the FY 2005 budget to develop a comprehensive program for the preservation and protection of VA's inventory of historic properties.

CARES ISSUES

Establishing a Program for Medical Center Master Plans:

Each VA medical center needs to develop a detailed facility master plan.

CARES will *not* produce detailed facility master plans for each VISN medical center. Without these facility plans, the CARES recommendations cannot be efficiently implemented. Potential benefits of the lengthy and expensive CARES medical planning process will be jeopardized by hasty and ill-conceived construction planning. The construction budget should therefore include $100 million to fund master plans for the 167 VA medical centers. In order to implement this detailed facility planning, VA must immediately establish guidelines and formats for these master plans so that work can proceed. Since VISN 12 planning was completed in the CARES pilot phase, this network would be a good staring point for the master facility planning process.

Master plans for each medical center must be developed by contracted design professionals based on programmatic and operational decisions agreed to during CARES. Medical center master plans must be internally and externally coordinated. External coordination may prove to be the more complex undertaking. For example, where current programs are relocated to from one medical center to another medical center, new construction at the second facility must be completed *before* related actions can be undertaken at the first. This requires that the proposed changes be a part of *two* facility master plans, one for the donor facility and one for the acquiring facility.

Similarly, construction priorities must be coordinated between the medical centers. Construction of an expanded SCI facility may be a high priority for the gaining facility, but the loss of an existing program may be a low priority for the donor facility. If construction funds will be expended at both facilities, it may be a practical budget policy to fund the two actions together.

Even when program changes will take place on a single campus, master plans must be developed so that a series of projects can be prioritized, coordinated, and phased. Each project is a logical step in achieving the long-range CARES objectives in an efficient and effective manner with the minimum disruption to patient care.

Master planning will allow preparation of accurate construction cost estimates that include sufficient contingency expenses for operational phasing. When complete, cost estimates prepared during master planning will either validate or challenge the original CARES strategic decisions. For example, if CARES called for use of renovated space for a relocated program and a more comprehensive examination indicates that the selected option is impractical, different options must be considered to achieve the desired results.

Master planning will also provide the mechanism for VA to address the three critical programs that were omitted for the CARES study. For long-term care, severe mental illness, and domiciliary care VA will need to accomplish both program and facility planning. Because these are significant programs, the impact of their incorporation in the planning process will be substantial.

Two other components of facility management were omitted from CARES: planning for historic structures and planning for existing vacant space on VA campuses. These must be addressed in a timely manner.

Master planning must follow immediately after CARES in order to efficiently implement necessary construction, to prepare accurate budgets, and to validate the original strategic planning decisions. VA should already have developed a master planning program as recommended in *The Independent Budget for Fiscal Year 2004*. The consequences of electing to bypass this critical step are already evident in VISN 12, where Chicago Lakeside demolition is currently scheduled to precede, rather than follow, Westside construction. Facility master planning should be funded and implemented immediately.

Recommendations:

Congress must appropriate $100 million for medical center master plans in the FY 2005 construction budget.

The facility master plans should address the long-term care, severe mental illness, and domiciliary care programs that were inexplicably omitted from the CARES study. Facility 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 VISN by local contractors. The format should be tested in a pilot project.

Each VA medical center should initiate their procurement process immediately so that they are ready to proceed after CARES is completed and adopted.

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Coordinate Planning and Design Time Frames in Order to Efficiently Manage Construction:

VA must develop realistic and compatible time frames for use in CARES, facility master planning, and individual project development.

Based on historical data, the VA project development process for design and construction takes from 8 to 10 years, measured from design initiation to building occupancy. The length of the process cannot be ignored in evaluating current CARES planning initiatives. The inherent contradiction is that a rather short, 17-year long-range planning process is coupled to a long, 10-year implementation process. The current project timeline does not include the critical new master planning step. Furthermore, many CARES-generated projects will require more complex construction phasing and private-sector real estate transactions. Therefore implementation of CARES projects will take longer than current projects—even if funding were immediately available. This reality has ramifications for CARES planning because it impacts its implementation.

The medical center master planning process will add at least one year to the current project development process. Even if master planning were initiated for every medical center immediately after CARES was adopted, building occupancy of the first CARES project would be more than a decade later. As a practical matter, the assumption must be that the majority of the CARES projects will *not* be completed by 2020, the second CARES planning target date. Very few projects will be completed by 2012, the "bump" year and the first CARES target date.

Recognition of these time frames means that CARES plans must be viewed in a different light. For example, the higher demand for veterans' services that are projected for 2012 (the "bump") must be addressed by *nonconstruction* alternatives. There is simply not sufficient time to construct new facilities to meet the forecast need. VA should therefore begin to address this responsibility immediately by means of operational adjustments.

In order to efficiently manage its assets and construction, VA must develop realistic and coordinated cycles for medical planning, facility planning, and project design. Statistical data gathering, for example, should be conducted annually. Now that planning tools have been adopted for CARES, the same data should be evaluated and updated annually. This will allow VA to monitor previous planning projections. Was the CARES demand forecast for future services accurate? If not, why not? This analysis will also allow VA to conduct future long-range planning more easily, more inexpensively, and more accurately. Comprehensive medical planning (like CARES) should be conducted on a 10-year cycle but reviewed and updated annually.

Facility master planning should be conducted on the same cycle as comprehensive medical planning, but it should be updated every 3 years to reflect ongoing changes in demand for services and in philosophy of care. VA should make every effort to reduce the length of the design and construction process so that newly completed facilities reflect the most current planning data, the most advanced medical technologies, and the

newest models for patient care. Medical advances occur at much too swift a pace to be compatible with a long and 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 facility 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.

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Uses for CARES Statistical Data in Facility Management and Budgeting:

VA and Congress should make full use of the data produced by the CARES initiative.

The CARES process has produced extensive new data that is potentially useful to Congress and VA, regardless of full acceptance or implementation of the entire study. Even if there is disagreement on the planning assumptions, one category of CARES data paints a clear picture of VA facilities as they exist today. This category is "existing space deficiencies."

CARES provides a statistical analysis of the VA system's current deficiencies in functional space that is available to support the medical services that are currently delivered. By the application of established planning algorithms, the current space requirements have been mathematically computed for every program except long-term care, severe mental illness, and domiciliary. This computation establishes an objective benchmark that is compared to existing space inventories. These inventories are available on a program-by-program basis for each medical center, for each VISN, and for the overall VA system. The mathematical difference between the benchmark and the inventory represents the deficiency. This deficiency is the current need for new facility construction in order to provide quality medical care to today's veterans. Using this CARES data, a specific medical center, for example, can be identified as the "most deficient" in the VA system. By extension, this facility is most in need of new construction. Specific medical programs can also be compared on a similar basis.

This data identifies the current need for new space and therefore establishes the magnitude of construction that is necessary to adequately address today's veterans' needs. This data will also allow prioritization of construction funding, based on a variety of different criteria, including geographic regions or medical programs. This data is based on completely objective measurements, not based on any assumptions regarding future needs.

The CARES data category that is based on assumptions is "projected space deficiencies." These projections are based on various planning assumptions regarding veteran eligibility, population demographics, and future military actions. Actuarial data is used to project these future demands for veterans' health-care services. Because of these fundamental assumptions and unforeseeable medical advances, these space projections are based on much less solid information than existing space deficiencies. These projections must be considered, however, because VA must plan to the best of their abilities for future needs. Long-range planning is particularly critical for an efficient construction program because the implementation process is so long. Future projections can also be used to project the future need for construction and as a basis for resource allocation.

The newly collected CARES data illustrate the scope of both the system's current and future construction needs. These data can be used to establish the magni-

tude of future construction budgets and provide a rational basis to allocate 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. Funding could also be adjusted to emphasize one medical program over another. Data of this type should have been available for decades for both management and oversight purposes.

With the new CARES data, better systemwide facility and medical management will now be possible. CARES data should therefore be periodically updated in order to verify the accuracy of the underlying assumptions and make the necessary adjustments to the facility and operational plans. Similar statistical data should be generated and maintained for the three missing programs (long-term care, severe mental illness, and domiciliary).

Recommendations:

VA should generate similar statistical data for long-term care, severe mental illness, and domiciliary.

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 the CARES data as an important tool for systemwide planning and management.

What Should Follow CARES?

VA must immediately undertake certain activities in order to secure the potential benefits of CARES.

The CARES long-range planning study has been completed, and it is certainly time to initiate a major construction program to enhance VA's medical facilities. The CARES study has attempted to project the future demand for services and identify what types of patient programs will be needed. In addition, CARES has proposed a realignment of existing assets to best meet these needs. During the past few years, construction funding has been virtually frozen pending the outcome of CARES. This severe funding reduction has been detrimental to the maintenance of VA's capital assets and has allowed atrophy in the construction management program. It is now time to ramp up construction in order to meet the system's current and future needs. This expanded construction program needs to be implemented in an efficient and deliberate manner.

In order to initiate a new era of expanded medical facility construction, VA must establish a national program of facility master planning that describes, in detail, the most efficient means of implementing the medical program planning that was agreed to in the CARES study. In addition, VA needs to establish an ongoing national planning program that collects, maintains, and evaluates critical statistical data. The new planning program should monitor CARES projections and adjust the conclusions, as necessary, as future events unfold. New statistical data for the three medical programs (long-term care, severe mental health, and domiciliary) that were omitted from CARES should be added as quickly as possible.

VA must coordinate its planning, construction, and management responsibilities. Appropriate cycles for planning activities need to be established and implemented. Management mechanisms need to be estab-

lished to collect and evaluate planning data. Inaccurate planning forecasts cannot be allowed to continue uncorrected, as was the case with MEDIPP in the late 1990s. Better long-range planning also needs to be coupled with shorter design and construction time frames in order to deliver a better product in a more efficient manner.

Several aspects of the facility inventory management were not addressed in CARES. These include the historic properties that VA owns and the vacant space that exists at many medical centers. Comprehensive solutions for these management issues need to be developed, approved, and implemented.

Recommendations:

VA construction should be expanded in order to meet the system's current and projected space needs.

VA must initiate new programs for facility master planning based on the CARES recommendations.

VA must maintain and analyze new planning data and streamline the current design and construction process.

VA must develop programs to address historic properties and vacant 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 appointment of a new director and deputy director who have the opportunity to take Vocational Rehabilitation and Employment in a new direction.

Vocational Rehabilitation and Employment Issues

Services for Disabled Veterans Lacking:

Many disabled veterans are not receiving suitable vocational rehabilitation and employment services required to provide a smooth transition into the workforce.

On January 10, 2000, the Department of Veterans Affairs changed the name of the Vocational Rehabilitation and Counseling Service (VR&C) to Vocational Rehabilitation and Employment Service (VR&E). The purpose of the name change was to reenergize the focus of the organization's mission, preparing disabled veterans for suitable employment and providing independent living services to those veterans who are severely disabled and are unlikely to secure suitable employment at the time of their entry into independent living. We applaud the Veterans Benefits Administration's efforts and look forward to their continuing changes to improve delivery of meaningful services to disabled veterans. For too many years, and in spite of many individual successes, VR&E was the recipient of valid criticism. Many of these criticisms remain of concern, including the following:

- Inadequate and sometimes nonexistent case management;
- Outdated regulations, as well as policies and procedures manuals;
- Long delays in the time taken to process applications;
- Lack of accountability for poor decision making—there needs to be consistency with flexibility and accountability;
- Inadequate use of electronic information technology;
- Failure to explore entrepreneurial opportunities for severely disabled veterans and other disabled veterans who are unable to obtain or retain employment or are suitable for self-employment;
- Declaring veterans rehabilitated after training without ensuring that they achieve suitable employment;
- Case loads too large;
- VR&E's Case Management Information Management System (Corporate WINRS is in need of updating and implementation);
- Staff shortages;
- Need for collaboration with the Department of Labor and the Small Business Administration.

We encourage VR&E to continue with its efforts to improve its services and to involve and seek recommendations from the IBVSOs and other stakeholders.

Recommendations:

VBA must place a higher emphasis on complementing VR&E's staffing requirements and needs.

VR&E should continue its efforts to improve case management techniques and use state-of-the-art information technology.

VR&E should rewrite its operational policies and procedure manuals.

General Counsel should expedite the promulgation of new regulations for VR&E.

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

VR&E should develop plans and partnerships to enhance the availability of entrepreneurial opportunities for disabled veterans.

VR&E should develop plans to continue follow-up of rehabilitated veterans for at least 2 years to ensure that rehabilitation is successful.

Unpaid Work Experience:

For vocational rehabilitation clients, the unpaid work experience program should be expanded to include work in the private and nonprofit sector.

For many years disabled veteran clients under vocational rehabilitation could participate in a program of unpaid work experience as part of their rehabilitation program with Federal Government agencies. Several years ago that authority was expanded to include state and local governments but not private- or not-for-profit-sector employers.

In today's labor market it is beneficial for those seeking career employment not only to be trained properly but also to have some related work experience, either as an intern or volunteer or in some other capacity. The concept of unpaid work experience as part of a veteran's training program is significant and should result in a higher success rate of employment outcomes.

Recommendation:

Congress should extend the authority for unpaid work experience to private-sector and not-for-profit-sector employers who are willing to develop such unpaid work experience opportunities consistent with the veterans' training program.

Assistance Programs Inadequate:

The Transition Assistance Program and Disabled Transition Assistance Program do not adequately serve servicemembers.

For several years the Department of Defense (DOD), the Department of Labor (DOL), and VA have been providing transition assistance workshops to separating military personnel through the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP). 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 session in which a representative from VA's Vocational Rehabilitation and Employment Service advises disabled veterans with potential eligibility about their rights and how the programs work. DTAP has been viewed as a "stand alone" program. Typically, a DTAP participant does not benefit from other transition services.

The number of military members being separated annually is still high (more than 200,000 as projected by the DOD) and could increase because of large numbers of soldiers leaving due to the current operational tempo. The IBVSOs believe that TAP must continue to provide its important services. The Commission on Servicemembers and Veterans Transition Assistance has recommended the continuation of TAP/DTAP.

The IBVSOs are concerned, as well, that too little is being done for transitioning disabled veterans.

Recommendations:

Congress should pass legislation ensuring the eligibility of all disabled veterans on a priority basis for all federally funded employment and training programs.

The DOD should ensure that separating servicemembers with disabilities receive all of the services provided under TAP as well as the separate DTAP session by VR&E.

Congress has authorized the provision of TAP services to separating servicemembers 1 year prior to discharge and for military retirees up to 2 years prior to discharge. In the event that notification of separation or retirement occurs less than that authorized, transi-

tion services should begin as soon as possible following notification.

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.

Certification and Licensing of Transitioning Military Personnel:

Civilian licensure and certification barriers facing transitioning military members must be reduced.

In recent years there has been an increased reliance on licensure and certification as a primary form of competency recognition. The public, professional associations, employers, and the Government have turned to credentialing to regulate entry into employment and to promote safety, professionalism, and career growth. Hundreds of professional and trade associations currently offer certification in their fields, and there has been an increase in occupational regulation by states and the Federal Government. The trends suggest that in the 21st century the interest in competency recognition will accelerate.

The emphasis on licensure and certification can present significant barriers for transitioning military personnel seeking employment in the civilian workforce. Credentialing standards, such as education, training, and experience requirements, are developed based on traditional methods for obtaining competency in the civilian workforce. As a result, many transitioning military personnel who have received their career preparation through military service find it difficult to meet certification and licensing requirements due to the lack of civilian recognition of military training and experience. For some, this inability to become credentialed bars entry into employment in their fields entirely. For others, the lack of credentials will make it difficult to compete with their civilian-sector peers for jobs. Those who are able to obtain employment in their fields without the applicable credentials may face decreased earnings and limited promotion potential.

Pilot programs have been initiated in some states to provide credentialing to servicemembers in a limited number of fields. The IBVSOs believe that there are a number of factors that have an impact on the ability of current and former military personnel to obtain civilian credentials. Many civilian credentialing boards do not have adequate knowledge of and do not give proper recognition to military training and experience. The lack of clarity regarding the procedures for exchange of transcripts between military and civilian credentialing boards creates undue barriers for military personnel.

The IBVSOs believe the DOD must assist members preparing to transition from active duty to civilian jobs through the proper dissemination of information. The DOD must maintain involvement with the certifying organizations and coordinate efforts among Federal agencies and private industry.

Recommendation:

Armed Forces training schools need to pay greater attention to the activities and requirements of civilian credentialing agencies.

Performance Standards:

Performance standards in the Veterans Employment and Training Service system are inconsistent and inadequate.

Within the Veterans Employment and Training Service (VETS) system there are currently no performance standards that can be used to compare one state to another or even office to office within a 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. Given the limits of state civil service systems, some State Employment Security Agency (SESA) administrators have a similar difficulty in holding local managers accountable for performance. The only real tools VETS possesses is the staff members' own powers of moral suasion and personal relationships they may have developed.

The only real authority is the seldom-used power to recapture funds when a state has acted in a way contrary to law. The power to declare a state out of compliance can be likened to the power to declare nuclear war: Everyone is afraid to use it because it might well destroy everything. For several years many have seen a need for some sort of standards for both Disabled Veterans' Outreach Program (DVOP)/Local Veterans' Employment Representative Program (LVER) staff and for the SESAs as an entity. The problem has always been both a technical one, how to develop national standards and for what purpose, and a political one, the states have viewed even the minimal standards of behavior currently in place as constituting intrusive interference from Washington. Current standards compare services to nonveterans and veterans—a state need only do a little better for veterans than for nonveterans. If it places 3% of its nonveteran applicants, the state need only place 4% of its veteran applicants to be in compliance.

This certainly conflicts with 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 Job and Job Training Counseling Service Program, Employment Placement Service Program, and Job Training Placement Service Program for eligible veterans so as to provide such veterans and persons the maximum of employment and training opportunities.

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 its grants to states, to provide cash and other incentives to individuals who are most effective in assisting veterans, particularly those with barriers to employment, find work. This recognition is only for individuals and not entities. Congress should amend this law so that such entities as Career One-Stops who do a good job for veterans can be recognized.

Congress should consider the feasibility and practicality of alternative means of delivering employment services for veterans, such as a competitive bidding process.

Training Institute Inadequately Funded:

The National Veterans Training Institute lacks adequate funding to properly administer its training programs, which are unavailable elsewhere.

The National Veterans Training Institute (NVTI) was established in 1986 and authorized in 1988 by P.L. 100-323. NVTI is administered by staff from the Department of Labor/VETS through a contract currently with the University of Colorado at Denver. NVTI trains Federal and state employees and managers who provide direct employment and training services to veterans and servicemembers. The NVTI curriculum offers courses for staff of the DVOP and LVER programs in core professional skills, marketing and accessing the media, case management, vocational rehabilitation and counseling program support, and facilitation of Transition Assistance Program (TAP) workshops.

Training offered to VETS staff includes a basic course on the Uniformed Services Employment and Reemployment Rights Act (USERRA), enacted in October 1994; a new investigative techniques course; a quality management course; and a grants management course.

NVTI offers DOD employees TAP management training, through reimbursable agreements under the Economy Act (at actual cost of training). 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.

Recommendation:

Congress must fund NVTI at an adequate level to ensure training is continued and expanded to state and Federal personnel who provide direct employment and training services to veterans and servicemembers in an ever-changing environment.

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Program Reassessment:

Leadership is needed on a comprehensive reassessment of veterans' employment and training programs.

This reassessment must involve all veterans and other stakeholders, as well as congressional oversight. The Senate or House Veterans' Affairs Committee should take the lead to involve veterans service organizations; the National Association of State Workforce Agencies; veteran-based organizations, such as the National Coalition of Homeless Veterans (NCHV) and the Office of the Assistant Secretary for Veterans Employment and Training (OASVET); and possibly the International Association of Personnel Employment Services (IAPES) Veterans' Committee in discussing these matters of standards and accountability for veterans' employment programs. These issues include accountability at every level, backed up by:

- Significant incentives and reasonable sanctions, and
- The selective use of competition to ensure performance.

A meeting to discuss a more effective basis for delivering employment and training services to veterans should take place at an early date. The need is to secure the best ideas of veterans and the various stakeholders, solicit their support of general concepts, forge common ground for modifications to the law, and ensure early and effective compliance should such changes to the law be authorized and the funding appropriated. The de facto devolution of the SESAs is proceeding at an accelerating rate. The enactment of the Workforce Investment Act of 1998 is accentuating this trend.

Someone must take the lead, and the IBVSOs recommend it be the House or Senate Veterans' Affairs Committee. The progressive movement toward one-stops does not make the traditional way of delivering employment services to veterans a viable alternative.

Veterans continue to receive far less than a proportionate amount of the primary Job Training Partnership resources (Title IIA and Title III), and there are virtually no veteran-specific projects funded by this $2.3 billion resource at the state or local level.

Unless there is a paradigm shift, there will likely be reductions in force of DVOP specialists and LVERs and a further erosion of the buying power of each dollar appropriated for the programs administered through VETS. To do nothing is tantamount to waiting for the system operation to become increasingly problematic, contentious, and even less effective. Some have suggested that trying to keep everything the way it was is irresponsible in light of the dramatically changed realities.

Recommendations:

The House or Senate Veterans' Affairs Committees should conduct oversight to assure full implementation of P.L. 107-288 to ensure the President's National Hire Veterans Committee fulfills it purposes of:

- Raising employer awareness of the advantages of hiring separating servicemembers and recently separated veterans;
- Facilitating the employment of separating servicemembers and veterans through America's Career Kit, the national electronic labor exchange; and
- Directing and coordinating departmental, state, and local marketing initiatives.

Congress should provide the DOL adequate funding to enforce Uniformed Services Employment and Reemployment Rights Act, P.L. 103-353.

National Cemetery Administration

The National Cemetery Administration (NCA) has as its mission: "To honor veterans with a final resting place and lasting memorials that commemorate their service to our Nation."

Building on a proud and compassionate history beginning in the Civil War, the administration of NCA cemeteries continues to contribute every day to that mission.

Through a system of 120 national cemeteries in 39 states, the District of Columbia, and Puerto Rico, as well as 34 soldiers' lots and monument sites, The NCA maintains more than 2.6 million gravesites in approximately 14,000 acres of cemetery land while providing nearly 90,000 interments annually.

A new cemetery in Oklahoma, Fort Sill National Cemetery, was scheduled for completion and dedication in late 2003. Since November 2001, the facility has operated a fast-track section that permits interments, with dignity and reverence, prior to final completion of all construction activities. In addition, continued progress is anticipated on cemetery development in Atlanta, Miami, Pittsburgh, Detroit, and Sacramento.

In November 2003, the President signed into law H.R. 1516 (P.L. 108-109), the National Cemetery Expansion Act, to authorize the Department of Veterans Affairs to continue developing new cemeteries in areas not currently served by either a national veterans' cemetery or a state veterans' cemetery. These areas include development of six new national cemeteries in Philadelphia, Pennsylvania; Birmingham, Alabama; Jacksonville, Florida; Bakersfield, California; Greenville, South Carolina; and Sarasota County, Florida.

The development of these new national cemeteries will provide burial options for veterans, spouses, and dependents. Clearly, the rapid aging of the current veteran population has placed great demands on NCA operations and available burial space. Nearly 655,000 veteran deaths are estimated in 2005 with the death rate peaking at 690,000 in 2009; of these, it is expected that 109,000 will seek burial in a national cemetery. As veteran deaths accelerate, it is obvious the demand for veterans' burial benefits will increase.

It is important to note that the staffing needs of the NCA have become more critical as the volume and intensity of cemetery operations have increased. While the *The Independent Budget* veterans service organizations (IBVSOs) support efforts to increase efficiency of operations, it is essential to remind decisionmakers that much of the NCA work is labor-intensive, requiring a fully staffed and fully equipped workforce.

The increased burial rate with its resulting demand on support services necessitates an appropriate budgetary increase for the NCA. *The Independent Budget for Fiscal Year 2005* recommends an operations budget of $175 million for NCA to meet the increasing demands of interments, gravesite maintenance, and other areas of cemetery operations.

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NCA ACCOUNT

Although the NCA has benefited from marginal increases to its appropriations over the past 3 years, prior years of successive restrained budgets have made it impossible to address long-term field management and operational needs of the system. Shortfalls have forced the system to address only the highest priority projects while backlogging important preventive maintenance and infrastructure repairs.

Resources must keep pace as the workload continues to grow due to increasing demands of interments, gravesite maintenance, repairs, upkeep, and related labor-intensive requirements of cemetery operations. In addition, VA is scheduled to open new cemeteries in Atlanta, Oklahoma City, Pittsburgh, Detroit, Miami, and Sacramento. Also, under P.L. 108-109, VA is directed to design and construct cemeteries at six new national locations in Philadelphia, Pennsylvania; Birmingham, Alabama; Jacksonville, Florida; Bakersfield, California; Greenville, South Carolina; and Sarasota County, Florida. These requirements combined with dramatic increases in the interment rate necessitate increases in funding if the NCA is to carry out its statutory mandates.

The report in *Volume 2* of the *Study on Improvements to Veterans Cemeteries,* submitted in 2002 by VA to Congress as directed under the Veterans Millennium Health Care and Benefits Act (P.L. 106-117), identifies more than 900 projects for gravesite renovation, repair, upgrade, and maintenance. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery. A major contributing factor in these project repair recommendations is the accumulation of uncorrected past deficiencies.

As reported in *Volume 3* of the *Study on Improvements to Veterans Cemeteries,* many of the individual cemeteries within the system are steeped in history. The monuments, markers, grounds, and related memorial tributes represent the history and very foundation of our country. This volume serves as a planning presentation of the scope of work required to help set national standards to improve the appearance of NCA cemeteries and guide the application of future resources.

In this regard, the IBVSOs recommend that Congress fund the National Cemetery Administration operating account at $175 million for fiscal year 2005, $31 million more than last year's recommendation. The increase results mainly from a response to needs outlined in the *Study on Improvements to Veterans Cemeteries*, the growing costs of administrative expenses due to increased workload, addition of new cemeteries, general inflation, and wage increases.

Four years after Congress declared that national cemeteries should be awe-inspiring shrines to veterans, the NCA should be provided the funding necessary to remove decades of blemishes and scars from these honored grounds across the Country.

A fundamental part of the operations budget is the maintenance and enhancement of the grounds and memorials. Improving the appearance of our national cemeteries embraces the achievement of those interred. It allows visitors to see the evidence of our Nation's gratitude for those buried there and what they did. Problems and deficiencies in this regard are clearly identified in the *Study on Improvements to Veterans Cemeteries,* a comprehensive report about the conditions of each cemetery, submitted to Congress by VA in 2002.

In addition to the management of national cemeteries, the NCA has responsibility for the Memorial Program Service and the State Cemetery Grants Program (SCGP).

The Memorial Programs Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Law 107-103 and P.L. 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 only provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries.

Under the Presidential Memorial Certificate program, the award of a certificate signed by the President is, in addition to the provision of the United States flag, furnished by VA to all veterans honorably discharged from military service or otherwise eligible for burial in a national cemetery.

The SCGP complements the NCA mission to establish gravesites for veterans in those areas where 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% 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.

The SCGP makes burial options more available, more accessible and more convenient. Since 1973, VA has more than doubled acreage available and accommodated more than a 100% increase in burials.

To help provide reasonable access to burial options for veterans and their eligible family members, The IBVSOs recommend $37 million for the SCGP The availability of this funding will help the NCA help states establish, expand, and improve state-owned veterans' cemeteries.

IB Recommended NCA FY 2005 Appropriation
(Dollars in Thousands)

FY 2005 RECOMMENDED APPROPRIATION BY TYPE OF SERVICE	
Personnel Compensation	$97,690
Travel and Transportation of Persons	3,944
Rental Payments to GSA	1,100
Communications, Utilities, and Miscellaneous Charges	8,349
Other Services	42,313
Supplies and Materials	9,303
Equipment	12,301
IB Recommended FY 2005 Appropriation	**$175,000**

NCA ISSUES

The National Cemetery Administration 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 facing the NCA is to ensure that all national cemeteries are maintained in a manner appropriate to their status as national shires and memorials of reverence. In addition, 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 stemming the serious erosion in the value of burial allowance benefits. The IBVSOs 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 their Country honorably and faithfully.

State Cemeteries Grant Program:

Heightened interest in the SCGP results in stronger state participation and increased demands on the program.

The SCGP provides funds to assist states in establishing, expanding, and improving state-owned cemeteries. The program has helped develop 52 operating cemeteries across the country, which accounted for 18,189 burials of veterans and their eligible family members in FY 2003, an increase of nearly 6% over the prior year.

With the enactment of the Veterans Benefits Improvements Act of 1998, the state SCGP became instantly more attractive to states by substantially increasing the Federal share to 100% of allowable costs, including design, construction, and purchase of equipment for new cemeteries.

In FY 2003 the State Cemetery Grants Program awarded $26.2 million. Over the past two years the program helped develop seven new cemeteries at Grand Junction, Colorado; Sierra Vista, Arizona; Fort Dodge, Kansas; Caribou, Maine; Bloomfield and Jacksonville, Missouri; and Fort Campbell (Hopkinsville), Kentucky. In addition, the program has on hand 32 preapplications for $138 million and 3 pending awards for $14.7 million.

During FY 2004 the IBVSOs anticipate fast-track openings at new cemeteries under construction: Boise, Idaho (the last state in the United States without a veterans cemetery); Wakeeney, Kansas (300 miles east of Denver and west of Kansas City, serving rural area in western Kansas); Winchendon, Massachusetts (serving the densely populated northern part of the state); and Suffolk, Virginia (serving 200,000 veterans in the Tidewater area).

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.

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.

A PricewaterhouseCoopers study, submitted to VA in December 2000, indicates serious erosion in the value of burial allowance benefits. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973, when the Federal Government first started paying burial benefits for our veterans.

In the 107th Congress, the plot allowance, limited to wartime veterans, was increased for the first time in more than 28 years to $300 from $150, approximately 6% of funeral costs. The IBVSOs recommend increasing the plot allowance from $300 to $725, 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.

Also in the last Congress, the allowance for service-connected deaths was increased $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 IBVSOs recommend increasing the service-connected benefit from $2,000 to $4,000, bringing it back up to its original proportionate level of burial costs.

The nonservice-connected benefit was last adjusted in 1978, and today it covers just 6% of funeral costs. We recommend increasing the nonservice-connected benefit from $300 to $1,225, bringing it back up to the original 22% level.

Finally, the IBVSOs recognize the need to adjust burial benefits for inflation annually to maintain the value of these important benefits.

Recommendations:

Congress should increase plot allowance from $300 to $725 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 $4,000.

Congress should increase the nonservice-connected benefit from $300 to $1,225.

Congress should enact legislation to adjust these burial benefits for inflation annually.

Strategic Planning and Performance Goals

The strategic planning process for the National Cemetery Administration requires meeting the increasing demands for burials and maintaining existing cemeteries to high standards.

The Veterans Millennium Heath Care and Benefits Act (P.L. 106-117) required VA to contract for an assessment of the current and future burial needs of our Nation's veterans. An independent study, titled *An Independent Study on Improvements to Veterans Cemeteries,* was submitted to Congress in 2002. Three volumes comprise the study: *Future Burial Needs, National Shrine Commitment*, and *Cemetery Standards of Appearance*. In whole, the completed study would help form the platform for adopting further improvements to veterans cemeteries.

Volume 1: Future Burial Needs identifies those areas in the United States with the greatest concentration of veterans whose burial needs are not served by a national cemetery. According to the report, current and planned cemeteries under the NCA fiscal year 2000 strategic plan, which runs through 2006, will service

most large population centers. However, the report states that an additional 22 cemeteries will be required to ensure that 90% of veterans live within 75 miles of a national cemetery.

The IBVSOs encourage Congress and the Administration to carefully consider the report's findings in achieving burial service objectives. The analysis provides useful guidelines to continue a strong state grant program, to expand existing cemeteries wherever appropriate, and to build new national cemeteries at or near densely populated areas of veterans. Without the strong commitment of Congress and its authorizing and appropriations committees, VA would likely fall short of burial space for millions of veterans and their eligible dependents.

Volume 2: National Shrine Commitment provides a systemwide comprehensive review of the conditions at 119 national cemeteries. *Volume 2* 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 total estimated cost of completing these projects is nearly $280 million, according to the study.

The IBVSOs agree with this assessment and believe that Congress needs to address the condition of NCA cemeteries and ensure they remain respectful settings for deceased veterans and visitors. The operations budget and minor construction budget recommended by *The Independent Budget* contain funding to begin these projects based on the severity of the problems.

Volume 3: Cemetery Standards of Appearance is a careful presentation of the scope of work required to elevate existing national cemeteries as national shrines. *Volume 3* serves as a planning tool to review and refine overall operations in order to express the appreciation and respect of a grateful Nation for the service and sacrifice of military veterans.

Volume 3 describes one of the most important elements of veterans' cemeteries—namely, to honor the memory of America's brave men and women who served in the Armed Forces. "The commitment of the nation," the report finds, "as expressed by law, is to create and maintain national shrines, transcending the provisions of benefits to the individual."

The IBVSOs agree with this assessment. 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: The monuments, markers, grounds, and related memorial tributes represent the very foundation of the 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.

Indeed, Congress formally recognized veterans cemeteries as national shrines in 1973 stating, "All national and other veterans cemeteries…shall be considered national shrines as a tribute to our gallant dead." (P.L. 93-43).

In this vein, 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. The current and future needs of NCA require continued adequate funding to ensure that the NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the Nation.

An Independent Study on Improvements to Veterans Cemeteries presents valuable information and tools for the development of a truly national veterans' cemetery system. We recommend Congress give it close examination because the suggestions it contains require Congressional and Administrative budgetary support.

As we look forward to funding decisions for fiscal year 2005, the IBVSOs await Congressional action on appropriating funds for construction of recommended cemeteries in areas already approved for new sites. Because the planning and construction horizons of new cemeteries can take up to 10 years or more, it is important that the system develop concrete plans to address the increased demand for burial benefits in subsequent fiscal years.

Recommendations:

Congress and the Administration should use *An Independent Study on Improvements to Veterans Cemeteries* to help form the platform for adopting improvements to veterans cemeteries and for setting the course to meet increasing burial demand.

Congress should make funds available to ensure the proper planning and fast-track construction of needed national cemeteries. Adequate funding must be assured to complete construction of additional national cemeteries in areas that remain unserved.

Congress and the Administration must find ways to expand the useful life of currently operating national cemeteries, build new cemeteries where appropriate, and encourage state grant program cemeteries as a means of providing service to veterans.

Additional copies of this document are available at:

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