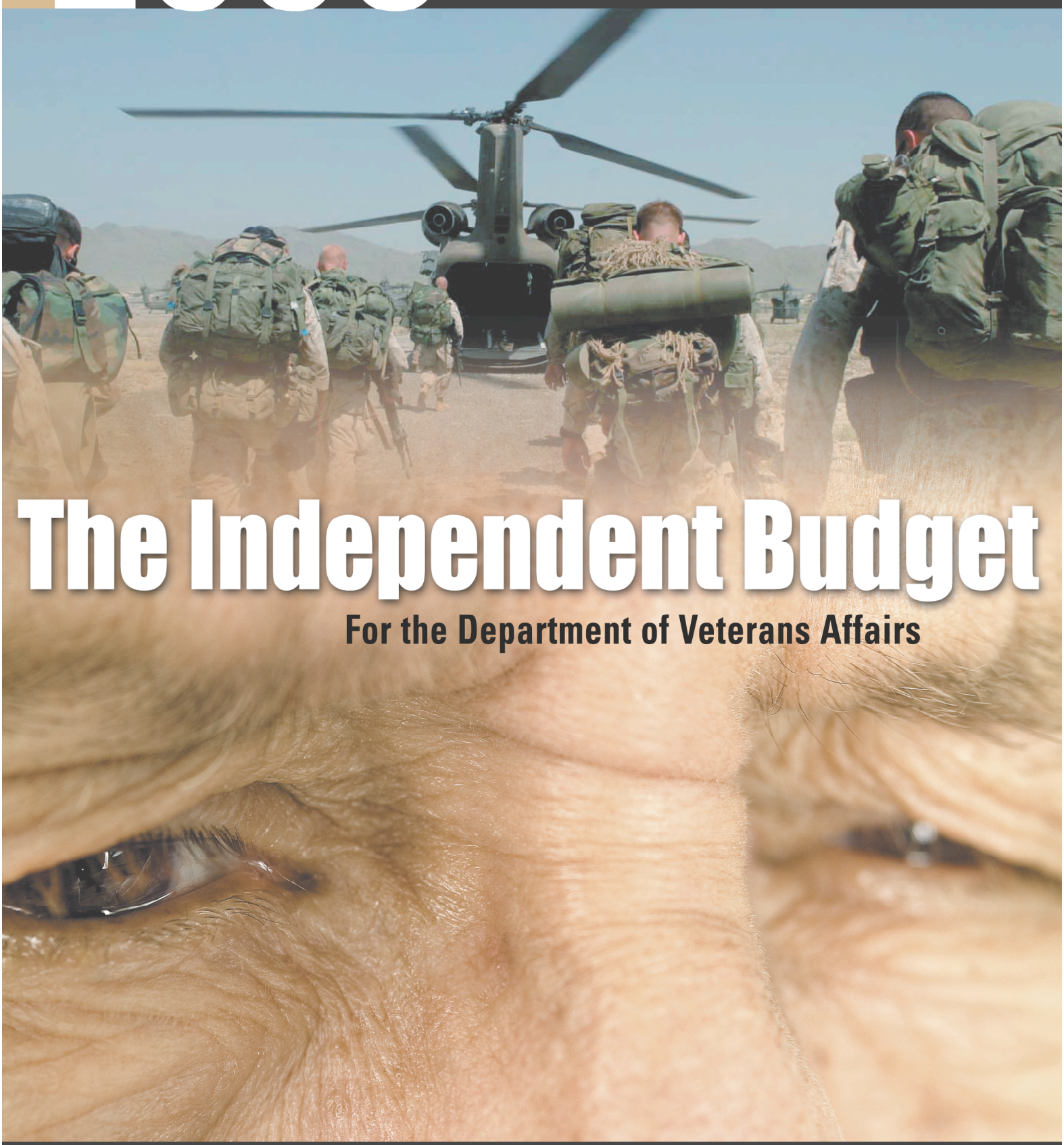
Fiscal Year 2006

A Comprehensive Budget and Policy Document Created by Veterans for Veterans



The Independent Budget

For the Department of Veterans Affairs

Prologue

This is the 19th 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 2006 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 3 years alone, Congress has failed to even pass a VA appropriations bill until months into the new fiscal year, leaving VA hospitals limping along on wholly inadequate continuing resolutions. The system does not suffer in this process, veterans do, veterans waiting months for a doctor's appointment or hours for a nurse to answer a call button.

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

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FY 2006 *INDEPENDENT BUDGET* SUPPORTERS

Administrators of Internal Medicine (AIM)

Alliance for Academic Internal Medicine (AAIM)

Alliance for Aging Research

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

American Military Retirees Association, Inc. (AMRA)

American Thoracic Society

Association of American Medical Colleges

Association of Program Directors in Internal Medicine (APDIM)

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Blinded Veterans Association (BVA)

Blue Star Mothers of America, Inc.

Catholic War Veterans, USA

Christopher Reeve Paralysis Foundation

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Gold Star Wives of America, Inc.

Military Officers Association of America (MOAA)

National Association of County Veterans Service Officers (NAVCO)

National Association for Uniformed Services (NAUS)

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National Association of Veterans' Research and Education Foundations (NAVREF)

National Mental Health Association

National Military Family Association (NMFA)

National Spinal Cord Injury Association (NSCIA)

Non Commissioned Officers Association of the USA (NCOA)

Rhode Island Veterans Action Center

Veterans Affairs Physician Assistant Association (VAPAA)

Veterans of the Vietnam War, Inc. and the Veterans Coalition

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 19th year, *The Independent Budget* veterans service organizations (IBVSOs) face the task of assessing the medical care needs of veterans for the upcoming fiscal year and providing best estimates on the resources necessary to carry out a responsible budget at the Department of Veterans Affairs (VA). We are proud that 27 veteran, military, and medical service organizations support these recommendations. In whole, these recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans in 2006.

As the global war on terrorism wages on, with many troops overseas and heightened security measures at home, it is important that the needs of our sons and daughters returning home from the battlefield are fully met. It is time to recognize the VA health-care and benefits system for what it is—a critical national resource for our nation's increasing veteran population. Veterans depend on VA for the health-care, housing, education, vocational rehabilitation, and insurance benefits they earned serving our country. This year more than ever VA is once again faced with the challenges of skyrocketing health-care costs, increasing demand for services, and eroding value of benefits. As the Administration and Congress consider the monetary needs of VA this fiscal year, they should pause to consider how much is at stake.

Each year, the IBVSOs call on Congress for sufficient funding for VA health care and a budget that reflects the increasing need for medical services. But year after year, VA remains underfunded and unable to provide timely access to quality health care to many of our nation's veterans. The annual budget crisis only adds to the struggle veterans face in obtaining timely and quality care. That is why *The Independent Budget (IB)* again recommends Congress take action to enact legislation providing adequate mandatory funding for the VA health-care system. Mandatory funding would ensure that the government meets its obligation to ensure all veterans eligible for VA health care have access to timely, quality care. Until mandatory funding becomes a reality, it is vital that the VA health-care system receive the resources it needs through the annual appropriations process, and that this funding be provided at the start of the fiscal year—not delayed for months, a situation that has become far too common.

As the largest federal provider of health-care services, VA is also faced with operating and maintaining thousands of medical facilities, centers, clinics, and nursing homes. This year's *IB* recommends a sizable increase for major and minor construction to help eliminate backlogs caused by the moratorium on facility improvement provided for in the Capital Asset Realignment for Enhanced Services (CARES) process. Also, with the loss of increasing numbers of our senior veterans, we call for major expansion and improvements in the VA cemetery program. Currently, the National Cemetery Administration (NCA) maintains more than 2.6 million gravesites on approximately 14,000 acres of cemetery land, while providing

nearly 90,000 interments annually. The NCA requires increases in funding if it is to carry out its statutory mandates. Without the firm 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.

On the benefits side, the *IB* continues to be concerned over the backlog in claims processing. According to the Government Accountability Office, the Veterans Benefits Administration still faces problems with large backlogs and long waits for decisions, despite years of studying these problems and the determination that the primary cause is directly attributed to the massive full-time employee equivalent reductions imposed on the Veterans Benefits Administration from fiscal years 1992 through 1998. Nearly one-third of adjudication decisions are incorrect or have technical or procedural errors. The IBVSOs reiterate our concern over the shrinking value of benefits that continue to decline in value because of a lack of increases, in some cases, for years. Veterans' benefits are part of a covenant between our nation and its defenders and should never be denied, reduced, or delayed.

The Independent Budget covers the broadest 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 in its defense. The *IB* recognizes that veterans' health care and benefits cost money, but these men and women have paid the price. They have taken the oath. They have served our country honorably and admirably. Promises were made to them, and we have an obligation to keep those promises.

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

	FY 2005 Appropriation	FY 2006 Administration Request	FY 2006 IB Recommended Appropriation
Medical Services	$19,316,995	$19,995,141	$22,486,154
Medical Administration	4,667,360	4,517,874	4,866,036
Medical Facilities	3,715,040	3,297,669	3,874,808
Total, Medical Care	**27,699,395**	**27,810,684**	**31,226,998**
Medical and Prosthetic Research	402,348	393,000	460,000
Subtotal, Veterans Health Administration	28,101,743	28,203,684	31,686,998
Veterans Benefits Administration	1,027,193	1,082,976	1,162,500
General Administration	297,560	324,889	388,035
Total, General Operating Expenses (GOE)	**1,324,753**	**1,407,865**	**1,550,535**
National Cemetery Administration	147,734	167,409	204,046
Office of Inspector General	69,153	70,174	71,383
Subtotal, Department Administration and Miscellaneous Programs	1,541,640	1,645,448	1,825,964
Construction, Major	455,130	607,100	562,800
Construction, Minor	228,933	208,726	720,000
Grants for State Extended Care Facilities	104,322	—	150,000
Grants for Construction of State Veterans Cemeteries	31,744	32,000	37,000
Subtotal, Construction Programs	820,129	847,826	1,469,800
Total, Discretionary	**$30,463,512**	**$30,696,958**	**$34,982,762**

Benefits 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). Veterans' pensions provide a measure of financial relief for needy veterans of wartime service who are totally disabled by nonservice-connected causes or who have attained age 65. Death pensions are paid to needy eligible survivors of wartime veterans. Burial benefits assist families in meeting the costs of veterans' funerals and burials and provide for burial flags and grave markers. Miscellaneous assistance includes other special allowances for smaller select groups of veterans and dependents and attorney fee awards under the Equal Access to Justice Act. Because of an apparent correlation between veterans' service in Vietnam and spina bifida and other birth defects in the children of these veterans, Congress authorized special programs to provide a monthly monetary allowance, medical treatment, and vocation rehabilitation to these children.

In recognition of the disadvantages that result from interruption of civilian life to perform military service, Congress has authorized various benefits to aid veterans in their readjustment to civilian life. These readjustment benefits provide monetary assistance to veterans undertaking education or vocational rehabilitation programs and to seriously disabled veterans in acquiring specially adapted housing and automobiles. Educational benefits are also available

for children and spouses of veterans who are permanently and totally disabled or die as a result of service-connected disability. Qualifying students pursuing 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.

Under its home loan program, VA guarantees home loans for veterans, certain surviving spouses of veterans, certain service members, and eligible reservists and National Guard personnel. VA also makes direct loans to supplement specially adapted housing grants. Under a program authorized until December 31, 2008, VA makes direct housing loans to Native Americans living on trust lands.

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

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

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

Benefits Issues

COMPENSATION AND PENSIONS
Compensation

Annual Cost-of-Living Adjustment:

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

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

Recommendation:

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

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Full Cost-of-Living Adjustment for Compensation:

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

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

Recommendation:

Congress should reject 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.

Standard for Service Connection:

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

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

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

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

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

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

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

Recommendation:

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

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Concurrent Receipt of Compensation and Military Retired Pay:

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

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

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

To the extent that military retired pay and disability compensation now offset each other, the disabled retiree is treated less fairly than the nondisabled military retiree. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after his or her enlistment expires can receive full compensation and full civilian retired pay. A veteran who has served this country for 20 years or more should have that same right. The veteran should not be penalized for choosing 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 Independent Budget* veterans service organizations urge Congress to correct this serious inequity.

Recommendation:

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

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

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

Under current law, the government pays disability compensation monthly to eligible veterans on account of and at a rate commensurate with diminished earning capacity resulting form the effects of service-connected diseases and injuries. By design, compensation continues to provide relief from the service-connected disability for as long as the veteran continues to suffer its effects at a compensable level. By law, the level of disability determines the rate of compensation, thereby requiring reevaluation of the disability upon change in its degree. Lump-sum payments have been recommended as a way for the government to avoid the administrative costs of reevaluating service-connected disabilities and as a way to avoid future liabilities to service-connected disabled veterans when their disabilities worsen or cause secondary disabilities. Under such a scheme, the Department of Veterans Affairs (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 Independent Budget* veterans service organizations strongly oppose any change in law to provide for lump-sum payments of compensation.

Recommendation:

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

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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 (HUD) and other means-tested federal programs.

Current policy at 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 Department of Veterans Affairs (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 Department of Defense (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 service members. In past years, many 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 Department of Veterans Affairs (VA) showed that more than 70 percent of veterans, as compared to about 50 percent 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 service members 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 service members 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 service members 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 service members. 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 was on the premise that cigarette manufacturers, and not smokers, are responsible for the effects of smoking that state governments and the federal government recouped 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 use 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.

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Compensable Disability Rating for Hearing Loss Necessitating Hearing Aid:

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

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

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

Recommendation:

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

Temporary Total Compensation Awards:

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

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

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

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

Recommendation:

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

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Dependency and Indemnity Compensation

Repeal of Offset Against Survivor Benefit Plan:

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

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

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

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

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

Recommendation:

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

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READJUSTMENT BENEFITS

Montgomery GI Bill

Expansion of Montgomery GI Bill Eligibility:

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

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

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

Recommendation:

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

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Refund of Montgomery GI Bill Contributions for Ineligible Veterans:

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

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

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

Recommendation:

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

Housing Grants

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

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

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

Increases in housing and home adaptation grants have been infrequent, although real estate and construction costs rise continually. Unless the amounts of the grants are periodically adjusted, inflation erodes the value and effectiveness of these benefits, which are payable to a select few but who include 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.

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/or changes in the special adaptations. These things merit a second grant to cover the costs of adaptations to a new home.

Recommendation:

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

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Automobile Grants and Adaptive Equipment

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

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

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

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

Because of a lack of adjustments to keep pace with increased costs, the value of the automobile allowance has substantially eroded through the years. In 1946 the $1,600 allowance represented 85 percent of average retail cost and a sufficient amount to pay the full cost of automobiles in the "low-price field." By contrast, in 1997 the allowance was $5,500, and the average retail cost of new automobiles was $21,750, according the National Automobile Dealers Association. The 1997 average cost of an automobile was 1,155 percent of the 1946 cost, but the automobile allowance of $5,500 was only 343 percent of the 1946 award. Currently, the $11,000 automobile allowance represents only about 39 percent of the average cost of a new automobile, which is $27,782. To restore the comparability between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be $22,226.

Veterans eligible for the automobile allowance under 38 U.S.C. § 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the nature of their disabilities requires the larger and more expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current $11,000 allowance is only a fraction of the cost of even the modest and smaller models, which are often not suited to these veterans' needs.

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

Recommendation:

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

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Home Loans

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

Funding fees are contrary to the principles underlying our benefit programs for veterans, and increased funding fees are negating the benefits and advantages of Department of Veterans Affairs (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 (IB)* 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 *IB* 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

Lower Premium Schedule to Reflect Improved Life Expectancy:

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

Because of service-connected disabilities, disabled veterans have difficulty getting or are charged higher premiums for life insurance on the commercial market. 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. VA continues to base its rates on mortality tables from 1941 however. Consequently, SDVI premiums are no longer competitive with commercial insurance and therefore no longer provide the intended benefit for eligible veterans.

Recommendation:

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

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Increase in Maximum SDVI Coverage:

The current $10,000 maximum for life insurance under Service-Disabled Veterans' Insurance (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 service members in 1917 was considerably less than $5,000. A $10,000 life insurance policy provided sufficiently for the loss of income from the death of an insured service member in 1917.

Today, more than 87 years later, maximum coverage under the base SDVI policy is still $10,000. Given that the annual cost of living is 1,375 percent higher than 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 the Department of Veterans Affairs, it was recommended that basic SDVI coverage be increased to $50,000 maximum. *The Independent Budget* veterans service organizations therefore recommend that the maximum protection available under SDVI be increased to at least $50,000.

Recommendation:

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

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Veterans' Mortgage Life Insurance

Increase in VMLI Maximum Coverage:

The maximum amount of mortgage protection under Veterans' Mortgage Life Insurance (VMLI) needs to be increased.

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

Recommendation:

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

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OTHER SUGGESTED BENEFIT IMPROVEMENTS

Protection of Veterans' Benefits Against Claims of Third Parties

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

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

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

Thus while as a general rule an individual's income and assets should rightfully be subject to legal claims of others, the special purposes and special status of veterans' benefits trump the rights of all others except liabilities to the U.S. 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' benefits 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 Independent Budget veterans service organizations make the following recommendations for improving VA performance and service to veterans.

General Operating Expenses (GOE)
(in thousands)

FY 2005	$1,324,753
FY 2006 Administration Request	1,407,865
FY 2006 *Independent Budget* Recommendation	1,550,535

General Operating Expense Issues

VETERANS BENEFITS ADMINISTRATION

Veterans Benefits Administration Management

Line Authority Over Field Offices:

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

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

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 the Compensation and Pension Service (C&P) especially, NAPA concluded that the C&P director's lack of influence or authority over its field office employees would greatly hamper any efforts to implement reforms and real accountability. NAPA recommended that the Under Secretary for Benefits strengthen C&P influence over field operations and close the gaps in accountability.

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

Recommendation:

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

Departmental Policy for Veterans Programs

Improvements in Rulemaking:

Today's Department of Veterans Affairs (VA) 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. 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.

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.

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 regu-

lations 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 VA's regulations more frequently, 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 he 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.

Information Technology Test Center

Funding to Support Continued Predeployment of Information Technology (IT) Upgrades:

To ensure new information technology applications are tested for performance before they are put into service in field offices, the Department of Veterans Affairs (VA) must maintain testing capacity at its Hines Information Technology Center.

By automated testing of new information technology at the Hines test center, field office staff are not diverted from their regular duties to test new applications. Adequate funding must be provided to avoid reductions in system upgrades or deployment of untested software to VA field offices. Based on experience, it is estimated that $4 million will be needed to fund this activity in FY 2006.

Recommendation:

Congress should provide $4 million in FY 2006 for testing of information technology at VA's Hines Information Technology Center.

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Training for Information Technology Personnel:

The Department of Veterans Affairs (VA) information technology staff needs regular training to stay abreast of continual changes in information technology (IT) systems.

Information systems are undergoing constant and rapid changes. Both Veterans Benefits Administration's (VBA) current and new IT staff of more than 300 stationed at the VA Central Office; the Hines, Illinois, and Philadelphia, Pennsylvania, Information Technology Centers; and the Austin, Texas, and St. Petersburg, Florida, System Development Centers must be trained in such areas as equipment upgrades, new programming, and database development. Based on experience, it is estimated that the VBA will need $1 million to cover the costs of IT training in fiscal year 2006 (FY 2006).

Recommendation:

Congress should provide $1 million to fund training of VBA's information technology staff in FY 2006.

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Compensation and Pension Service

Improvements in Claims Processing Accuracy:

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

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

VA can promptly deliver benefits to entitled veterans only if it can process and adjudicate claims in a timely and accurate fashion. Given the critical importance of disability benefits, VA has a paramount responsibility to maintain an effective delivery system, taking decisive and appropriate action to correct any deficiencies as soon as they become evident. However, VA has neither maintained the necessary capacity to match and meet its claims workload nor corrected systemic deficiencies that compound the problem of inadequate capacity.

Rather than making headway and overcoming the chronic claims backlog and consequent protracted delays in claims disposition, VA has lost ground to the problem, with the backlog of pending claims growing substantially larger. In *The Independent Budget for Fiscal Year 2005*, we observed that VA had increased its monthly claims decisions by more than 70 percent despite a workforce with many inexperienced adjudicators and other factors that would be expected to slow production. With the emphasis on production targets and a corresponding compromise in quality, we warned that the reduction in pending caseload would likely be temporary:

> With [VA's] 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.

Regrettably, that scenario has materialized. The claims backlog has swollen, and the appellate workload is growing at an alarming rate, suggesting further degradation of quality or at least continuation of quality problems.

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

Insufficient resources are the result of misplaced priorities, in which the agenda is to reduce spending on veterans' programs despite a need for greater resources

to meet a growing workload in a time of war and a need for added resources to overcome the deficiencies and failures of the past. Instead of requesting the additional resources needed, the President has sought and Congress has provided fewer resources. Recent budgets have sought reductions in full-time employees for the VBA in fiscal years 2003, 2004, and 2005. Such reductions in staffing are clearly at odds with the realities of VA's workload and its failure to improve quality and make gains against the claims backlog. During congressional hearings, *VA is forced to defend a budget that it knows is inadequate*.

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

To end this long series of repeated failures from inadequate resources and misplaced priorities, *The Independent Budget* will recommend funding levels for fiscal year 2006 adequate to meet the real staffing (see "Sufficient Staffing Levels" discussion) and other needs of the VBA.

Recommendations:

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

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

Sufficient Staffing Levels:

With a probable increase in compensation claims, the Department of Veterans Affairs (VA) must maintain staffing at least at its fiscal year 2004 (FY 2004) level for the Compensation and Pension (C&P) Service.

Within VA, the pressing imperative to overcome persisting large claims backlogs and consequent delays for veterans in need of disability benefits means that the C&P Service must have adequate personnel. At the same time, external factors are increasing the workload on this service. With the casualties of the war in Iraq and the ongoing combat operations in Afghanistan, VA is receiving additional new claims. New legislation authorizing concurrent receipt of disability compensation and pay based on military retirement has also added to the workload. It is estimated that disability claims will increase by approximately 8 percent in 2005 and, along with the carryover into FY 2006, continue at higher levels indefinitely into the future.

During FY 2004, VA's actual staffing level in the C&P Service was 8,929 full-time employee equivalents (FTEEs). Authority for fewer FTEEs in the FY 2006 budget will add to the existing severe strains and inability to overcome the longstanding quality and timeliness problems that have plagued that business line. Unavoidably, the pending caseload will grow to even more unacceptable levels, as will processing times and waiting times for disabled veterans. Other services provided by C&P will also likely deteriorate, such as phone service and Benefits Delivery at Discharge, an activity proven to save resources and more promptly deliver benefits to disabled veterans.

These realities cannot fairly or wisely be ignored. They require that VA maintain its staffing levels of 8,929 FTEEs for the C&P Service in FY 2006.

Recommendation:

Congress should authorize 8,929 total FTEEs for the C&P Service in FY 2006.

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Improved Claims Processing with Information Technology:

To meet its workload demands and fulfill its mission of delivering benefits and services to veterans, the Department of Veterans Affairs (VA) must develop and install modern information technology.

For a claims processing and awards program as massive as VA's, modern data systems are indispensable. VA is in the midst of developing and deploying applications, or subsystems, for compensation and pension to be incorporated in a new integrated system (VETSNET), a replacement for its antiquated and inadequate Benefits Delivery Network (BDN) system. This involves design, development, and converting or migrating data from the old legacy database management system to a modern enterprisewide system. For a new hardware platform and conversion of data from legacy to the new system, VA will need $12 million in fiscal year 2006.

Recommendation:

Congress should provide $12 million to continue development of VETSNET in FY 2006.

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Improved Claims Processing with Electronic Files:

To improve its business processes through reliance on more efficient modern information technology, the Department of Veterans Affairs (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 Veterans Benefits Administration (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 when the system is fully deployed.

To continue document preparation and scanning at the pension maintenance centers and evaluation of the system for use nationwide, VA needs $2 million in fiscal year 2006.

Recommendation:

Congress should provide $2 million to support continuing use of VA's Virtual VA electronic file system at its pension maintenance centers and to continue evaluation of the system for eventual installation in all VBA regional offices.

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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 Vocational Rehabilitation and Employment (VR&E) Task Force, VR&E needs to increase its staffing.

During fiscal year 2005 (FY 2005) and continuing into FY 2006, VR&E's workload is expected to increase between 10 percent and 13 percent primarily as a consequence of the war in Iraq and ongoing military operations in Afghanistan. Also, given its increased reliance on contract services, VR&E needs approximately 60 additional full-time employee equivalents (FTEEs) dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA VR&E Task Force recommended in its March 2004 report the creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

To meet its increasing workload and implement reforms to improve the effectiveness and efficiency of its programs, it is projected that VR&E will need a minimum of 1,017 direct program FTEEs in FY 2006, approximately 94 more than current staffing in that program.

Recommendation:

Congress should authorize 1,017 direct program FTEEs for the Vocational Rehabilitation and Employment Service for FY 2006.

Expansion of Case Management and Information System:

Vocational Rehabilitation and Employment (VR&E) can attain additional processing efficiencies by proceeding with its linkage of its Corporate WINRS case and information management system to the Internet.

VR&E's case management and information system is WINRS, also called Corporate WINRS. Since its introduction of WINRS in 1997, the Department of Veterans Affairs (VA) has refined and expanded the functions of the system to allow management and sharing claims information by VA offices nationwide. To allow for more efficient award processing and sharing of information with contractors, employment services, and outside partnership entities, VA needs to Web-enable the system in fiscal year 2006 (FY 2006). For this phase of the system's development, it is estimated VA will need $3 million.

Recommendation:

Congress should provide $3 million in FY 2006 to enable VR&E to expand its automated case management and information system, WINRS, to include a Web-based version.

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Internet Application:

For efficiency, Vocational Rehabilitation and Employment (VR&E) needs the capacity for electronic data exchange with education and training institutions and to allow veterans to confirm enrollment and other pertinent information via the Internet.

With the capacity to interact electronically with claimants and schools over the Internet, VR&E can significantly reduce cumbersome and inefficient manual processes by electronically receiving enrollment information from schools and having online contact between veterans and case managers. In addition, VR&E can enhance its automation of award processing. For this initiative, it is estimated that VA will need $2 million in fiscal year 2006 (FY 2006).

Recommendation:

Congress should provide $2 million in FY 2006 to fund VR&E's Internet Application Initiative.

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Education Service

Adequate Staffing:

To sustain services at current levels and meet added workload demands consequent to liberalizations in education programs, the Department of Veterans Affairs (VA) Education Service needs to retain its fiscal year 2003 (FY 2003) staffing level.

As it has with its other benefit programs, VA has been striving to provide more timely and efficient service to its claimants for education benefits. However, with the inability to hire new employees during FY 2004, Education Service timeliness in processing original and supplemental education claims declined during FY 2004. In addition, legislation authorizing a new education benefit for members of the National Guard and Reserves pressed into active service for 90 or more days will add to the existing workload during FY 2005 and future years, making it even more difficult to address the education caseload in a timely manner. Without an increase in staffing adequate to meet the existing and added workload, service to veterans seeking educational benefits will continue to decline. Based on experience with the average number of claims decisions a claims examiner can process and the average number of telephone and Internet contacts an employee can handle, to meet its workload demands in a satisfactory fashion, VBA must increase direct program staffing in its Education Service in FY 2006 to 770 full-time employee equivalents (FTEEs), 33 FTEEs more than requested for FY 2005.

Recommendation:

Congress should authorize 770 direct program FTEEs for VA's Education Service.

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Further Enhancement of Imaging Technology Needed:

To improve and maintain its capacity for electronic processing, management, and storage of education claims, Department of Veterans Affairs (VA) Education Service must continue enhancing TIMS (The Imaging Management System).

TIMS is the Education Service's system for electronic education claims files, storage of imaged documents, and workflow management. VA needs to consolidate four separate TIMS databases into one database accessible by the Internet and add capacity to meet increased workload demands. This will make the system fully interactive nationwide and will include the critical additional capacity necessary for continued viability of the system. It is estimated that this initiative will require $2 million in fiscal year 2006 (FY 2006).

Recommendation:

Congress should provide $2 million for necessary enhancements of the Education Service's Imaging Management System in FY 2006.

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Loan Guaranty Service

Increased Efficiency with Enhancement of Information Technology:

To continue to achieve greater effectiveness and efficiency of its data systems, the Loan Guaranty Service needs to upgrade and expand online access to its data systems.

Through its Loan Servicing System, which includes online interface with lenders, the Department of Veterans Affairs (VA) operates an automated system to service loans and increasingly is allowing Web-based access by claimants. The long-term information technology (IT) enterprise architecture plan and business process strategy necessarily include ongoing upgrading and expansion of these systems to better meet the needs of data systems in today's environment. To upgrade its Loan Servicing System and to allow claimants direct access to its Automated Certificate of Eligibility application, Loan Guaranty will need an estimated $3 million in fiscal year 2006 (FY 2006).

Recommendation:

Congress should provide $3 million in FY 2006 for upgrading and expansion of the Loan Guaranty Service's IT systems.

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) 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 separate branch of government.

For the most part, judicial review of the claims decisions of VA has lived up to the 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 them 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 process of judicial review in veterans' benefits matters.

Judicial Review Issues

THE COURT OF APPEALS FOR VETERANS CLAIMS
Scope of Review

Standard for Reversal of Erroneous Findings of Fact:

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

The CAVC upholds 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 the Board of Veterans' Appeals (BVA) findings.

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

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

While Congress chose not to replace the clearly erroneous standard of review, it did foreclose the application of this standard in ways inconsistent with the benefit-of-the-doubt rule. Also, Congress made it clear that the CAVC is not to routinely remand cases for new BVA fact-finding when the findings of fact before the court did not have sufficient support in the record and the current record supports a conclusion opposite of that reached by 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 CAVC will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

Recommendation:

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

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 the Board of Veterans' Appeals (BVA), the Court of Appeals for Veterans Claims (CAVC) has—contrary to congressional intent and the law—imposed formal pleading requirements upon Department of Veterans Affairs (VA) 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 danger that courts might attempt to impose 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 administrative 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 of Appeal for Veterans Claims (CAVC) should be housed in its own dedicated building, designed and constructed to its specific needs and befitting its authority, status, and function as an appellate court of the United States.

During the nearly 17 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse. This court for veterans should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Rather than being a tenant in a commercial office building, the 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 and 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 Department of Veterans Affairs (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 a reduction in earning capacity. *The Independent Budget* veterans service organizations 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 percent 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

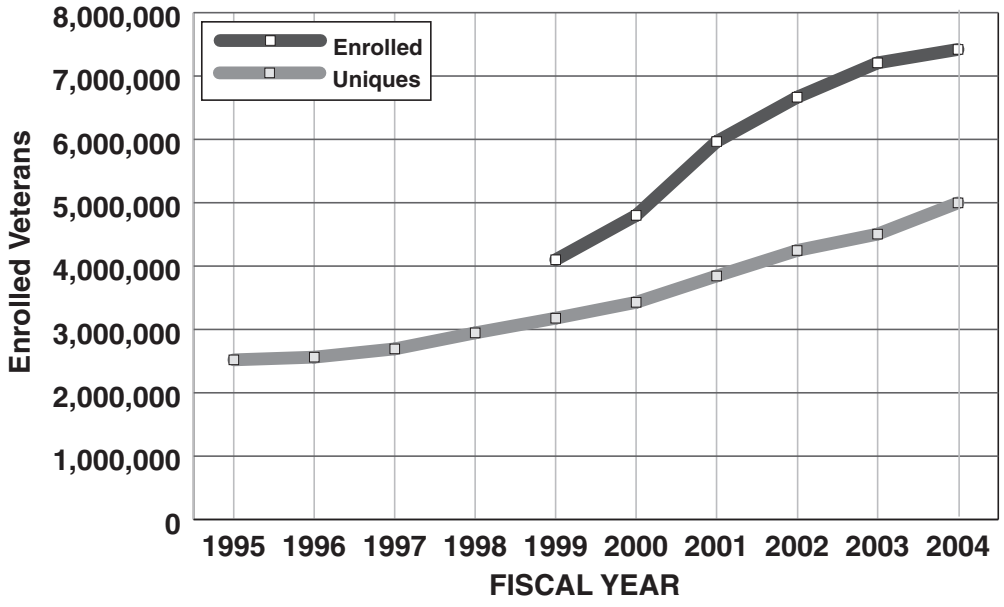
Medical Programs

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

Of the 7.4 million enrolled veterans in fiscal year 2004, the VHA provided health care to more than 4.99 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.

CHART 1. UNIQUE VHA PATIENTS & ENROLLED VETERANS

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



Even though the Secretary of Veterans Affairs placed a moratorium on the enrollment of priority 8 veterans during FY 2003 that appears to have reduced the number of new enrollees, Chart 2 shows there has been no impact regarding the increasing number of patients treated in VHA facilities.

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

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

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.

For fiscal year 2005 (FY 2005), after rescissions, VA health care received an increase of $992 million, far below *The Independent Budget* recommendation of more than $3 billion. But this $992 million figure is deceptive. After adjustments are made, including transfers and a shortfall attributed to VA's rosy yet wrong estimate of collections, the final amount of the FY 2005 increase is approximately $480 million. Table 3, at right, which utilizes the VA's own figures, illustrates these adjustments. This amount does not even meet the mandated payroll increases for existing employees, which VA estimated to be $650 million in its FY 2005 budget submission, let alone begin to cover the cost of spiraling medical inflation and increased demand for health-care services. The actual budget impact of the final FY 2005 cost-of-living increase approved at the end of the year was more than twice the amount VA originally budgeted. In effect, the actual impact of the $1.2 billion "increase" to improve VA health-care services was practically nullified. This funding shortfall will be made up through increased health-care rationing, longer waiting times for basic health care, and a further weakening of the health-care system devoted to the care of veterans.

TABLE 3

FY 2005 Adjustments to FY 2005 Medical Care Appropriation Increase (Dollars in millions)

Medical Care Appropriation	+$1,200
Collections	-466
Rescission	-228
VBA Transfer	-125
Hurricane Supplemental, P.L. 108-324	+124
Add-on for Medical Research	-21
Add-on for Inspector General	-5
Total Adjustments	+479

(Source: Department of Veterans Affairs)

Sadly, this increase was considered by many in Congress to be more than adequate. Over the years, VA has gone through periods of flat-lined budgets and budgets that fall far short of 13–14 percent annual increase VA itself identified it needed during testimony before a congressional committee, an increase that only reflects the amount needed to maintain current services.

Also complicating VA's ability to provide quality health care are threats to VA's ability to achieve pharmaceutical discounts through the Federal Supply Schedule for Pharmaceuticals (FSS-P). A number of states and the District of Columbia have recently introduced legislation that would tie Medicaid drug prices to the FSS-P. Passage of federal legislation mandating that FSS-P pricing be opened to Medicaid programs could threaten VA's ability to receive discounted pricing, since vendor contracts contain a clause allowing

the cancellation of these contracts in this event. Legislation has been previously introduced in Congress that would tie the new Medicare Part D Prescription Drug Benefit to the FSS-P. Prior experience, most notably with Medicaid drug provisions contained in the Omnibus Budget Reconciliation Act of 1990 (PL. 101-508), has demonstrated that if these legislative initiatives are enacted VA's pharmaceutical costs would undoubtedly increase, harming both the VA health-care system and veterans.

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

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

VA is the second largest 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. Last year, more than 87,000 health professionals were 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 percent 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.

Medical Care
(in thousands)

MEDICAL CARE (COMBINED ACCOUNTS)

FY 2005	$27,699,395
FY 2006 Administration Request	27,810,684
FY 2006 *Independent Budget* Recommendation	31,226,998

(excludes MCCF)

MEDICAL SERVICES

FY 2005	$19,316,995
FY 2006 Administration Request	19,995,141
FY 2006 *Independent Budget* Recommendation	22,486,154

FY 2006 Recommendation (in thousands)

Current Services Estimate	$20,303,749
Enroll Priority 8 Veterans	415,497
Increased Demand	1,266,908
Improve Specialized Services and Programs	500,000
Total, FY 2006 Recommendation	$22,486,154

MEDICAL ADMINISTRATION

FY 2005	$4,667,360
FY 2006 Administration Request	4,517,874
FY 2006 *Independent Budget* Recommendation	4,866,036

MEDICAL FACILITIES

FY 2005	$3,715,040
FY 2006 Administration Request	3,297,669
FY 2006 *Independent Budget* Recommendation	3,874,808

MEDICAL CARE ACCOUNT

Adequate Funding for VA Health Care Needed:

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

Once again this year, VA faces a critical situation in funding for health care. Ever-increasing demand on the system coupled with inadequate resources provided after the start of the new fiscal year (FY) has placed enormous stress on the system and has left VA struggling to provide the care that veterans have earned and deserve.

For fiscal year 2005 the Administration requested an increase of only $310 million in appropriated dollars, a mere 1.2 percent increase over the FY 2004 level. This was the lowest appropriation request for VA health care made by any administration in nearly a decade. The Administration chose to use budget gimmicks, higher out-of-pocket costs for veterans (including a proposed $250 user fee for category 7 and 8 veterans and increased copayments), and major cuts in long-term care programs as a substitute for requesting real dollars. VA has also chosen to continue to deny enrollment to new category 8 veterans as a cost-saving measure.

In contrast, *The Independent Budget* recommended $29.8 billion for veterans health care for FY 2005, a $3.2 billion increase over FY 2004. This amount represents the cost to provide care not only for all veterans currently seeking care from VA but also for veterans who were denied care by VA last year. The House and Senate Committees on Appropriations provided a $1.2 billion increase (before rescission) over the budget request, the same amount as VA Secretary Anthony Principi requested from the Office of Management and Budget (OMB). This increase would fall short of *The Independent Budget* recommendation as well as the 13–14 percent annual increase that VA has testified it needs to simply maintain the same level of services as the previous year.

The VA funding crisis is exacerbated by Congress not passing the VA, HUD, and Independent Agencies appropriations bill prior to the start of the new fiscal year on October 1, 2004. Unfortunately, failing to provide a VA budget on time is becoming an annual event. In the past five fiscal years, VA has not received its appropriation before the start of the new fiscal year. In the past two years, the appropriation was not enacted until after January 1 of the next year—more than one-third of the way through the new fiscal year.

The inadequate increase VA received in the omnibus spending bill for FY 2005 was not received in a timely manner, thus preventing VA from properly planning to meet the needs of veterans and from effectively competing to hire nurses, doctors, therapists, and other health-care professionals. The omnibus spending bill may also force VA to make difficult decisions about providing certain services to certain veterans, such as canceling or postponing surgeries for non–life-threatening conditions because resources are not available to perform the procedures.

Faced with growing federal budget deficits, there will be increased pressure to reduce discretionary spending in all federal programs, including VA health care. Earlier this year, Congress considered budget control legislation that would have placed spending caps on all discretionary programs. These caps would have meant real cuts in funding. Likewise, VA faces the possibility of a reduction in funding beginning next year. News reports earlier in 2004 indicated the OMB had requested that VA identify $900 million in cuts in discretionary spending, primarily from health-care funding. Such a cut would likely force VA to further restrict enrollment of new veterans seeking access to the system and could mean staff cuts, which would result in longer wait times for veterans. Yet, as these events are taking place, opinion polls show that the majority of Americans believe that veterans' health care should be a high funding priority in the federal budget.

VA is also dealing with increased demand as it provides care to sick and disabled veterans returning from Iraq and Afghanistan. By law, VA is required to provide "hospital care, medical services, and nursing home care for any illness" determined to be service connected for these returning service members for a period of two years.

The Independent Budget veterans service organizations believe that without adequate resources veterans will

continue to face health-care rationing, longer wait times for basic health-care services, and lower quality care. To that end, *The Independent Budget* has proposed that funding for veterans' health care be removed from the discretionary budget process and made mandatory. This would not create a new entitlement; rather, it would change the manner of health-care funding, removing VA from the vagaries of the appropriations process. Until this proposal becomes law however, Congress and the Administration must ensure VA is fully funded through the current process.

As the number of new veterans seeking health care continues to grow, and VA continues to care for veterans of prior conflicts, we must ensure that VA provides the quality health care that our veterans have earned with their service and their sacrifices.

Recommendation:

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

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MEDICAL CARE ISSUES

Accountability:

Accountability is sadly lacking throughout much of the Veterans Health Administration (VHA) with respect to clearly prescribed objectives and goals and well-defined, enforceable outcomes.

The Independent Budget veterans service organizations (IBVSOs) continue to emphasize the importance of providing adequate funding for the Department of Veterans Affairs (VA) medical care on a timely basis. This is paramount toward ensuring the VHA's ability to deliver high-quality and accessible services to veterans. Even so, it is also evident that simply providing additional dollars, in and of itself, is not enough to achieve much needed enhancements to operational efficiency and effectiveness in the VHA.

Accountability—with respect to clearly prescribed objectives and goals and defined, enforceable outcomes—is sadly lacking throughout much of the VHA. It is in this crucial area that the IBVSOs insist upon much greater focus and, ultimately, meaningful improvement.

In this regard, it is evident that past and present VHA Under Secretaries have not been successful in establishing and institutionalizing common purposes and goals, creating measurements with common indices to monitor progress, demanding accountability, and promoting more efficient and effective provision of health care to veterans. It is now time for the establishment of a corporate culture of accountability throughout the VHA.

Concurrently, to make management structure and function more effective within the VHA, individual managers—from the Office of the Secretary to a community-based outpatient clinic office manager—must be held individually responsible for their areas of operation. Performance appraisals and senior employment contracts must accurately reflect execution in achieving specific outcomes. Success should be fittingly rewarded and failure appropriately penalized.

Essential here is that management be provided with the requisite tools to enforce performance standards among the personnel under their direction. They must be able to create an environment that promotes superior service, discourages mediocrity, and precludes substandard performance.

Achieving accountability within the VHA will directly contribute toward providing greatly enhanced health-care services to veterans within the context of finite budgetary resources. Individual managers must be held responsible for their areas of operation so

performance appraisals and senior employment contracts accurately reflect execution in achieving specific outcomes. The VHA must develop and enforce meaningful performance standards and reward those individuals who exceed these standards and take appropriate measures with those whose performance is substandard or unacceptable. Management must be provided with all the requisite tools to enforce performance standards among the personnel under their direction.

Recommendations:

The VHA must develop and enforce meaningful performance standards. The VHA should then reward those individuals who exceed the standards and properly penalize those whose performance is substandard or unacceptable.

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

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Guaranteed Full Funding for VA Health Care:

Congress should enact legislation that will guarantee a reliable, predictable funding stream for veterans' health care so that enrolled veterans have access to high quality and timely health-care services.

Each year *The Independent Budget* veterans service organizations (IBVSOs) fight for sufficient funding for Department of Veterans Affairs (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, year after year funding provided under the current discretionary funding mechanism falls short of what is needed to provide quality health-care services in a timely manner to our nation's sick and disabled veterans. The amount of discretionary funding provided to VA for veterans' health care is determined by political processes and, unfortunately, based more on political considerations than funding needs. To make matters worse, for the past six years Congress has not enacted the VA budget at the start of the fiscal year. The lack of a consistent and reliable budget process has prevented VA from adequately planning for and meeting the growing needs of veterans seeking health care. Clearly, the current funding mechanism for veterans' health care is broken and in need of reform. We believe direct/guaranteed full funding for VA health care is a comprehensive and reasonable solution to address these serious problems.

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 or task force). The task force was charged to identify ways to improve health-care delivery to VA and Department of Defense (DOD) beneficiaries. Of most importance to the IBVSOs is the task force's recognition of a "growing dilemma" concerning VA health care. The PTF noted in its final report that "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." The IBVSOs believe the cumulative effects of insufficient, inflation-eroded appropriations for health-care funding, coupled with a significantly increased demand for care, have already had a negative impact on VA health-care delivery and have resulted in the severe rationing of medical 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 achieve the desired goal to ensure 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 a guarantee that the full amount determined will be available to VA to meet that need. Including priority group 8 veterans under a guaranteed full 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 Congress has increased discretionary appropriations for veterans' health care in the recent past, funding levels have simply not kept pace with medical care inflation or the significant increase in demand for services. VA has seen a 134 percent increase in the number of enrolled veterans from 1996 to 2004. Unfortunately, VA health-care funding has increased only 60 percent over the same period. On average, VA has received only a 5 percent increase in appropriations over the past eight years. VA has testified that—at a minimum—a 14 percent increase is needed annually for medical care just to maintain current services.

The IBVSOs firmly believe that our nation's veterans have earned the right to medical care through their extraordinary sacrifices and service to this nation. 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."

In response to the VA health-care funding crisis and the PTF's report, nine veterans service organizations formed the Partnership for Veterans Health Care Budget Reform in support of direct/mandatory funding for VA health care. The partnership is composed of The American Legion, AMVETS (American Veterans), Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans of the USA, Military Order of the Purple Heart of the U.S.A., Paralyzed Veterans of America, Veterans of Foreign Wars of the United States, and the Vietnam Veterans of America.

During the 108th Congress, mandatory funding bills were introduced in both chambers. The Assured Funding for Veterans Health Care Act of 2003 was introduced in the House of Representatives as H.R. 2318, and in the Senate as S. 50. H.R. 2318 would have, in FY 2005, made available to VA 130 percent of the amount obligated during FY 2003. The amount would continue to be adjusted in the following fiscal years based on the number of enrolled veterans and the number of persons eligible but not enrolled who are provided care, multiplied by the per capita baseline amount for FY 2003, as increased by the percentage increase in the Hospital Consumer Price Index. Unfortunately, neither of these measures was enacted.

Additionally, in the last session of the 108th Congress, the Senate considered an alternative funding plan in the form of an amendment to resolve VA's health-care funding crisis. The amendment called for a combination of direct and discretionary funding. The discretionary funding level would have remained at the FY 2004 level with the direct funding level based on the formula contained in H.R. 2318 less the amount of discretionary funding. Unfortunately, the amendment was defeated—even with full support of the Partnership for Veterans Health Care Budget Reform.

We believe it is disingenuous for our government to promise health care to 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 continue to carry the physical and mental scars of that service. Providing direct funding for veterans' health care would eliminate the year-to-year uncertainty about funding levels that have prevented VA from being able to adequately plan for and meet the needs of the constantly growing number of veterans seeking treatment. It would also provide Congress the ability to continue its fiscal oversight of VA health-care programs.

We propose to simply shift funding for VA health care from discretionary appropriations to direct funding so that all eligible veterans enrolled in the VA health-care system have timely access to VA medical programs and services currently provided under title 38, United States Code. This will guarantee full funding for VA health care even when Congress cannot pass timely appropriations bills and will alleviate the need for continuous debate in Congress each year. We believe this will also stop the severe rationing of health care that is typical of today's veterans' health-care system.

Guaranteed full 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 through 8 or the medical benefits package defined in current regulations, only how 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 into the future. 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.

Veterans expect the federal government to honor its commitment and obligation to those who previously served in the armed forces and to those who are currently serving in Iraq and Afghanistan and fighting the war on terror in other parts of the world. Our nation's sick and disabled veterans cannot wait any longer for the government to take action. Now is the perfect opportunity for Congress to move forward on the recommendations of the PTF, charged with improving health-care delivery for our nation's veterans, and to support a permanent solution to resolve this untenable situation.

Recommendation:

Congress should enact legislation that would shift funding for VA health care from discretionary appropriations to direct funding so that all eligible veterans enrolled in the VA health-care system have timely access to VA medical programs and services currently provided under title 38, United States Code.

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Homeland Security/Funding for the Fourth Mission:

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

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

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

As part of its fourth mission, VA also has a critical role in homeland security and in responding to domestic emergencies. The National Disaster Medical System

(NDMS), created by P.L. 107-188 (the "Public Health Security and Bioterrorism Preparedness Response Act of 2002"), has the responsibility for managing and coordinating the federal medical response to major emergencies and federally declared disasters, including natural disasters, technological disasters, major transportation accidents, and acts of terrorism, including weapons of mass destruction events, in accordance with the National Response Plan. The NDMS is a partnership between the Department of Homeland Security, VA, the DOD, and the Department of Health and Human Services. According to the VA Web site (www.va.gov), some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance and evaluation of the local NDMS program. VA has also assigned "area emergency managers" to each veteran integrated service network to support this effort and assist local VA management in fulfilling this responsibility.

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

Also in 2002, P.L. 107-287, the "Department of Veterans Affairs Emergency Preparedness Act of 2002," was enacted. This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and development of methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary, or other explosive weapons or devices posing threats to the public health and safety; education, training, and advice for health-care professionals; and laboratory, epidemiological, medical, and other appropriate assistance for federal, state, and local health-care agencies and personnel involved in or responding to a disaster or emergency. These centers, although authorized by law, have not received funding.

VA has been spending ever-increasing sums to attempt to meet its fourth mission requirements. During a hearing before the House Committee on Veterans' Affairs on August 26, 2004, VA testified that its funding for medical emergency preparedness rose from $80.3 million in fiscal year 2002 (FY 2002) to $257.3 million in FY 2004. VA also stated that it requested $281 million for FY 2005. Unfortunately, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. This funding is simply drawn from the medical care account, providing VA with fewer resources with which to meet the health-care needs of veterans.

The Independent Budget veterans service organizations (IBVSOs) are concerned that VA lacks the resources to meet its fourth mission responsibilities. Without sufficient funding, VA has drawn resources away from other critical programs to accomplish this mission. VA has many responsibilities to meet, and it will strive to meet these responsibilities, but if sufficient funding is not provided, scarce resources will be diverted from direct health-care services.

The fourth mission allows the Secretary of Veterans Affairs to furnish medical care to active duty military personnel. However, there is a caveat, in that 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 of the armed forces. According to former Under Secretary for Health Robert Roswell, these may include 482 physicians, 172 dentists, 2,209 registered nurses, 3,259 in other medical fields, and 7,144 men and women in support roles. If these 13,266 VHA employees are, in fact, called up with reserve forces, how does VHA support its fourth mission?

Public Law 107-188 directs that "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 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."

The Secretary must also ensure that not only staff, but patients as well, are protected in event of an emergency, whether chemical, biological, 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. public loan 107-188 authorized an appropriation 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."

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 General Accountability Office reported (GA0-02-145T) 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."

This is a decrease of 77% of available beds in the intervening 15 years. Looking through the Draft National Critical Asset Realignment for Enhanced Services plan, it appears that the VHA may be giving up an additional 4,441 beds, of which 666 would come our of the DOD Contingency Plan; thus we have a total loss, since 1986, of an estimated 79% of the DOD contingency beds.

VA's fourth mission is vital to our defense, homeland security, and emergency preparedness needs. These important roles once again point out the importance of maintaining the integrity of the VA system and its ability to provide a full range of health-care services. The IBVSOs do not believe VA currently has the resources nor the ability it needs to adequately care for veterans, much less those needed to complete its fourth mission. If VA is to fulfill its responsibilities, it must be provided these resources.

Recommendations:

Congress should provide funds necessary in the VHA's FY 2006 appropriation to fund the VA's fourth mission.

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

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

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Seamless Transition from the DOD to VA:

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

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

The Independent Budget supported the recommendations of the report of the President's Task Force to

Improve Health Care Delivery for Our Nation's Veterans (PTF), released in May 2003, regarding transition of soldiers to veteran status. The PTF stated that "providing these [veterans] timely access to the full range of benefits earned by their service to the country is an obligation that deserves the attention of both VA and the DOD. To this end, increased collaboration between the Departments for the transfer of personnel and health information is needed."

An important recommendation of the PTF was the subject of a letter sent last year to VA Secretary Anthony Principi and Defense Secretary Donald Rumsfeld. Specifically, we believe the DOD and VA must develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. These electronic medical records should also include an easily transferable electronic form DD 214 (Certificate of Release or Discharge from Active Duty) forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and benefits.

The Departments have each taken positive steps to share data from their health information systems. The Federal Health Information Exchange initiative and the pharmacy data project are steps in the right direction. However, obstacles remain that will hinder the momentum of progress made toward the goal of a bidirectional health information exchange by next year.

The Chairmen and Ranking Members of the House Veterans' Affairs and Armed Services Committees sent letters last year to Secretary Principi and Secretary Rumsfeld, expressing concern with the current transition of servicemen and women. The letter stated that "despite earnest desire by both the DOD and VA to provide each service member with a seamless transition, their efforts remain largely uncoordinated in important respects and suffer from the failure to make planning for transition a high priority for the Executive Branch."

The Independent Budget concurred with the PTF recommendation that "DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process." This would enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

We have expressed support for the Disabled Soldier Support System (DS3) implemented by the Department of the Army and the Disabled Marine Support System (DMS2) by the Department of the Navy in 2004. These programs' responsibilities are to assist the most severely injured service members and their families in transition from military to civilian life. Currently, the programs have limited staffing, with a limited budget to assist these veterans. *The Independent Budget* supports legislation to authorize additional funding for the DS3 and DMS2 programs and allow DOD to expand them to address more service member's needs. With a high number of severely injured soldiers and Marines returning from Iraq and Afghanistan, it is essential that Congress and the Administration support and enhance this successful program.

The IBVSOs believe the men and women exiting military service should be afforded easy access to the health care and benefits that they have earned. This can only be accomplished by ensuring that the DOD and VA improve their coordination and information sharing to provide a seamless transition.

Recommendations:

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

The DOD and VA must develop electronic medical records that are interoperable and bidirectional, allowing for two-way electronic exchange of health information and occupational and environmental exposure data. The records should also include an electronic form DD 214.

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

Congress and the Administration must provide additional funding for the DS3 program to allow the DOD to expand this program so that it can address the needs of more seriously disabled soldiers.

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

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

The Secretary of the Department of Veterans Affairs (VA), on May 7, 2004, made a comprehensive, multi-faceted decision on a national process to reorganize the Veterans Health Administration (VHA) through a data-driven assessment of its infrastructure and programs. Through the CARES project, in February 2002 and ongoing, VA is evaluating the demand for health-care services and identifying changes that will help meet veterans' current and future health-care needs. By its very nature, CARES is a complex process that involves the development of sophisticated actuarial models to forecast tomorrow's demand for veterans' health care and the calculation of the current supply and identification of current and future gaps in infrastructure capacity. This eventually resulted in a Draft National CARES Plan (DNCP) to rectify deficiencies through the realignment of VA's capital asset infrastructure. Subsequently, the Secretary established a commission to review the entire CARES plan and to provide recommendations on the realignment of mission and facilities.

Since publication of *The Independent Budget for Fiscal Year 2005*, the commission has been actively evaluating the DNCP proposed by VA. The CARES Commission report was published in March 2004. The VA Secretary formally accepted the CARES Commission report with the publication of the Secretary's CARES decision document in July 2004.

Initially, we note, the DNCP market plans did not include any projections for mental health services or long-term care. The commission, however, recognized the importance of mental health services and long-term care to the veteran population and stated, in part, that "in reviewing the early projections for CARES, VA realized that it needed to make modification to its projections for outpatient, acute inpatient, and long-term psychiatric mental health care programs." The commission acknowledged that VA is currently making adjustments to these models and recommended that when complete, the forecast be rerun, that gaps in service be identified, and that VA plan to address those gaps. It also recommended that VA take action to ensure consistent availability of mental health services across the system, to provide mental health care at community-based outpatient clinics, and to co-locate acute mental health services with other acute inpatient service wherever feasible.

The commission also provided several recommendations for VA to address long-term care while implementing the CARES program. The main recommendation was that VA "develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliary, residential treatment facilities and nursing homes, and for seriously mentally ill veterans." Moreover, the commission recommended the plan should include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible, and identifying freestanding nursing homes as an acceptable care model.

The IBVSOs concur with the CARES Commission's recommendations on mental health-care services and long-term care. It is our contention that mental health services and long-term care are part of the full continuum of care for veterans and should not be excluded from the CARES process.

Recommendation:

VA, in implementing the CARES plan, must ensure that mental health services and long-term care are part of the full continuum of care for veterans.

Inappropriate Billing:

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

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

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

VA acknowledges that because of data integrity not all cases with more than six service-connected conditions have been identified under the new plan. While continued improvements to the VBA database are being made, VA will be reviewing and validating the results prior to establishing a routine monthly update to provide complete 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 Department of Veterans Affairs (VA) medical care appropriation.

The fiscal year 2006 *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.

VA is pursuing additional revenue sources and improved collections, and more revenue from these sources could improve access to care within VA. Many VA beneficiaries, especially priority 7 and 8 veterans, are Medicare-eligible. However, the Centers for Medicare and Medicaid Services is prohibited by law from reimbursing 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) enhanced-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 Independent Budget veteran service organizations (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 the Veterans Health Administration 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 the 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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Waiver of Health-Care Copayments and Fees for Catastrophically Disabled Veterans:

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

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

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

It is certainly a tribute to these individuals to have sought gainful employment to support themselves and their families despite the nature of their catastrophic disabilities. Far too often veterans with such disabilities give up opportunities to lead productive lives, falling back on low-income veterans' pensions and

other federal and state support systems. In so doing they fall within the complete definition of priority 4 health-care enrollment and are exempt from all fees and copayments. Yet when a veteran's industry and employment brings annual income above the means-test levels, he or she is unduly penalized by exorbitant fees. This "catch-22" status does little to reward or provide an incentive for a highly disabled veteran to maintain employment and a productive life.

Recommendation:

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

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Access Issues

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

Advanced Clinic Access Initiative:

Veterans have to wait too long for appointments.

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 Department of Veterans Affairs (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 six months or more for care and the other half having no scheduled appointment. VHA now reports the national total of veterans who will likely wait six months or more for nonemergent clinic visit has been reduced from 43,217, on October 15, 2003, to 22,077 as of September 1, 2004. Also, over the same period, the number of veterans waiting for their first appointment to be scheduled (audiology, primary care, cardiology, eye care, orthopedics, and urology) was reduced from 17,496 to 4,957. VA also reported 25,775, veterans waiting for a follow-up appointment.

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, these actions do 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

waiting times. The goal is to build a system in which veterans can see their health-care providers when needed. Through the work of a few leaders, this program reduced average waiting times and significantly improved veterans' access to their health-care system as measured in 2002 and 2003.

In 2004, 94 percent of primary care patients and 93 percent of specialty care patients were able to schedule an appointment within 30 days of their desired date despite increased demand. Although VA states that this is an improvement from 2003, this measurement is not equivalent to that used in 2002 and 2003 when veterans' access to care was measured by the average number of days they had to wait for treatment. The change in measuring veterans' access to care reflects VA's struggle on how to best capture and measure the veterans' experience in seeking VA health care with rudimentary impediments, such as a cumbersome scheduling software package.

Despite any measurable improvements in waiting times for needed appointments, continued disparities exist in the implementation of the Advanced Clinic Access Initiative nationwide. With a growing number of volunteer coaches who serve as consultants and trainers, and growing support from Veterans Integrated Service Networks (VISNs) and facilities, success is largely dependent upon the availability of funding. Furthermore, only one dedicated full-time employee and one half-time employee manage the Advanced Clinic Access Initiative. A fully staffed and supported Advanced Clinic Access initiative could develop better ways to properly measure 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:

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

The VHA should provide adequate funding for successful implementation of 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.

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

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Community-Based Outpatient Clinics:

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

As of July 2004, the Veterans Health Administration (VHA) operated 691 community-based outpatient clinics. Additionally, contained in the Secretary's Critical Asset Realignment for Enhanced Services decision (May 2004) is establishment of 156 priority CBOCs by 2012, pending availability of resources and validation with the most current data available. *The Independent Budget* veterans service organizations (IBVSOs) commend the VHA's efforts to expand access to needed primary care services. For many veterans who live long distances from VA medical centers (VAMCs), and for those whose medical conditions make travel to VAMCs difficult, CBOCs reduce the necessity for travel. CBOCs also improve veterans' access to timely attention for medical problems, reduce hospital stays, and improve access to, and shorten waiting times for, follow-up care.

While we support establishment of CBOCs, we remain concerned that they often fail to meet the needs of

veterans who require specialized services. For example, many CBOCs do not have appropriate mental health providers on staff. Nor do they necessarily improve access to specialty health care for either the general veteran population or for those with service-connected mental illness. In that connection, to VA's credit, the revised criteria for establishment of CBOCs includes the availability of mental health services. Moreover, 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, some veterans service organizations caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care program. Inadequately trained providers are less likely to render appropriate primary or preventive care or to accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with Section 504 of the Rehabilitation Act (29 U.S.C. §791 et seq.) regarding physical accessibility to medical facilities. Veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

CBOCs must contribute to the 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. The IBVSOs are concerned that valuable resources will 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 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 is recognized.

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

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Veterans Rural Access Hospital (Critical Access Hospital):

Many community based outpatient clinics (CBOCs) are being redesignated as critical access hospitals.

Last year, *The Independent Budget* veterans service organizations (IBVSOs) recommended that further data be obtained to support various Capital Asset Realignment for Enhanced Services (CARES) recommendations that would close or change the mission of certain small or rural Department of Veterans Affairs (VA) facilities. The CARES Commission also recommended that VA establish a clear definition and clear policy on the critical access hospital designation prior to making decisions on the use of this designation.

Accordingly, VA is currently developing a policy to define the appropriate scope of services that should be provided at small and rural facilities. The Veterans Rural Access Hospital (VRAH) policy, specifically, will define the clinical and operations characteristics of small and rural facilities within VA.

Our concern is whether VA's new VRAH policy considers the implications referrals will have on providing quality health care in a timely manner, particularly at other medical centers within a Veterans Integrated Service Network. VA must also consider patient satisfaction in the criteria they use for determining which facilities will retain acute-care services. If acute-care beds are to remain in one facility because of distances that veterans must travel to access inpatient services, the same logic should be used systemwide. For example, a decision was made to retain the inpatient care mission at the Cheyenne VA Medical Center because the medical center is more than 100 miles from the nearest VA medical center (Denver), and the closest private hospital that is joint commission accredited is more than 60 minutes away. Another decision was made to close inpatient medical services at Ft. Wayne, Indiana, and Kerrville, Texas, and refer patients well over a hundred miles to other VA facilities without recognizing the inconvenience to the veteran and the potential impact that the closure would have on area hospitals and other VA facilities workload.

Recommendation:

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

VHA-DOD Sharing:

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

The Independent Budget veterans service organizations (IBVSOs) have been discussing this initiative for a number of years, as has Congress, with little success for our efforts. Federal law (38 U.S.C. § 8111(a)) states: "The Secretary and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed to operate such facilities properly [.]."

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

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

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

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

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

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

■ Leadership and Reporting

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

The CARES Commission report states that:

> At those locations where collaboration was not successful or where it had been proposed for some time but had not gained momentum, the Commission found…no mutual commitment to the proposed collaboration, no dedication, and no effort. At such sites the Commission also detected a lack of direction from national leadership, in some instances, particularly from the Department of Defense to the local leadership in support of the collaboration.
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> From its review, the Commission concluded that to ensure a successful collaborative relationship between DOD and VA, there must be a clear commitment from their senior leadership, both to the initial establishment of collaboration and to its ongoing maintenance, especially when there is a change in leadership. The Commission noted a number of collaborations that did not continue after one or both of the senior local leaders was reassigned or retired.

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

■ Joint Venture Sites

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

One issue regarding joint venture sites of real concern to the IBVSOs is physical access. Appendix A of the Secretary of Veterans Affairs CARES Decision,

released in May 2004, lists a number of existing or proposed joint venture sites located aboard military installations. In event of an increase in either terrorist threat level, or force protection level, the probability is that military installations will go into "lock down" status. This would effectively deny VHA enrolled patients, who are not military retirees, access to their health-care facility. We suggest that the involved military installations accept the VA Universal Identification Card for access to the installation and issue a vehicular decal to VHA patients. Currently the DOD issues color-coded vehicular decals to personnel requiring access to the facility. These decals are blue for military officers, red for enlisted personnel, green for civilian employees, and black for vendors and contractors. Perhaps a fifth color could be used for VHA patients.

■ VA and DOD Access Standards

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

■ Fully Fund Enrolled Veterans

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

The PTF recommendation is clear: The gap between resources and demand must be closed by increasing, *and sustaining,* VA health-care funding. As outlined elsewhere in *The Independent Budget*, we strongly recommend mandatory funding for all enrolled veterans whom the Secretary has directed care be provided to. The IBVSOs appreciate that the PTF acknowledged the funding mismatch problem and expressed concern that VA-DOD collaboration *cannot work without fundamentally addressing this issue*.

Recommendations:

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

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

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

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

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

Congress should require mandatory funding of VA health care.

Enrollment of Priority 4 Veterans Still Problematic:

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

Seven years ago Congress enacted Public Law 104-262, which specifies that veterans who are receiving an increased pension based on a need for regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled will be classified as enrollment priority 4.

Prior to the Department of Veterans Affairs (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 to be the case, thousands of misclassified veterans could be affected.

The Veterans Health Administration (VHA) has not developed a consistent and effective mechanism for identifying eligible veterans and properly classifying them as priority group 4. National service officers attempting to help veterans obtain appropriate reclassification to priority group 4 report 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-Department of Veterans Affairs (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 Independent Budget veterans service organizations 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:

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

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

The IBVSOs also are in full support of the decision to distribute fiscal year 2005 (FY 2005)prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures and utilization reporting. This decision continues to improve the budget reporting process.

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

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

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

The IBVSOs are pleased that centralized funding continued in FY 2005. The allocated budget for prosthetics was approximately $947 million, up from $846 million in FY 2004. Funding allocations for FY 2005 were primarily based on FY 2004 NPPD expenditure data, coupled with Denver Distribution Center billings. The prosthetics budget also includes funds for surgical, dental, and radiology implants.

While VHA facilities received a FY 2005 budget allocation of $947 million, prosthetics requested approximately $1.1 billion to cover the actual anticipated FY 2005 prosthetics budget. The advancements in prosthetics technology bring with them a high price. For example, a single prosthetic limb, the C-leg, has an anticipated cost of $30,000; a single IBOT wheelchair, $25,000; and a single service dog, $20,000.

In FY 2006 the IBVSOs anticipate that the prosthetics budget will need to be increased to more than $1.25 billion. Part of these funds must be used to allocate the latest technological advances in prosthetics and sensory aids. Considerable advances which are still being made in prosthetics technology, 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 prosthetics and sensory aids needs of veterans with disabilities are appropriately met.

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

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

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

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

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.

The Independent Budget veterans service organizations (IBVSOs) continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Our 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 compliance 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 has been 95 percent. This means that for every 100 devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased "off-contract" (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such high compliance rates is that inappropriate pressure may be placed on clinicians to meet these goals due to a counterproductive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe national contract awards should be multiple sourced. Additionally, compliance rates, if any, should be reasonable. National contracts need to be designed to meet individual patient needs. Extreme target goals or compliance rates will most likely be detrimental to veterans with special needs. The high compliance rates set thus far appear arbitrary and lack sufficient clinical trial.

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

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.
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> 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 Department of Veterans Affairs (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 relates to surgical implants. While funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device, coronary stents, cochlear implants), the surgical costs associated with implanting the devices come from local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule 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 needs and medical condition, not costs associated with equipment and services. VHA clinicians must be permitted to prescribe devices that are "off-contract" without arduous waiver procedures or fear of repercussions.

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

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

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

Restructuring of Prosthetics Programs:

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

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

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

Recommendation:

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

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Failure to Develop Future Prosthetics Managers:

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

The Veterans Health Administration (VHA) has developed and requested 12 training billets for the National Prosthetics Representative Training Program. VHA's National Leadership Board has approved the reimplementation of this vital program. This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. In the past there was a serious shortage in the number of qualified prosthetic representatives who were available to fill current or future vacant positions. This has led to many inappropriate prosthetics personnel selections around the country. Currently seven prosthetics representative trainees from the 2003 program will graduate in 2005 and be ready for permanent placement. Twelve slots were approved for fiscal year 2004 (FY 2004) and another 12 are pending approval for FY 2005.

In the past, some Veterans Integrated Service Networks (VISNs) have selected individuals who do not have the requisite training and experience to fill

the critical VISN prosthetics representative positions. The IBVSOs believe the future strength and viability of VA's prosthetics programs depend on the selection of high-caliber prosthetics leaders. To do otherwise will continually lead to grave outcomes based on the inability to understand the complexity of the prosthetics needs of patients or the creation of prosthetics gatekeepers—individuals whose primary mission would be to save dollars at the expense of the veteran.

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

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

Recommendations:

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

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

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

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

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Consistent Application of National VHA Prosthetics 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 Department of Veterans Affairs (VA) care and treatment.

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

Handbook 1173 is translated in VISN and facility-level operating guidelines accurately.

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

Recommendations:

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

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

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Mental Health Services:

Department of Veterans Affairs (VA) leadership is to be applauded for adopting a framework for improving veterans' access to mental health services that foster rehabilitation and recovery. Congress must provide the funding needed to sustain and expand those efforts

Our country's ongoing military engagement in Iraq and Afghanistan—and the debt we owe our returned and returning combatants—dramatically heightens the importance of ensuring that the VA health-care system is effectively treating veterans' psychic wounds as well as their physical injuries. Meeting this critical obligation will require VA to continue a rebuilding process aimed at transforming its mental health service delivery system. VA leaders have taken heroic first steps; Congress must lend needed funding support.

VA has long had a special obligation to veterans with mental illness, given both the prevalence of mental health and substance-use problems among veterans and the high numbers of those whose illness was of service origin. Recent VA data show that more than 480,000 veterans are service-connected for a mental disorder. Of that number, more than 215,000 are service-connected for post-traumatic stress disorder (PTSD). Some 17 percent—nearly 800,000—of the 4.7 million who received VA care in fiscal year 2003 received some type of mental health service.

The Independent Budget (IB) applauds Congress for having codified into law special safeguards to ensure that VA gives a priority to the needs of veterans with mental illness. With the nation at war—and an already high percentage of returning veterans showing evidence of war-related mental health problems—VA's statutory obligation to veterans with mental health problems has special poignancy.

The VA health-care system has had an uneven record of service to veterans with mental health needs. Years of oversight repeatedly hammered at the enormous variability across the country in the availability of mental health treatment services and, where services were available, the relatively limited capacity devoted to rehabilitative help. But following the release of the report of the President's New Freedom Commission on Mental Health in July 2003, VA undertook an unprecedented, critical examination of its mental health services. Like other institutions providing mental health care, VA has tended to focus on managing the symptoms of patients' mental health problems. Yet the President's Commission found that many people with mental illness can regain a productive life, and it provided the President with a blueprint for system change based on the goal of recovery. VA leaders, to their credit, understood the importance of achieving the mental health system change the commission envisioned and developed an agenda

(built in significant part on earlier recommendations of VA's Committee on the Care of Severely Mentally Ill Veterans) for realizing that goal. Under VA Secretary Anthony J. Principi's committed leadership, the transformation under way in VA mental health service delivery—built on an understanding that veterans with mental disorders can recover and lead productive lives—is vitally important to keeping faith with the obligations VA has to America's veterans.

The Secretary's establishment of a task force in December 2003 to review VA's ability to provide mental health and substance abuse treatment and to provide needed recommendations marks an important step on the road to transforming VA mental health care. To his great credit, the Secretary has adopted the recommendations advanced by that task force, including measures aimed at eliminating the variability and gaps in VA care for veterans with mental illness, restoring VA's ability to deliver state-of-the-art care to veterans with substance abuse disorders, establishing case management programs for homeless veterans with mental health problems, and providing supportive rehabilitative services to veterans with mental illness.

Any transformation or major change—from eliminating the longstanding variability in VA care to changing its mission from symptom-management to recovery—will take sustained leadership and support on the part of VA and Congress. Given the wide gap between VA's mental health capacity and the needs veterans have for mental health treatment and support services, these changes will also require new funding.

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

- VA does not have in place the needed arsenal of rehabilitative services—from supported employment to housing assistance to peer supports—that veterans need to achieve the fullest possible recovery from chronic mental illness.
- VA and the DOD have not yet developed needed mechanisms to provide screening and early intervention services to help returning service members get early treatment for war-related mental health problems.
- Veterans with substance use problems, and those with co-occurring mental health and substance-use problems, still do not have adequate access to VA treatment.
- VA lacks the capacity to meet the needs of veterans with special needs, including aging veterans with profound mental illness and/or dementia-related conditions, and female veterans who have mental health needs associated with sexual assault in service.

In what should be a shared journey, VA and Congress each must do its part to make VA mental health care a real priority and ensure that priority is maintained. Both must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness becomes a guiding beacon for VA mental health planning and programming.

The Independent Budget recognizes that bridging the gaps still facing VA mental health care must be approached with thoughtful deliberation and care and recommends that funding be augmented steadily over a five-year period.

Recommendations:

Congress must incrementally augment funding for specialized treatment and support services for veterans who have mental illness, PTSD, or substance-use disorders by $500 million each year from fiscal year 2006 (FY 2006) through FY 2010.

VA must adopt a strategic plan for mental health services and give priority to realizing the elements of such a plan.

The Veterans Health Administration (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 necessary support services.

VA must press the Administration and the DOD to ensure the development of a seamless initiative to

provide early intervention services to help returning service members get early treatment for war-related mental health problems.

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

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Specialized Services Issues

Blinded Veterans:

The Veterans Health Administration (VHA) needs to 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 1,600 blinded veterans are awaiting entrance into 1 of the 10 VA BRCs. Then, in order to gain access to one of these programs, the veteran must wait an average of 24 weeks. 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 nine-day rehabilitation program, called Visual Impairment Services Outpatient Rehabilitation Program (VISOR), at the Department of Veterans Affairs Medical Center (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 full-time employees, 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 23 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 enactment of P.L. 104-262.

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

The VHA must require the Veterans Integrated Service Networks (VISNs) to restore clinical staff resources in both inpatient and outpatient blind rehabilitation programs.

The VA must require the VISNs to include in their five-year strategic plans the provision of a full continuum of vision rehabilitation care.

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 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.

BRS national program consultants, currently decentralized, must be recentralized and report directly to the BRS director in the Department of Veterans Affairs Central Office.

VA must seek legislative relief to amend the beneficiary travel program to include those severely disabled veterans accepted to one of the special-disabilities programs who are currently eligible to receive this benefit.

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Spinal Cord Dysfunction:

The recruitment of qualified staff to support the mission of the spinal cord injury/dysfunction (SCI/D) program remains the major impediment to providing quality care to the patient with spinal cord injury or dysfunction.

The Department of Veterans Affairs (VA) is currently experiencing a serious shortage of qualified, board certified SCI chiefs of service. Several major SCI programs are under "acting" management with resultant delays in policy development and a loss of continuity of care. In some VA hospitals the recruitment for a new chief of service has been inordinately prolonged; in one instance, an SCI service had an extended search committee in place for more than two years, and another has been without a full-time chief for more than three years.

It must be recognized that SCI medicine is a major subspecialty, and clinical leadership of these departments is as vital to the VA's health-care program as the specialties of general medicine and surgery. Neglect to promptly fill these vacancies reflects adversely on the management of the local VA hospital and the Veterans Health Administration (VHA) systemwide. It can be assumed that either the process is flawed, applicants were not available, or that appropriate incentives have not been included to make these positions attractive.

■ Nursing staff:

The Independent Budget veterans service organizations continue to support the belief that base salaries for nurses who provide bedside care is still too low to be competitive with community hospital nurses, resulting in a high turnover as these individuals leave VA for more attractive compensations.

VA has a system of classifying patients according to the amount of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of injury, amount of time spent with the patient, technical expertise, and clinical needs of each patient. A category III patient in the middle of the scoring system is the "average" SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. These hours are converted into the number of full-time employee equivalents (FTEEs) needed for continuous coverage. This formula covers bedside nursing care hours over a week, month, quarter, or the year. It is adjusted for net hours of work with annual, sick, holiday, and administrative leave included in the formula.

The emphasis of this classification system is based on bedside nursing care. It does not include administrative nurses, non-bedside specialty nurses or light-duty nursing personnel because these individuals do not or are not able to provide full-time labor-intensive bedside care for the SCI/D patient.

Nurse staffing in SCI/D units has been delineated in VHA Handbook 1176.1 and VHA Directive 2004-004. This staffing ratio was derived from 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. Currently nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses, and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

VHA Directive 2004-044 mandates 1,347.4 bedside nurses provide nursing care for 85 percent of the available beds at the 23 SCI centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians.

At the end of fiscal year 2004, nurse staffing was 1,315.3. This number is 32.1 FTEEs short of the mandated requirement of 1,347.6. The 1,315.3 FTEEs include nursing administrators and non-bedside RNs (75.24) as well as light duty staff (42.5). Removing the administrators and light duty staff makes the total number of nursing personnel 1,197.56 to provide bedside nursing care.

The regulation calls for a staff mix of approximately 50 percent RNs. Not all SCI centers are in full compliance with this ratio of professional nurses to other nursing personnel. There are 489.5 RNs working in spinal cord injury. Of that number, 75.24 are in non-bedside or administrative positions, leaving 414.26 RNs providing bedside nursing care. With 1,315.3 nursing personnel and 414.26 of those RNs, this leaves an RN ratio of 31.49 percent to provide bedside nursing care. Even if the non-bedside RNs were included, the percentage of RNs is 37 percent. These numbers are far below the mandated 50 percent RN ratio.

SCI facilities recruit only to the minimum nurse staffing required by VHA Directive 2004-044. As shown above, when the minimal staffing levels include non-bedside nurses and light duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with lower levels of staffing.

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

This nurse shortage has manifested itself recently by VA facilities beginning to admit non-SCI patients to the SCI center wards. One acute care VA facility, until advised by VHA central office, was admitting patients ranging from mental health to general medicine in SCI designated beds. That VA facility was faced with a severe nursing shortage throughout the medical center and unable to open beds to accommodate these patients. Situations such as this create a severe compromise of patient safety and continue to stress the need to enhance the nurse recruitment and retention programs.

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

Recommendations:

The VHA should authorize substantial recruitment incentives and bonuses to attract board certified physicians for the positions of SCI chief.

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

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

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

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Gulf War Veterans:

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

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 War veterans suffer from real illnesses, there is no single disease or medical condition affecting them.

In the 13 years since the Gulf War, both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) have seen 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 Gulf War veterans. *The Independent Budget* veterans service organizations (IBVSOs), therefore, expect to see additional health-care issues and disability claims related to some of the same undiagnosed illnesses the veterans of the Gulf War have experienced.

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 to which hazardous toxins members of the armed forces may have been exposed while serving in the Persian Gulf. Upon iden-

tification of those toxins, the 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 P.L. 107-135, thus prolonging eligibility for VA health care of veterans who served in Southwest Asia during the 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 for chronic pain and fatigue. VA has not yet, however, developed clinical practice or treatment guidelines for management of patients with multisymptom-based illnesses. Nor has VA tailored its health-care or benefits systems to meet the unique needs of Gulf War veterans; instead, VA continues to medically treat and handle these cases in a traditional manner.

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

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 P.L. 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 of Veterans Affairs 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 P.L. 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 federal government and private entities.

A new program announced November 12, 2004, by the Secretary of Veterans Affairs calls for up to $15 million for additional research funding for Gulf War illnesses. This new program reflects a new level of cooperation and initiatives specifically dedicated to Gulf War illnesses.

Recommendations:

VA should continue to foster and maintain a close working relationship with the NAS in an effort to determine 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 the NAS adhere to time limits imposed upon them so they effectively and efficiently address the continuing health-care needs of Gulf War veterans.

Women Veterans:

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

In contrast to the overall declining veteran population, the female veterans' population of the United States is increasing. According to a 2003 United States Census Bureau survey, of the 23.7 million veterans, 1.4 million, or 6 percent, were women. Likewise, the percentage of active duty personnel who are women has increased significantly from 1.6 percent in 1973 to 15 percent at the start of 2003. Today, more than 213,000 women serve on active duty in the military services of the Department of Defense. Another 3,800 women serve in the active Coast Guard. The Reserve and National Guard components also have an increasing percentage of women, who constitute 17.2 percent of the current personnel with 151,441. As of July 28, 2004, 20,255 women veterans served and have separated from military service in Operation Iraqi Freedom (OIF) and Enduring Freedom (OEF) theaters of operations.

As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health-care services. According to VA, among the more than 20,000 women having served in OIF and/or OEF, 20 percent, or 4,045, have received health care from VA since separation from military service. Women veterans comprise approximately 5 percent of all users of VA health-care services and within the next decade this figure is expected to double. Additionally, the average woman veteran is younger than her male counterpart and more likely to belong to a minority group. The Bureau of Labor and Statistics reported in 2003 that 46.3 percent of women veterans are less than 45 years of age. With increased numbers of women veterans seeking VA health care following military service, it is essential that VA is responsive to the unique demographics of this veterans' population and adjust programs and services as needed to meet their changing health care needs. As we see growth in the number of women veterans using VA health-care services, we also expect to see increased VA health-care expenditures for women's health programs.

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

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

The Independent Budget veterans service organizations (IBVSOs) are concerned that although VA has markedly improved the way health care is being provided to women veterans, privacy and other deficiencies still exist at some facilities. VA needs to enforce, at the Veterans Integrated Service Networks (VISNs) 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 VISNs or local levels.

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 vari-

able. There has been a trend in the VHA away from comprehensive or full-service women's health clinics dedicated to both the delivery of primary and gender-specific health care to women veterans. 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 care delivery model to an outpatient health-care delivery model focused on preventative medicine. The IBVSOs are 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 percent of a primary care practitioner's clientele, women veterans comprise less than 5 percent of VA's total population. As a result, VA clinicians are generally less familiar with women's health issues, less skilled in routine gender specific care, and often hesitant to perform exams essential to assessing a woman's complete health status. With the advent of primary care in VA, many women's clinics are being dismantled and women veterans are assigned to the remaining primary care teams on a rotating basis. This practice further reduces the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women's health.

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

We are pleased that VA, in recognition of the changing demographics in the veteran population and the special health-care needs of women veterans, has established women's health as a research priority to develop new knowledge about how to best provide for the health and care of women veterans. In 2004 VHA's Office of Research and Development held a groundbreaking conference titled "Moving Toward a VA's Women's Health Research Agenda: Setting Evidence-Based Research Priorities for Improving the Health and Care of Women Veterans." The participants of the conference were tasked with identifying gaps in understanding women veterans' health and health care and with identifying the research priorities and infrastructure required to fill these gaps. The acting chief of VA's Research and Development department noted that VA is working to develop a strategic plan for women's health research. We strongly encourage VA 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.

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

According to VA, approximately 20 percent of the women screened between fiscal years 2002 and 2004 responded "yes" to experiencing military sexual trauma (MST) compared to 1 percent of men screened. In response to these reports, VA has committed to establishing a committee to explore ways to address the mental health needs of women veterans and to improving mental health services to women who have experi-

enced MST. We encourage the VHA to implement recommendations made by the Mental Health Strategic Health Care Group Subcommittee on Women's Mental Health, including screening all women for MST, development of an MST provider certification program, providing separate subunits for inpatient psychiatry and other residential services, improved coordination with the Department of Defense (DOD) on transition of women veterans, and promotion and advancement of women's health research agenda. We also encourage VA to strengthen its partnership with the DOD, to ensure a seamless transition for women from military service to veteran status. Improvements in sharing data and health information between the departments is essential to understanding and best addressing the health concerns of women veterans.

We are pleased VA is preparing for the return of women veterans from combat theaters and has provided guidance for medical facilities to evaluate the adequacy of programs and services for returning OIF/OEF women veterans in anticipation of gender-specific health issues, including recommendations for women veteran program managers to develop educational literature targeting women veterans and listing VA contacts in local catchment areas.

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 IBVSOs are 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 women 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 ensure priority is given to women veterans' programs so that quality health care and specialized services are equally available to women veterans as male veterans. VA must continue to work to provide an appropriate clinical environment for treatment where there is a disparity in numbers, such as exists between women and men in VA facilities. Given the changing roles of women in the military, VA must also be prepared to meet the specialized needs of women veterans who were sexually assaulted in military service or catastrophically wounded in combat theaters suffering amputations, blindness, spinal cord injury, or traumatic brain injury. Although it is anticipated that many of the medical problems of male and female veterans returning from combat operations will be the same, VA facilities must prepare for health issues that pose special problems for women. Finally, the IBVSOs recommend VA focus its women's health research on finding which health-care delivery model demonstrates the best clinical outcomes for women veterans. Likewise, VA should create a strategic plan to collaborate with the DOD to collect critical information about the health and health-care needs of women veterans with a focus on evidence-based practices to identify other strategic priorities for women's health research agenda.

Recommendations:

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

VA must ensure that priority is 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, as women veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

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

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

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

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

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Long-Term Care Issues

The Department of Veterans Affairs (VA) is ill-prepared to meet the long-term care needs of America's aging veteran population. VA will see a significant increase in long-term care needs over the next decade. The number of aging veterans is increasing rapidly, and those who are 85 years old and older are expected to increase from approximately 870,000 to 1.3 million over this period. This group of veterans will have a significant need for institutional care and require a variety of noninstitutional long-term care services.

Concern over VA's ability to meet the growing veteran demand for long-term care services was highlighted during testimony by the Government Accountability Office (GAO) on January 28, 2004, before the House Committee on Veterans' Affairs. The GAO stated that: "Recent trends in VA nursing home care and noninstitutional service delivery raise important questions, particularly whether access to services is sufficient to meet the needs of a rapidly growing elderly veteran population."

This concern is further magnified by VA's fiscal year 2005 (FY 2005) budget submission workload numbers that propose a decrease in capacity for the core of VA's institutional long-term care programs. The subacute program will experience a modest increase. The State Home Domiciliary and the Community Nursing Home Programs, while not decreasing, are expected to remain at FY 2004 levels.

VA Institutional Long-Term Care Workload

(The following data is taken from VA's FY 2005 budget submission and is expressed in average daily census (ADC) numbers):

	2003	2004	2005	INCREASE/(DECREASE)
VA Residential Rehab.	5,425	5,378	5,312	(66)
Psych. Res. Rehab	1,436	1,279	1,143	(136)
State Home Domiciliary	3,758	4,389	4,389	0
Subacute	595	613	686	73
VA Nursing	12,339	11,000	8,500	(2,500)
Community Nursing	4,069	4,069	4,069	0
State Nursing	17,000	18,000	19,010	(1,010)
Institutional Total	44,622	44,728	43,109	(1,619)

VA Institutional (Nursing Home Care) Issues

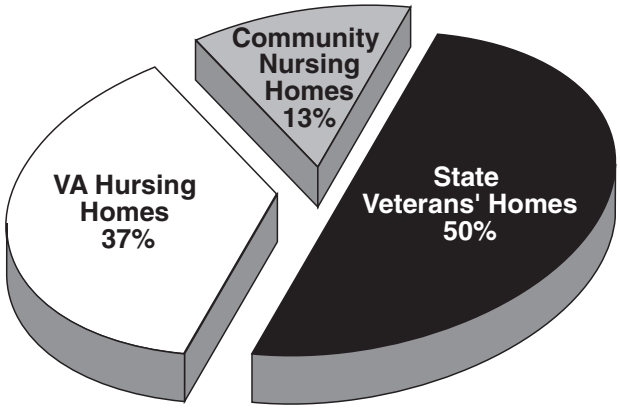
Operational Issues: Capacity Mandate

Once again, VA has failed to meet the congressional average daily census (ADC) requirement of 13,391 for VA nursing home care as mandated by P.L. 106-117, "The Veterans Millennium Health Care and Benefits Act of 1999" (Mill Bill). VA's budget submission for fiscal year 2005 (FY 2005) projected the ADC goal for VA nursing home care to be at 8,500 (Note: VA's unofficial ADC VA nursing home care estimate for the end of FY 2004 is said to be approximately 12,400).

It appears that VA does not believe it must follow the congressional Mill Bill mandate. VA is clearly moving to reduce its own nursing home capacity and expenditures by shifting its nursing home responsibility to state veterans' homes. State veterans' homes are an attractive option for VA because VA pays about one-third of the cost of care in state veterans' nursing homes. The Government Accountability Office (GAO) reported the following examples: First, the percentage of workload in VA's own nursing homes declined from 40 to 37 percent between 1998 and 2003. Thirteen Veterans Integrated Service Networks (VISNs) provided a smaller percentage of workload in VA-operated nursing homes during this period. Second, the percentage of VA nursing home workload met in state veterans' homes increased from 43 to 50 percent between 1998 and 2003. Third, the percentage of workload in community nursing homes declined from 17 to 13 percent. Seventeen VISNs reduced the percentage of their nursing home workload in community nursing homes during this period. (Note: The GAO reported in November of 2004 (GAO report-05-65) that in FY 2003 half (50 percent) of VA's average daily nursing home workload was provided in state veterans' nursing homes, 13 percent was provided in community nursing homes, and 37 percent was provided in VA nursing homes.)

The following pie chart depicts the percentages of VA's nursing home workload for 2003 (from GAO Report to the Chairman, Committee on Veterans' Affairs, House of Representatives, VA Long-Term Care: Oversight of Nursing Home Program Impeded by Data Gaps (GAO-05-65) (2004):

CHART 2.
2003 VA NURSING HOME WORKLOAD



Meanwhile, VA is trying to persuade Congress to modify the capacity mandate of the Mill Bill requiring an ADC 13,391 (1998 baseline year) for only VA nursing home care to include an ADC number that includes a combination of VA nursing home, community nursing home, and state veterans' nursing home care. This new methodology would allow VA to dramatically reduce its VA nursing home capacity and backfill with contract community nursing home beds or state veterans' home bed space if available.

The Independent Budget veterans service organizations are opposed to this proposal because it shifts VA's responsibility to veterans and reduces its internal capacity to care for America's aging veterans. Care for aging veterans should not be shifted to private providers because it is more convenient or more cost-effective to do so. VA nursing home care is an entitlement to certain eligible veterans, and these individuals should not be forced to accept other forms of nursing home care because VA has reduced its capacity.

Advantages of VA nursing home care include prompt access to VA medical care because VA nursing homes are either co-located or in close proximity to, VA medical centers. In these situations, prompt access to medical treatment for elderly veterans is easily facilitated and continuity of care can be readily achieved. Also, veteran patients with complex specialized medical conditions and high acuity needs are not easily placed in community nursing homes or state veterans homes. In many instances, these veterans can only be placed in VA nursing home facilities. VA nursing homes provide a rich veteran culture for veteran patients that cannot be matched by community nursing homes. Patient surveys indicate that VA nursing home quality is superior to private community nursing homes, and these VA facilities instill a patriotic spirit of responsibility in its workforce. Accountability for care in VA facilities is not clouded by layers of community nursing home management or reduced by remote off-site locations. Regarding state veterans' homes, admission can sometimes be a barrier because admission is determined by eligibility criteria established by the states. The VA may refer patients to these state veterans' nursing homes for care, but it does not control the admission process, and therefore cannot guarantee admission.

■ Operational Issues: Data Collection

VA's lack of data on veterans who have been shifted from VA nursing home care to state veterans' homes and to community nursing homes is a serious issue. The November 2004 GAO report cited earlier (GAO-05-65) pointed out that gaps in VA data on length of stay and eligibility for state veterans' homes and community nursing homes impedes VA's ability to provide adequate program oversight.

The GAO recommended that VA collect data on veterans' length of stay and eligibility for community nursing homes and state veterans' nursing homes comparable to data VA collects for VA nursing homes. While VA stated it concurred in principle with GAO's recommendations, it did not indicate specific plans to collect the data GAO recommended.

■ Institutional Care Budget Issues: Dollars and Venues of Care

The November 2004 GAO report cited earlier (GAO-05-65) also reported that "the VA currently operates a $2.3 billion nursing home program that provides or pays for veterans' care in VA's 21 health-care networks. Meeting veterans' nursing home care needs is a key issue for VA because it has a large elderly population, many of whom are in need of such care."

In fiscal year 2003, VA nursing homes accounted for almost $1.7 billion, or about three-quarters of the approximately $2.3 billion VA spent to provide or pay for veterans to receive nursing home care. Care in state veterans' nursing homes accounted for about $352 million, and care in community nursing homes accounted for about $272 million.

In 2003, VA operated nursing homes in 132 locations, which are located throughout VA's 21 health-care networks. Almost all of these locations are attached or in close proximity to a VA medical center. Also in 2003, VA contracted with 1,723 community nursing homes through its medical centers and with an additional 508 more nursing homes under its Regional Community Nursing Home initiative. Finally, 109 state veterans' nursing homes located in 44 states and Puerto Rico received VA payments to provide care in 2003.

VA Institutional Care Budget Obligation History and FY 2005 Forecast

The following data was taken from VA's FY 2005 budget submission:

OBLIGATIONS ($000):	2003	2004	2005	INCREASE/DECREASE
Nursing Home Care	$2,412,858	$2,523,494	$2,029,442	($494,051)
Subacute Care	$293,042	$263,738	$237,364	($26,374)
Residential Care	$477,384	$525,998	$578,176	$52,178
GEM 1/	$4,667	$4,821	$4,980	$159
GRECC	$31,682	$32,728	$33,808	$1,080
Total Institutional	$3,219,633	$3,350,778	$2,833,770	($467,008)

VA's budget submission for FY 2005 proposed to reduce VA expenditures for institutional nursing home care by $494 million from the FY 2004 level. This comes at a time when GAO says VA is expecting a greater demand for these services over the next decade.

Congress must appropriate sufficient operational dollars for VA to reach the VA nursing home capacity mandate of the Mill Bill. Additionally, Congress must provide the funding necessary to meet the future demand for both institutional and noninstitutional long-term care that is expected over the next decade.

■ VA Noninstitutional (Home- and Community-Based) Care Issues

Noninstitutional long-term care programs have developed from the philosophy that home- and community-based services are the preferred settings for aging veterans. This is certainly true; most aging veterans wish to remain in their own homes as long as possible. However, there is also an economic factor driving the expansion in home- and community-based long-term care service delivery. Simply put, home- and community-based care are less expensive than institutional nursing home care services.

"The Veterans Health Care Eligibility Reform Act of 1996" (P.L. 104-262) provided for a uniform benefits package for enrolled veterans, including home health care and hospice care. The Mill Bill of 1999 directed that VA shall provide access to a continuum of extended care services including alternatives to institutional long-term care.

In recent years, VA has been increasing its level of home- and community-based long-term care services, but more needs to be done and program gaps still exist. GAO issued a report in May of 2003 (GAO-03-487) titled "Service Gaps and Facility Restrictions Limit Veterans' Access to Non-Institutional Care." The report stated that of the 139 VA facilities reviewed, 126 do not offer all six of the noninstitutional services mandated by the Mill Bill. The authors of *The Independent Budget* believe many of these problems still exist and that the GAO should be asked to review the current status of access to these services.

Operational Issues: Program Service Gaps

As previously mentioned, the May 2003 GAO report (GAO-03-487) identified a number of operational problems with VA's noninstitutional long-term care programs. Among these, GAO cited service gaps and facility restrictions that limit access to these services. The service gaps identified by GAO included VA's services for adult day care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care. The GAO also reported that access is even more limited than the numbers suggest because even when VA facilities offer these services, they often do so in only part of the geographic area they serve.

Operational Issues: Data Collection

In order to eliminate service gaps in noninstitutional care services, VA must mount an intensive data collection effort concerning the availability of access to noninstitutional services across the entire VA system. Each VA network and each individual facility must be surveyed to determine that all of VA's noninstitutional care services are operational and readily accessible. Data on program availability and workload will help VA understand current utilization and predict future need.

VA Noninstitutional Long-Term Care Workload

The following data is taken from VA's FY 2005 budget submission and is expressed in average daily census numbers:

HOME & COMM. CARE	2003	2004	2005	INCREASE/DECREASE
Home Based Primary Care	8,368	10,471	14,592	4,121
Purchased Skill. Home Health Care	4,336	5,424	6,400	976
VA/Contract Adult Day Care	1,263	1,528	1,803	275
Homemaker Home Health	4,317	5,400	6,372	972
Comm. Residential Care	6,050	6,050	6,050	0
Home Respite	2	318	636	318
Home Hospice	77	440	671	231
H & C-B Total	24,413	29,631	36,524	6,893

Noninstitutional Care Budget Issues: Dollars and Venues of Care

VA's budget submission for FY 2005 called for an increase in VA expenditures for noninstitutional care by $132 million, for a total of $514.9 million. The 2004 level of VA spending on noninstitutional care for FY 2004 level was $382.9 million. While increased VA spending on noninstitutional long-term care services seems like a step in the right direction, it must be understood that VA simultaneously proposed reducing the institutional care budget by $467 million.

While it may be true that noninstitutional care services may reduce the number of veterans who require institutional care (nursing home) services in the short run, *The Independent Budget* authors are concerned that the demand for both programs is constantly rising because of an aging veteran population.

VA can no longer continue the shell-game of shifting resources from institutional nursing home care services by ignoring the Mill Bill's capacity mandate to meet the growing demand for noninstitutional care. Congress must appropriate more dollars to meet veteran demand for both institutional and noninstitutional long-term care services. VA is serving record numbers of new veterans each year. Shifting resources from one program to another does not solve the increasing demand problem of an aging veteran population; it serves only to stress existing programs that veterans desperately need.

VA Noninstitutional Care Budget Obligation History and FY 2005 Forecast

The following data was taken from VA's FY 2005 budget submission:

OBLIGATIONS ($000):	2003	2004	2005	INCREASE/DECREASE
Home-Based Primary Care	$72,688	$78,350	$113,339	$34,989
Contract Home Health Care	$105,911	$140,286	$171,813	$31,527
Adult Day Care	$32,934	$30,900	$55,220	$24,320
Homemaker Aide Services	$77,608	$92,223	$112,964	$20,741
Community Residential Care	$13,745	$12,205	$12,669	$464
Home Respite	$41	$6,394	$13,273	$6,879
Home Hospice	$38,070	$22,560	$35,711	$13,151
Total H & C-B	$340,997	$382,918	$514,989	$132,071

■ Capital Asset Realignment for Enhanced Services (CARES) and VA Long-Term Care

The CARES Commission found that VA has not yet developed the forecasts and policies needed to project and plan to meet future demands for long-term care. The commission made several recommendations concerning how VA should address long-term care while implementing CARES.

The CARES Commission's central recommendation was that VA develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliaries, residential treatment facilities, and nursing homes, and facilities for seriously mentally ill veterans. The commission further recommended that the plan include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible and identifying freestanding nursing homes as an acceptable care model. Pending completion of VA's long-term care strategic plan, the commission recommended that VA only proceed with long-term care projects that make necessary life safety and maintenance improvements to existing facilities.

The Secretary's response to the CARES Commission's recommendations was supportive and indicates that VA will move forward to formulate the forecasts and policies necessary to implement a strategic plan that will address consistency of access to care across VA's health-care system. Also, the Secretary's response noted the importance on keeping veterans in need of long-term care in the least restrictive setting possible—allowing them to remain in their homes and close to their families, but recognizing that many veterans will need inpatient nursing home and inpatient mental health care.

The Independent Budget recommends that VA immediately proceed with the development of its strategic plan for long-term care. The decade of increased demand for long-term care is already upon VA, and the development of the necessary models to analyze workload and project long-term care demand should already have been created. Nevertheless, this work must be of the first priority. *The Independent Budget* calls upon VA to thoroughly explain its current waypoint regarding various modeling techniques and to provide a timetable for the publication of its long-term care strategic care plan.

■ Long-Term Care for Veterans with Spinal Cord Injury or Disease (SCI/D)

Both institutional and noninstitutional VA long-term care services are designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D. Older veterans with these conditions are especially vulnerable and require a high degree of long-term and acute care coordination.

Veterans with SCI/D who require VA institutional long-term care services require specialized care from specifically trained professional long-term care providers. These veterans have complex acuity needs and require an environment that is architecturally designed to meet their specific needs. These facilities must be staffed by personnel trained in the specialties of SCI/D care.

VA's CARES initiative has called for the creation of additional long-term institutional care beds in four locations across America. This is an opportunity for VA to refine the paradigm for SCI/D long-term care facility design and to develop a SCI/D long-term care staff training program. Additionally, VA should work with the Paralyzed Veterans of America to develop staffing guidelines for VA long-term care facilities and create a "SCI/D Long-Term Care Handbook" that identifies the operational policies of SCI/D long-term care.

■ Summary

VA's Office of Geriatrics and Extended Care must make every effort to ensure the availability and quality of its institutional and noninstitutional long-term care programs to meet the increasing veteran demand for these services. According to the GAO, "VA will experience a significant increase in long-term care need over the next decade because of the aging veteran population."

Despite this GAO prediction, and mandating legislation by Congress, VA has once again failed to meet the average daily census mandate of P.L. 106-117, "The Veterans Millennium Health Care and Benefits Act of

1999." Additionally, when viewed systemwide, many of VA's long-term care services are provided in a haphazard manner. The provision of each program in the long-term care benefit package is not provided in a uniform fashion across VA, and access to these programs is further complicated by individual facility interpretation of eligibility rules. Long-term care program tracking measures need to be improved and new ones developed so VA can better understand the quality of services veterans are receiving in community and state veterans' nursing homes.

Congress must also shoulder its fair share of responsibility for VA's long-term care problems. Mandating benefits and levels of service without providing VA with the necessary financial resources to achieve these goals has been a recipe for failure. Without adequate resources VA has been forced to pit one long-term care program against another, often at the veterans' expense.

VA would also like Congress to amend the Mill Bill's capacity mandate by allowing VA to count nursing home care furnished by private providers and state veterans' homes. VA's 2005 budget submission evidence VA's desire to further reduce in-house nursing home capacity and fall further behind the congressional capacity mandate. These disturbing trends make veterans and the organizations that represent them question VA's commitment to its aging veterans.

The challenges associated with an aging veteran population have been well known for more than a decade. VA and other federal agencies were acutely aware, as early as the 1980s, that a surge of long-term care demand was coming. It is discouraging that at the beginning of the 21st century, when millions of aging veterans desperately need long-term care, that VA has not adequately prepared to meet their needs.

Recommendations:

Congress must provide the resources necessary for VA to met the capacity mandate and provide all of the long-term care services required by P.L. 106-117 (Mill Bill).

VA must ensure that it provides comprehensive coverage of all mandated long-term care services in each VA facility.

VA must meet the congressional long-term care institutional care capacity mandate contained in the Mill Bill.

Congress must not allow VA to restructure the Mill Bill capacity mandate to include average daily census numbers from community and state veterans' nursing homes.

VA must develop adequate tracking measures to monitor quality and access to community and state veterans' nursing homes.

VA must refine its data collection efforts to eliminate service gaps in the delivery of its institutional and noninstitutional long-term care programs.

VA must promptly comply with the CARES Commission's and the Secretary's final CARES decision recommendation that it develop a long-term care strategic plan as soon as possible.

VA must develop a staff training program for long-term care professionals providing institutional care to veterans with SCI/D.

VA should work with the Paralyzed Veterans of America to develop staffing guidelines for SCI/D long-term care facilities.

VA must improve its SCI/D long-term care facility design to meet the needs of an aging veteran population.

VA must develop a new VA "SCI/D Long-Term Care Handbook" that identifies the operational policies and procedures for this specialized venue of care.

Assisted Living

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

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

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

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

Some of the main findings of the ALPP report include the following:

- ALPP veterans showed very little change in health status over the 12 months post-enrollment. As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that ALPP may have helped maintain veterans' health over time.
- The mean cost per day for the first 515 veterans discharged from the AALP was $74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.
- The mean cost to VA for the veterans' stay in an ALPP facility was $5,030 per veteran. The additional cost of case management during this time was $3,793 per ALPP veteran.
- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.
- The average ALPP veteran was a 70-year-old unmarried white male who was not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.
- ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment: 22 percent received assistance with between 4 and 6 ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with between 1 to 3 ADLs; while 35 percent received no assistance.
- Case managers helped ALPP veterans apply for VA aid and attendance and other benefits to help cover some of the costs of staying in an ALPP facility at the end of the VA payment period.
- Veterans were very satisfied with ALPP care. The highest overall scores were given to VA case managers (mean = 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82)
- Vendors are quite satisfied with their participation in ALPP with a mean score of almost 8 (of 10).
- Case managers were very satisfied with ALPP. Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall in between the cracks."

While assisted living is not currently a benefit that is available to veterans, even though some veterans have eligibility for nursing home care, the IBVSOs believe

Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care. *The Independent Budget* recommends that Congress expand VA's Assisted Living Pilot Program across the entire country, to every VA health-care network.

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

■ Capital Asset Realignment for Enhanced Services (CARES) and Assisted Living

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

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

■ Summary

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

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

Recommendations:

Congress should authorize VA to expand its Assisted Living Pilot Program to include an initiative in each VA Veterans Integrated Service Network. This expanded effort will allow VA to gather important regional program cost and quality information.

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

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

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

VA MEDICAL AND PROSTHETIC RESEARCH

Funding for Medical and Prosthetic Research:

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

VA medical and prosthetic research is a national asset that attracts high-caliber clinicians 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. Sixty percent of VA researchers treat veterans. As a result, the Veterans Health Administration (VHA), which is the largest integrated medical care system in the world, has a unique ability to translate progress in medical science directly to improvements in clinical care.

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

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

For decades, VA has failed to request, and Congress has failed to mandate, construction funding sufficient to maintain, upgrade, and replace VA's aging research facilities. The result is a backlog of research sites in need of minor and major construction funding. Congress and VA must work together to establish a funding mechanism designated for research facility maintenance and improvements, as well as at least one major research construction project per year, until this backlog is addressed.

Medical and Prosthetic Research
(in thousands)

FY 2005	$402,3483
FY 2006 Administration Request	393,000
FY 2006 *Independent Budget* Recommendation	460,000

Medical and Prosthetic Research Account:

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

VA strives for improvements in treatments for conditions long prevalent among veterans such as diabetes, spinal cord injury, substance abuse, mental illnesses, heart diseases, infectious diseases, and prostate cancer. VA is equally obliged to develop better responses to the grievous conditions suffered by Iraq War veterans, such as multiple amputations, compression injuries, and stress disorders.

Recommendation:

The Independent Budget veterans service organizations recommend an FY 2006 appropriation of at least $460 million to support a major initiative in pre- and post-deployment health issues as well as the development of improved prosthetics and strategies for rehabilitation from traumatic injuries. Additionally, the appropriation must offset the higher costs of established research resulting from biomedical inflation and wage increases.

Medical and Prosthetic Research Issues

A Clear Vision for VA Research:

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

During 2004 the VA research program recovered from the previous year's turmoil while VA researchers added to their remarkable record of achievement. Now there is a need to build a broad consensus about the purpose and scope of the VA research program.

Recommendation:

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

Restructuring the Research Funding Methodology:

A thorough review of the Veterans Health Administration research funding methodology is needed to ensure adequate funds for both the direct and indirect costs of this world-class research program.

With the agreement of *The Independent Budget* veterans service organizations, Congress has chosen not to assign to the Office of Research and Development responsibility for administering the Veterans Equitable Resource Allocation (VERA) research support funds. However, ensuring adequate, accountable funding for both the direct and indirect costs of research is an essential factor in the success of any research enterprise, and the problem remains unsolved for the Department of Veterans Affairs (VA). A centralized means is needed 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.

Recommendation:

VA must demonstrate a workable plan for administration of the VERA research allocation implementation that provides accountability while preserving the local flexibility of the current methodology. At the same time, Congress must ensure adequate resources for both the direct and indirect costs of VA's efforts to advance medical diagnosis and treatment.

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Attracting and Retaining a Quality VHA Nursing Workforce:

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis.

The Department of Veterans Affairs (VA) Veterans Health Administration (VHA) has the largest nursing workforce in the country with more than 55,000 registered nurses, licensed practical nurses, and other nursing personnel. Unfortunately, VA and the country at large, are experiencing a shortage of nursing personnel. 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.

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis. Because the VA health-care budget has not kept up with rising health-care costs, the situation has grown more critical each fiscal year. Inadequate funding has resulted in nationwide hiring freezes. These hiring freezes have had a negative impact on the VA nursing workforce as nurses have been forced to assume non-nursing duties 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.

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

funds are appropriated for recruitment and retention programs for the nursing workforce.

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

The Executive Summary of the Nursing Commission Report states:

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

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

- **Leadership Development:**
  This goal focuses on supporting and developing new nurse leaders and creating a pipeline to continuously "grow" nursing leaders throughout the organization. The objective is to operationalize the high performance development model for all levels of nursing personnel. This goal also addresses issues related to the nursing professional qualification standards and the Nurse Professional Standards Board as discussed in the commission report.

- **Technology and System Design:**
  This goal focuses on creating mechanisms to obtain and manage clinical and administrative data to empower decision making. The objective is to develop and enhance systems and technology to support nursing roles. The commission report highlighted the importance of nursing input in the development stage of new technologies for patient care.

- **Care Coordination and Patient Self-Management:**
  This strategic goal focuses on promoting and recognizing innovations in care delivery and facilitating care coordination and patient self-management. The objectives are to strengthen nursing practice for the provision of high-quality, reliable, timely, and efficient care in all settings and to enhance the use of evidence-based nursing practice. This goal also encompasses recommendations from the commission related to the work environment of VA nurses.

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

  (1) **utilization:** to maximize the effective use of the available workforce;

  (2) **retention:** to retain a qualified and highly skilled nursing workforce;

  (3) **recruitment:** to recruit a highly qualified and diverse nursing staff into the VHA; and

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

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

- **Collaboration:**
  This goal focuses on forging relationships with professional partners within VA, across the federal community, and in public and private sectors. The objective is to strengthen collaborations in order to leverage resources, contribute to the knowledge base, offer consultation, and lead the advancement of the profession of nursing for the broader community. The priorities of this goal align with the VHA's Vision 2020 and the commission recommendations related to collaboration and professional development.
- **Evidence-Based Nursing Practice:**
  This goal focuses on identifying and measuring key indicators to support evidence-based nursing practice. The objective is to develop a standardized methodology to collect data related to nursing sensitive indicators of quality, workload, and performance within VHA facilities, which will be integrated into a standardized national database. The commission report applauded VA's progress to date related to this goal.

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

At the end of the 108th Congress, two measures were enacted that signal a good start to addressing medical personnel recruitment and retention issues in general and the nursing shortage in particular. The first measure would have simplified and improved pay provisions for physicians and dentists and authorizes alternative work schedules and executive pay for nurses. The second measure would have established a pilot program to study the use of outside recruitment, advertising and communications agencies, and interactive and online technologies, to improve VA's program for recruiting nursing personnel.

Recommendations:

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

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

Volunteer Programs:

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

Since its inception in 1946, the Department of Veterans Affairs Voluntary Service (VAVS) has donated in excess of 663.5 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 2004, VAVS volunteers contributed a total of 12,951,337 hours to VA health-care facilities. This represents 6,206 full-time employee equivalent (FTEE) positions. These volunteer hours represent more than $223 million if VA had to staff these volunteer positions with FTEE employees.

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

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

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

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

Recommendation:

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

Contract Care Coordination:

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

To ensure a full continuum of health-care services, it is critical that VA implement a program of contract care coordination that will, for the first time, include integrated clinical and claims information for both veterans receiving care within VA facilities and for those receiving some or all of their care in the community. VA currently spends approximately $2 billion a year on purchased care outside the walls of VA but is not able to track the care, related costs, outcomes, or veteran satisfaction. Current legislation allows VA to contract for non-VA health care (fee basis) and scarce medical specialty contracts only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to the veteran, and in certain emergency situations. Unfortunately, no consistent process exists in VA for veterans receiving contracted-care services to ensure that

(1) 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; and

(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 VA can

(1) receive a discounted rate for the 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 $34 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 the following:

- 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 plan, it is important for VA to develop an effective care-coordination model that achieves its health-care and economic objectives. Doing so will improve patient care quality, optimize the use of VA's increasingly 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 would 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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Administrative Issues

Veterans Affairs Physician Assistant:

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

The Department of Veterans Affairs (VA) is the largest single federal employer of physician assistants (PAs), with approximately 1,524 full-time PA FTEE positions. Since the "Veterans Benefits and Health Care Improvement Act of 2000" (P.L. 106-419) directed that the Under Secretary of Health appoint a PA advisor to his office, VA has continued to assign this duty as a part-time position as a PA in addition to his or her other duties. *The Independent Budget* has requested for four years that this be a full-time FTEE in the Veterans Health Administration, and in Senate Appropriations language in 2003 it was requested and ignored. VA has refused to establish this important FTEE as full time, and despite numerous requests from members of Congress and the veterans service organizations, has maintained this position as a field-based one with a very limited travel budget.

PAs in the VA health-care system were the providers for more than 8,500,000 veteran visits in FY 2003, and PAs work in primary care, ambulatory care clinics, and in 22 other medical and surgical specialties. PAs

are a vital part of VA health-care delivery and should have the PA advisor included in VA Central Office as a full-time FTEE in very close proximity to Washington, DC, which was the intent of the law. We urge Congress to fund this FTEE within the VA budget for FY 2006 and to ensure this position is based in Washington, DC.

Recommendation:

Congress should legislatively mandate that the position of physician assistant advisor be a full-time FTEE within VA's budget for FY 2006.

Construction Programs

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

VA has recently completed another phase of CARES, which is a national process to reorganize the Veterans Health Administration (VHA) through a data-driven assessment of its infrastructure and programs. Through CARES, an ongoing process, VA is evaluating the demands for health-care services and identifying changes that will help meet veterans' current and future health-care needs. The CARES process included the development of sophisticated actuarial models to forecast tomorrow's demand for veterans' health care and the calculation of the supply and identification of current and future gaps in infrastructure capacity. This resulted in a Draft National CARES Plan (DNCP) to rectify deficiencies through the realignment of VA's capital asset infrastructure.

Since the publication of the FY 2005 *Independent Budget (IB)*, the commission has been actively evaluating the DNCP proposed by VA. The CARES Commission report was published in March 2004. The Secretary of Veterans Affairs formally accepted the CARES Commission report with the publication of the Secretary's CARES decision document in July 2004.

Initially, the DNCP market plans included flawed projections for outpatient mental health services and questionable projections for inpatient mental health services. The plans did not include any projections for long-term care other than catastrophic care. Accordingly, the commission recognized the importance of mental health services and long-term care to the veteran population and acknowledged in the CARES Commission report that VA must make modifications to its projections to include mental health services and long-term care.

Also last year, during the initial stages of the CARES process, *The Independent Budget* veterans service organizations (IBVSOs) suggested that further data be obtained to support various CARES recommendations that would either close or change the mission of some VA facilities. We appreciate the Secretary's efforts in establishing a CARES Implementation Board and the plan to begin further feasibility studies of the 22 VA facilities identified for possible mission adjustments in the Secretary's CARES decision document. However, as stakeholders, we would like to remind VA that it is imperative that veterans service organiza-

tions remain involved in all phases of this new CARES study, which will be divided into three different segments: a health-delivery study, a comprehensive capital plan, and an excess property plan identifying new land usage or disposal.

We remain supportive of the CARES process as long as the primary emphasis is on the "ES" portion of the acronym. We still understand that the locations and missions of some VA facilities may need to change to improve veterans' access, to allow more resources to be devoted to medical care rather than to the upkeep of inefficient buildings, and to accommodate modern methods of health-service delivery. Accordingly, we concur with VA's plan to proceed with the feasibility study of the remaining 22 facilities contained in the Secretary's decision document.

The IBVSOs also remain concerned that Congress may not adequately fund all CARES proposed changes when CARES implementation costs are factored into the appropriations process. This will only further exacerbate the current obstacles impeding veterans' timely access to quality heath care. It is our opinion that VA should not proceed with the final implementation of CARES until sufficient funding is appropriated for the construction of new facilities and renovations of existing hospitals, as deemed appropriate and pertinent.

MAJOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate $563 million to the major construction account for FY 2006. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition, and claims.

Construction, Major Appropriation
FY 2006 IB Recommendation

CARES	$408,750
Advanced Planning Fund (VHA)	30,000
Asbestos Abatement	5,000
Claims Analyses	2,000
Judgment Fund	10,000
Hazardous Waste	2,000
NCA	85,050
Design Fund	5,000
Advanced Planning Fund	10,000
Staff Offices	5,000
Total, Major Construction	$562,800

MINOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate $716 million to the minor construction account for FY 2006. These funds contribute to construction projects costing less than $7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, staff offices account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects.

Construction, Minor Appropriation
FY 2006 Recommended

CARES	$263,000
Non-CARES	100,000
Seismic	150,000
NCA	30,000
VBA	36,000
Staff	5,000
Advanced Planning Fund	10,000
IG	1,000
Historic Preservation Grant Program	25,000
Architectural Master Plans Program	100,000
Total, Minor Construction	$720,000

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CONSTRUCTION ISSUES

Inadequate Funding and Declining Capital Asset Value:

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

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

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

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only $246 million annually, a recapitalization rate of 0.64 percent of the $38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA

invests less than 2 percent of plant replacement value for its entire facility infrastructure. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the Department of Defense adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

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

The PTF also indicated, "Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus but instead submits an annual top 20-facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within four years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program."

The PTF 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.

The Independent Budget veterans service organizations 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 the VHA can undertake all urgently needed projects.

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What Should Follow CARES:

The Department of Veterans Affairs (VA) must immediately undertake certain activities in order to secure the potential benefits of the Capital Asset Realignment for Enhanced Services (CARES).

The CARES long-range planning study is now complete, and the time is at hand to initiate a major construction program to enhance VA's medical facilities. The CARES study has attempted to forecast the future demand for services and identify what patient programs will be most needed. The study has also proposed realignments of existing assets to best meet these needs. During past years, construction funding has been frozen pending the CARES outcome. This expenditure reduction has been detrimental to the maintenance of VA's capital assets and has caused atrophy in the construction management program. Construction planning has now restarted, and an enhanced program should to be implemented in an efficient and deliberate manner.

In order to initiate this new era of expanded construction, VA must establish a national program of architectural master plans that describe the most efficient means of implementing CARES medical initiatives. In

addition, VA needs to establish a management mechanism that collects, maintains, and evaluates critical planning data. This new system should monitor CARES forecasts and adjust their conclusions as events unfold. Inaccurate forecasts cannot be allowed to remain uncorrected, as was the case with Medical District Initiated Planning Process (MEDIPP) in the late 1990s. Statistical data for the three medical programs (long-term care, mental health, and domiciliary) that were omitted from CARES should be added as quickly as possible.

VA must internally coordinate its planning, construction, and management responsibilities. Better long-range planning needs to be coupled with shorter design and construction time frames in order to deliver a better product in a more efficient manner. Comprehensive solutions need to be developed for aspects of their facility inventory that were not addressed by CARES. These include VA historic properties and the vacant space that exists at many medical centers.

Recommendations:

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

VA must initiate new programs for architectural 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.

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Establishing a Program for Architectural Master Plans for Medical Centers:

Each Department of Veterans Affairs (VA) medical center needs to develop a detailed architectural master plan.

This year's construction budget should include $100 million to fund architectural master plans. Without these plans, the Capital Asset Realignment for Enhanced Services (CARES) medical benefits will be jeopardized by hasty construction planning.

Currently VA plans construction in a reactive manner—i.e., funding the project and then fitting it on the site. There is no planning that addresses multiple projects; each project is planned individually. "Big picture" design is critical so that a succession of small projects don't "paint" the facility into a corner. If all projects are not simultaneously planned, the first project may be built in the best site for the second project. The development of master plans will prevent shortsighted construction that restricts, rather than expands, future options.

Every new project is a step in achieving the long-range CARES objectives. Master plans must be developed so that each project can be prioritized, coordinated, and phased. Phasing to avoid disrupting medical care can be a substantial project expense. Architectural master planning will allow preparation of more accurate cost estimates, which include contingency expenses for phasing. Cost estimates prepared during master planning will either validate, or challenge, the original CARES decisions. For example, if CARES called for use of renovated space for a relocated program and a more comprehensive examination indicates that the selected option is impractical, other options should be considered.

Some CARES plans involve projects constructed at more than one medical center. Master plans must coordinate the priorities of both medical centers. For example, construction of a new SCI facility may be a high priority for the "gaining" facility, a low priority for the "donor" facility. It may be best to fund the two actions together, even though they are split between two medical centers. Architectural master planning will also provide a mechanism to address the three critical programs that the CARES study omitted. Specifically, these are long-term care, severe mental illness, and domiciliary care.

In order to initiate architectural master planning, VA must establish formats for contracted architects to develop physical plans based on programmatic and operational decisions agreed to during CARES. Architectural master planning must begin immediately in order to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction. VA should already have developed a master planning program as recommended in *The Independent Budget for Fiscal Years 2004 and 2005.*

Recommendations:

Congress must appropriate $100 million for medical center master plans in the fiscal year 2006 construction budget.

The facility master plans should address the long-term care, severe mental illness, and domiciliary care programs. Architectural master plans should also address historic properties and vacant space.

VA must quickly develop a format for these master plans so there is standardization throughout the system, even though the planning work will be performed in each Veterans Integrated Service Network by local contractors. The format should be tested in pilot projects.

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

The Department of Veterans Affairs (VA) must develop realistic and compatible time frames for use in the Capital Asset Realignment for Enhanced Services (CARES) initiative, facility master planning, and individual project development.

The VA project development process from design initiation to building occupancy takes from 8 to 10 years. The duration of the process cannot be ignored as a factor in evaluating CARES planning initiatives. There is an inherent incompatibility between the 17-year, long-range planning process and the 10-year implementation process. The development process will increase as a result of CARES. The current project timeline does not include a master planning step. In addition, many CARES projects will require more complex construction phasing, and some may even involve private-sector real estate transactions.

Even if master planning were initiated immediately, occupancy of the first CARES project would occur more than a decade later. As a practical matter, one must assume that the majority of CARES projects will not be completed by 2022, the second CARES planning target date. Only a very few projects will be completed by the first 2012 target date. As a consequence of these long time frames, CARES plans must be viewed in a different light. For example, higher demand for veterans' services that are projected for 2012 must be addressed by nonconstruction alternatives. There is simply not sufficient time to construct new facilities to meet the forecasted need. VA should address these responsibilities by means of operational adjustments.

In order to properly manage construction, VA must coordinate cycles for medical planning, architectural master plans, and project design. Statistical data gathering, for example, should be conducted every year. Now that CARES planning tools have been adopted, the same data format should be updated annually. This will allow VA to monitor previous projections. For example, was the CARES demand forecast for services accurate? If not, why not? This analysis will also allow VA to improve future long-range planning.

Comprehensive systemwide planning (like CARES) should be conducted on a 10-year cycle, but updated each year. Architectural master planning should be conducted on the same cycle as comprehensive medical planning but should be adjusted every three years to reflect changes in demand for services, philosophy of care, and new medical technologies. VA should reduce the length of the design and construction process so that newly completed facilities reflect the current planning data, the most advanced medical technologies, and the newest models for patient care. Health-care advances occur at much too swift a pace to be compatible with a long, inflexible design and construction process.

Recommendations:

VA must develop nonconstruction alternatives to enable it to meet the projected increased demand for veterans' health-care services in the year 2012.

VA should conduct both medical program and architectural master planning on a regular cycle that is appropriate for each activity.

Congress Must Appropriate Sufficient Construction Funding Each Year in Order to Steadily Implement Planning Initiatives:

Using CARES statistical data in facility management and budgeting.

The Department of Veterans Affairs (VA) and Congress should make full use of the data produced by the Capital Asset Realignment for Enhanced Services (CARES) initiative.

The CARES study has produced new data that are potentially useful to Congress and VA. The study paints a statistical picture of the system's current deficiencies in functional space. By the application of planning algorithms, current space requirements have been mathematically computed for every medical program (except long-term care, mental illness, and domiciliary). This computation establishes a "benchmark" that is compared to existing space inventories. The mathematical difference between the benchmark and the inventory represents the deficiency. This is the net amount of new construction needed to provide quality medical care to today's veterans. Using this 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." Medical programs can also be compared on a similar basis.

CARES data will also allow prioritization (ranking) of construction funding, based on a variety of criteria, such as geographic regions or medical programs. Because these data are based on completely objective measurements, they are not the product of any assumptions regarding future needs.

The data that are based on more fragile forecasts are "projected space deficiencies." These are based on various planning postulates regarding veteran eligibility, population demographics, and future military actions. Actuarial data are used to project these future demands for veterans' health-care services. Because of these conjectures, the forecasts are less firm than existing deficiencies. These projections must be considered, however, because VA must plan for the system's future needs. Long-range planning is particularly critical for construction because of the length of the implementation process.

The CARES data illustrate the scope of both the system's current and future construction needs. These data can be used to establish the magnitude of construction budgets and provide a rational basis to distribute these resources. Allocations, for example, could be made to address the greatest current space deficiencies. Alternatively, funding could be prioritized to offset the greatest projected space needs. Budgets could be adjusted to emphasize one medical program over another. VA should have been collecting such data for decades for the purposes of system management and congressional oversight.

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

Recommendations:

VA should generate similar CARES 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.

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Updating and Expanding VA Design Guides:

The Department of Veterans Affairs (VA) must develop long-term care facility design guides for spinal cord injury (SCI) patients.

VA owns and operates the largest health-care system in the United States. An advantage of this role is the ability to develop, evaluate, and refine the design and operation of their many facilities. Every new clinic's design, for example, should benefit from lessons learned from previous clinics. VA should collect input from facility operators, such as medical staff and engineering officers, and also from users, including patients and their families. This feedback should generate improvements to future designs.

VA currently provides design guides for some facilities that support veterans' care. The guides are tools used by the designer, clinician, staff, and management during the design process. Currently, there are no design guides for long-term care facilities. The only available guide for extended care facilities is the 1990 VA Handbook 7610 Chapter 106, "Nursing Home Care Units." However, the data are limited, omitting such figures as square footage requirements for functional spaces. VA is currently preparing a new design guide for extended-care facilities. This design guide will specifically address the needs of aging patients who require varied levels of medical care. Even at the 50 percent completion level, the guide appears to have the necessary elements to build successful extended-care facilities.

The Capital Asset Realignment for Enhanced Services process advocates construction of several new long-term care SCI centers. Design guides for long-term spinal cord injury facilities must also be developed immediately. Currently, long-term care facilities utilize the same design concepts as acute-care facilities. This approach is not appropriate. Long-term care facilities should not provide the same patient environment as acute-care centers. Although they need to meet specialized accessibility criteria, they should be less institutional in their character with a more homelike environment. Rooms and communal spaces should be designed to accommodate patients who will live in these facilities for extended periods of time. Simple ideas that would make daily living more residential should be included. For example, corridor lengths

should be limited and should include wide areas with windows to create tranquil places or areas to gather. Centers should have courtyards in areas where the climate is temperate or indoor solariums where it is not. A complete guideline for these facilities would also include a discussion of design philosophies as well as specific criteria for each space.

Care for the long-term SCI patient results from primarily physical issues, not aging or mental health. An SCI long-term care patient could be a 19-year-old newly injured veteran or a 75-year-old veteran who has been a wheelchair user for decades. Both may be in a long-term facility due to a medical acuity, or they may not have the family support available to aid them. Because this type of care is unique, it is particularly important the design guidance be available to contracted architects.

Recommendations:

VA should continue to create extended-care design guides and to update guidelines for nursing home care.

VA should quickly develop specialized long-term care design guides for SCI patients.

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Preservation of VA's Historic Structures:

The Department of Veterans Affairs' (VA) extensive inventory of historic structures must be protected and preserved.

VA's historic structures illustrate America's heritage of veterans' care, and they enhance our understanding of the lives of the soldiers and sailors who have shaped our country. Of the almost 2,000 historic structures VA owns, many are neglected and deteriorate further every year. These structures must be stabilized, protected, and preserved. As the first step in addressing this responsibility, VA must develop a comprehensive national program for its historic properties. Because most heritage structures are not suitable for modern patient care, the Capital Asset Realignment for Enhanced Services planning process did not produce a national preservation strategy. VA must undertake a separate initiative for this purpose immediately.

VA must inventory its historic structures, classify their current physical condition, and evaluate their potential for adaptive reuse by either the medical centers, local governments, nonprofit organizations, or private-sector businesses. To accomplish these objectives, we recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and also with private organizations, such as the National Trust for Historic Preservation. Such expertise should prove helpful in establishing this new program. VA must also expand its limited preservation staffing.

For its adaptive reuse program, VA needs to develop models and policies that will protect historic structures that are leased or sold. VA's legal responsibilities, for example, could be addressed through easements on property elements, such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully assisted the Department of the Army in managing its historic properties.

We applaud the passage of HR 3936, which establishes a revolving fund for costs associated with transfer, renovation, or leasing these facilities. We propose a $25 million budget for FY 2006 for this fund in VA's activities related to veterans' facilities.

Recommendation:

Specific funds should be included in the FY 2006 budget to develop a comprehensive program with detailed responsibilities for the preservation and protection of VA's inventory of historic properties.

Empty or Underutilized Space at Medical Centers:

The Department of Veterans Affairs (VA) should avoid the temptation to reuse empty space inappropriately.

Studies have suggested that the VA medical system has extensive empty space that can be cost-effectively reused for medical services, and that one medical center's unused space may help address another's deficiency. Although these space inventories are accurate, the basic assumption regarding viability of space reuse is not.

Medical design is complex because of the intricate relationships that are required between functional elements and the demanding requirements of equipment that must be accommodated. For the same reasons, medical facility space is rarely interchangeable. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a second-floor space deficiency because there is no functional adjacency. Medical space has very critical inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care. In order to preserve these relationships, departmental expansions or relocations usually trigger "domino" effects on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Medical space's permanent features, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading cannot be altered. Different medical functions have different requirements based on these characteristics. Laboratory or clinical space, for example, is not interchangeable with ward space because of the need for different column spacing and perimeter configuration. Patient wards require natural light and column grids that are compatible with room layouts. Laboratories should have long structural bays and function best without windows. In renovation, if the "shell" space is not suited to its purpose, plans will be larger, less efficient, and more expensive.

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

Early VA centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most hospitals have been consolidated into large, tall "modern" structures. Over time, these central towers have become surrounded by radiating wings with corridors leading to secondary structures. Many medical centers are built around prototypical "Bradley buildings." The VA rushed to build these structures in the 1940s and 1950s for World War II veterans. Fifty years ago, these facilities were flexible and inexpensive, but today they provide a very poor chassis for the body of a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts. The Bradley hospital's central core has a few small elevator shafts that are inadequate for vertical distribution of modern services.

Much of the current vacant space is not situated in prime locations but is typically located in outlying buildings or on upper floor levels. The permanent structural characteristics of this vacant space often make it unsuitable for modern medical functions. VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved. Some space may be suitable for enhanced use. Some should be demolished. Each medical center should develop a plan to find suitable uses for its nonhistoric vacant properties.

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.

Vocational Rehabilitation and Employment

The relationship between veterans, disabled veterans, and work is vital to public policy in today's environment. People with disabilities, including disabled veterans, often encounter barriers to their entry or re-entry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties in turn contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels, our public eligibility and entitlement programs cannot keep pace with the resulting demand for benefits.

In recent years, there has been an increased reliance on licensing and certification as a primary form of competency recognition in many career fields. This emphasis on licensing and certification can present significant, unnecessary barriers for transitioning military personnel seeking employment in the civilian workforce. These men and women receive exceptional training in their particular fields while on active duty, yet in most cases, these learned skills and trades are not recognized by nonmilitary organizations. Efforts to enhance civilian awareness of the quality and depth of military training should be made to eliminate licensing requirements and employment barriers. We are encouraged by the emphasis now being placed on employment and not just the counseling portion of vocational rehabilitation.

In response to criticism of the Vocational Rehabilitation and Employment (VR&E) program, Department of Veterans Affairs (VA) Secretary Anthony Principi formed the Vocational Rehabilitation and Employment Task Force. The Secretary's intent was to conduct an "unvarnished top to bottom independent examination, evaluation, and analysis." The Secretary asked the task force to recommend "effective, efficient, up-to-date methods, materials, metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment. In March 2004, the task force released its report recommending needed changes to the VR&E program. *The Independent Budget* supports the recommendations of the task force, and we look forward to seeing these recommendations implemented.

Vocational Rehabilitation and Employment 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 (VA) 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 VA'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, the VR&E was the recipient of valid criticism. Many of these criticisms remain of concern, including the following:

- inadequate and sometimes nonexistent case management with lack of accountability for poor decision making;
- outdated regulations, as well as policies and procedures manuals;
- long delays in the time taken to process applications due to staff shortages and large case loads;
- inadequate use of electronic information technology;
- failure to explore entrepreneurial opportunities for disabled veterans;
- declaring veterans rehabilitated before suitable employment has been obtained;
- inadequate and inconsistent tracking of the electronic case management information system; and
- need for improved collaboration between the Department of Labor and the Small Business Administration.

In order to address the problems with the current VR&E program, the VR&E Task Force recommended a fundamental change in the program. The task force emphasized the need to have an employment-driven process, which it refers to as the Five-Track Employment Process. This new process provides the following services to veterans:

- reemployment of veterans,
- access to rapid employment services,
- self-employment,
- long-term vocational rehabilitation services, and
- independent living services.

Implementation of this new process can only improve the services that the VR&E provides. These improvements will allow veterans to obtain suitable employment necessary to leading a productive life. We are encouraged by the progress being made by the VR&E to implement the recommendations of the task force and look forward to seeing additional improvements made.

Recommendations:

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

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

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

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

The 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.

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

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

The VR&E should implement the Five-Track Employment Process to focus services more on achieving employment for veterans and not just training.

Unpaid Work Experience:

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

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, volunteer, or in some other capacity.

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. This authority was expanded to include state and local governments but not private or not-for-profit sector employers.

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 veteran's training program.

Assistance Programs Inadequate:

The Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) do not adequately serve service members.

The Departments of Defense (DOD), Labor (DOL), and Veterans Affairs (VA) provide transition assistance workshops to separating military personnel through the Transition Assistance Program and the Disabled Transition Assistance Program. These programs generally consist of a three-day briefing on employment and related subjects, as well as veterans benefits.

DTAP, however, has been largely relegated to a "stand-alone" session. Typically, a DTAP participant does not benefit from other transition services, nor does he or she automatically see a Vocational Rehabilitation and Employment Service (VR&E) representative.

The number of military members being separated annually remains high (more than 200,000 as projected by the DOD). The Independent Budget veterans service organizations (IBVSOs) believe TAP/DTAP must continue to provide their important services as recommended by the VR&E Task Force in March 2004.

The IBVSOs are encouraged that the VR&E is in the process of restructuring DTAP. However, we are concerned that too little is still being done for transitioning disabled veterans, and we will continue to monitor the changes and progress in the DTAP program.

Recommendations:

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

VA should assign primary responsibility for the DTAP program within the Veterans Benefits Administration to the VR&E service and designate a specific DTAP manager.

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

Whenever practical, the DOD should make pre-separation 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.

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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 both the state and federal governments. 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 tran-

sitioning military personnel who have received their career preparation through military service find it difficult to meet certification and licensing requirements because of a 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 service members in a limited number of fields. *The Independent Budget* veterans service organizations (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. There is a lack of clarity regarding the procedures for exchange of transcripts between military and civilian credentialing boards that creates undue barriers for military personnel.

The IBVSOs believe the Department of Defense (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.

Recommendations:

A standardized licensure and certification requirement must be adopted by the appropriate federal and state agencies.

Recently separated service members must be afforded the opportunity to take licensing and certification exams without a period of retraining.

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Performance Standards:

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

While progress is being made to implement the "Jobs for Veterans Act" (P.L. 107-288), there are still no clear performance standards that can be used to compare one state to another or even one office to another 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 are 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. For several years, many have seen a need for standards to be put in place for both Disabled Veterans' Outreach Program (DVOP)/Local Veterans' Employment Representative (LVER) staff and for the SESA as an entity. Beginning in 2002, VETS initiated performance measures that apply to all veterans served by the public labor exchange. These measures address the rates of entry to employment and the rates of retention in employment. In 2004 the same performance measures were applied to veterans served by the DVOP and LVER staff members. These reforms are essential to ensuring a viable job placement service. The ultimate goal is to accomplish the congressional intent and purpose as expressed in t 38 U.S.C. § 4102:

> The Congress declares as its intent and purpose that there shall be an effective (1) Job and Job Training Counseling Service Program,

(2) Employment Placement Service Program, and (3) Job Training Placement Service Program for eligible veterans…so as to provide such veterans and persons the maximum of employment and training opportunities.

Recommendations:

VETS must complete development of meaningful performance standards and reward states that exceed the standards by providing additional funding.

Public Law 107-288, the Jobs for Veterans Act, authorizes VETS, through grants to states, to provide cash and other incentives to individuals who are most effective in assisting veterans, particularly disabled veterans, find work. This recognition is only for individuals and not entities. Congress should amend this law so such entities as career one-stops who do a good job for veterans can be recognized.

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Training Institute Inadequately Funded:

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

The NVTI was established in 1986 and authorized in 1988 by P.L. 100-323. The NVTI is administered by staff from the DOL/Veterans Employment and Training Service (VETS) through a contract currently with the University of Colorado at Denver. The NVTI trains federal and state employees and managers who provide direct employment and training services to veterans and service members. The NVTI curriculum offers courses for staff of the Disabled Veterans' Outreach Program and Local Veterans' Employment Representative programs in core professional skills, marketing and accessing the media, case management, vocational rehabilitation and employment 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, enacted in October 1994, a new investigative techniques course, a quality management course, and a grants management course.

The NVTI offers Department of Defense employees TAP management training, through reimbursable agreements under the Economy Act (at actual cost of training). The NVTI also offers a Resource and Technical Assistance Center, a support center and repository for training and resource information related to veterans programs, projects, and activities.

The Independent Budget veterans service organizations are concerned that, after several years of level funding, appropriations for the NVTI for FY 2005 actually decreased. This reduction compromises the ability of the institute to provide quality training to those individuals serving veterans.

Recommendation:

Congress must fund the NVTI at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.

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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 and the House Veterans' Affairs Committees should take the lead in the reassessment and include veterans service organization the National Association of State Workforce Agencies, and veteran-based organizations, such as the National Coalition of Homeless Veterans and the Office of the Assistant Secretary for Veterans Employment and Training, in discussing these matters of standards and accountability for veterans employment programs.

Continuing discussions on a more effective basis for delivering employment and training services to veterans should take place. The need is to secure the best thoughts 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 progressive movement toward one-stops does not diminish the role of Disabled Veterans' Outreach Program (DVOP)/Local Veterans' Employment Representative (LVER) in delivering employment services to veterans. Unless there is a paradigm shift, there will likely be reductions in force of DVOP specialists and LVERs. The advantage of a face-to-face interaction between DVOPs/LVERs and veterans must not be eliminated.

Recommendations:

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

- raising employer awareness of the advantages of hiring separating service members and recently separated veterans;
- facilitating the employment of separating service members 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 Department of Labor adequate funding to enforce Uniformed Services Employment and Reemployment Rights Act provisions.

National Cemetery Administration

The National Cemetery Administration's (NCA) mission is to honor veterans with a dignified final resting place that exhibits evidence of the nation's gratitude for their military service. Its challenge is to provide all veterans and their families an available option for burial in a national or state veterans' cemetery.

In fiscal year 2004, the NCA maintained more than 2.6 million gravesites in approximately 14,000 acres of cemetery land and provided interments to nearly 90,000 individuals. NCA management responsibilities include 120 cemeteries: Of these, 60 have available, unassigned gravesites for burial of both casketed and cremated remains; 26 allow only cremated remains; and 34 are closed to new interments.

In addition, the NCA burial program calls for activation of six new cemeteries in the areas of Detroit, Michigan; Sacramento, California; Ft. Sill, Oklahoma; Miami, Florida; Atlanta, Georgia; and Pittsburgh, Pennsylvania. "Fast track" burials, which allow interment in a designated section of a cemetery prior to final completion of all construction activities, are already available in Oklahoma, Pennsylvania, and Florida and are planned for Michigan and Georgia in 2005. Construction funding is planned for California in the fiscal year 2005 budget.

Moreover, the fiscal year 2005 budget contains advanced planning funds for site selection and preliminary activities to serve veterans in six new national cemeteries: Philadelphia, Pennsylvania; Birmingham, Alabama; Jacksonville, Florida; Bakersfield, California; Greenville, South Carolina; and Sarasota, Florida.

With the opening of these new national cemeteries and state veterans' cemeteries over the next four years, the percentage of veterans served by burial option within 75 miles of their residence will rise to 83 percent in 2005 from a level of 73 percent in 2001. The completion of these new cemeteries will represent an 85 percent expansion of the number of gravesites available in the national cemetery system since 2001, almost doubling the number of gravesites during this period.

Expanding cemetery capacity is coincident with projections of expanding numbers of veteran deaths and interments performed by the NCA. With the aging of World War II and Korean War veterans, nearly 655,000 veteran deaths are estimated in 2005 with the death rate increasing annually and peaking at 676,000 in 2009. It is expected that one of every six of these veterans will request burial in a national cemetery.

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

In addition to NCA staffing requirements, the visual appearance of national cemeteries as shrines is another NCA high priority. Many individual cemeteries are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of our country. With this understanding, the national cemetery system represents a unique treasure that deserves to be protected and nurtured.

Unfortunately, despite continued high standards of service and despite a true need to protect and nurture this national treasure, the NCA system continues to face a serious challenge in improving the appearance of cemetery assets.

The Independent Budget for Fiscal Year 2006 recommends an operations budget of $200 million for the NCA to meet increasing demands for service, heightened gravesite maintenance, a nationwide shrine initiative, and other essential related areas of cemetery operations.

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NCA ACCOUNT

The National Cemetery Administration (NCA) is responsible for five primary missions: (1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application; (3) to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries; (4) to award a presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

As the veterans' population ages, demand for NCA services will remain high. In recent years, the NCA burial rate has averaged more than 90,000 interments per year. According to Department of Veterans Affairs' (VA) projections, annual individual burials will peak in 2008. Clearly, NCA resources must keep pace in order to meet the growing workload of increasing demands of interments, gravesite maintenance, cemetery repairs, general upkeep, and related labor-intensive requirements of cemetery operations.

The NCA also faces a challenge of completing a work schedule that attends to the repair and renovation needs of more than 900 projects identified in volume 2 of *An Independent Study on Improvements to Veterans Cemeteries*, a review of current and future burial needs submitted to Congress by VA in 2001. According to the study, these project recommendations, which have an estimated cost of $279 million, recognized existing, deteriorating conditions at individual cemeteries in the NCA portfolio.

If the National Cemetery Administration is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of the national cemeteries.

To fulfill a national commitment to maintain national cemeteries as national shrines, *The Independent Budget* veterans service organizations (IBVSOs) recommend Congress establish a five-year, $250 million program to restore and improve the condition and character of NCA cemeteries as part of this year's operations budget.

In addition to the management of national cemeteries, the NCA has responsibility for the Memorial Program Service.

The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries, who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries.

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.

In whole, *The Independent Budget* recommends an operations budget of slightly more than $200 million for the NCA to meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

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.

Congress should provide $200 million for fiscal year 2006 to offset the higher costs related to increased workload, additional staff needs, general inflation and wage increases, and an enhanced national shrine initiative.

Congress should include as part of the NCA appropriation, $50 million for the first stage of a $250 million five-year program to restore and improve the condition and character of existing NCA cemeteries.

National Cemetery Administration
(in thousands)

FY 2005	$147,734
FY 2006 Administration Request	167,409
FY 2006 *Independent Budget* Recommendation	204,046

FY 2006 Recommendation (in thousands)

Current Services Estimate	$154,046
Shrine Initiative	50,000
Total, FY 2006 Recommendation	$204,046

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 Independent Budget* veterans service organizations have identified these issues as critical to ensuring world-class, quality service delivery from the NCA and integral to the memory of all veterans who have served their Country honorably and faithfully.

State Cemeteries Grant Program:

Heightened interest in the State Cemeteries Grant Program (SCGP) results in stronger state participation and increased demands on the program.

The State Cemetery Grants Program (SCGP) complements the National Cemetery Administration (NCA) mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries.

The SCGP makes burial options more available, more accessible, and more convenient. Since 1973, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials.

The SCGP provides funds to assist states in establishing, expanding, and improving state-owned cemeteries. The program has helped develop 56 operating cemeteries across the country which accounted for 19,246 burials of veterans and their eligible family members in fiscal year 2004 (FY 2004), an increase of nearly 5.6 percent over the prior year.

In FY 2004, the state cemetery grant program awarded $39.8 million. Currently six new cemeteries are under construction: Boise, Idaho (the last state in the nation without a veterans' cemetery); Wakeeney, Kansas (300 miles east of Denver and west of Kansas City, serving rural area in western Kansas); Winchendon, Massachusetts (serves densely populated northern Massachusetts); Killeen (Ft. Hood), Texas; and Suffolk, Virginia (serves 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 the Department of Veterans Affairs (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 percent of funeral costs. *The Independent Budget* veterans service organizations (IBVSOs) recommend increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery—not just those who served during wartime.

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 $4,100, bringing it back up to its original proportionate level of burial costs.

The nonservice-connected benefit was last adjusted in 1978, and today it covers just 6 percent of funeral costs. We recommend increasing the nonservice-connected benefit from $300 to $1,270, bringing it back up to the original 22 percent 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 the plot allowance from $300 to $745 and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected benefit from $2,000 to $4,100.

Congress should increase the nonservice-connected benefit from $300 to $1,270.

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

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Strategic Planning and Performance Goals:

The strategic planning process for the National Cemetery Administration (NCA) 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 the Department of Veterans Affairs (VA) to contract for an assessment of the current and future burial needs of our nation's veterans. *An Independent Study on Improvements to Veterans Cemeteries* was submitted to Congress in 2002. Three volumes comprised the study: *Volume 1: Future Burial Needs; Volume 2: National Shrine Commitment;* and *Volume 3: 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 National Cemetery Administration 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 percent of veterans live within 75 miles of a national cemetery.

The Independent Budget veterans service organizations (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 visitors and deceased veterans. 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 the 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 2006, 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 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 ensured 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.

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Fiscal Year 2006

A Comprehensive Budget and Policy Document Created by Veterans for Veterans

The Independent Budget

For the Department of Veterans Affairs

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