The Independent Budget

for the Department of Veterans Affairs

Fiscal Year 2010

A Comprehensive Budget & Policy Document Created by Veterans for Veterans

The Independent Budget

Critical Issues Report

For Fiscal Year 2010

As the global war on terrorism enters its eighth year and the conflict in Iraq approaches its seventh year, servicemen and -women continue to experience traumatic effects as they place themselves in harm's way. Since fighting began in Afghanistan in October 2001 and Iraq in March 2003, more than 4, 000 service members have made the ultimate sacrifice and more than 40,000 others have been wounded. The sacrifices these brave soldiers, sailors, airmen, marines, and coast guard members have made will leave them dealing with a lifetime of visible and invisible wounds. It is for these men and women and the millions who came before them that we set out each year to assess the health of the one federal department whose sole task it is to care for them and their families.

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

Whereas *The Independent Budget for Fiscal Year 2010* will be released in February 2009 concurrent with the release of the President's proposed budget for the Department of Veterans Affairs (VA), this Critical Issues report is designed to alert the Administration, Members of Congress, VA, and the public to those issues concerning VA health care, benefits, and benefits delivery that we believe deserve special scrutiny and attention. We are releasing this report now as a guide to policy makers so they can produce a budget for FY 2010 that is more likely to correct existing problems and to better position VA to successfully meet the challenges of the future. We also hope that this document will provide direction and guidance for the new Administration and new Members of Congress.

As it becomes more and more likely that the global war on terrorism will be long, with dangers from unexpected directions and enemies who are creative and flexible in planning and executing attacks on our citizens and on our friends, our nation must continue to provide for those who serve in our defense. Additionally, we must be cognizant of the current fiscal realities in a time of turbulent and rapidly fluctuating economic conditions that may compel veterans of past service to seek VA care and benefits for the first time.

With this reality ever present in our minds, we must do everything we can to ensure that VA has *all* the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve in the darkest corners of the world, keeping the forces of anarchy, hatred, and intolerance at bay, need to know that they will come home to a nation that respects and honors them for their service, while also providing them with the best medical care to make them whole, the best vocational rehabilitation to help them overcome employment challenges created by injury, and the best claims processing system to

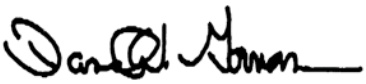
deliver education, compensation, and survivors' benefits in a minimum amount of time to those most harmed by their service to our nation.

We are proud that *The Independent Budget* has gained the respect that it has over its 23-year history. The co-authors of this important document—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States—work hard each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

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

Sincerely,

James B. King
National Executive Director
AMVETS



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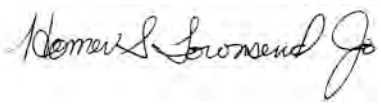

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CRITICAL ISSUE 1
Sufficient, Timely, and Predictable Funding for VA Health Care

VA must receive sufficient funding for veterans health care and Congress must reform the funding process to ensure sufficient, predictable, and timely VA health-care funding.

With the end of the 110th Congress nearing, it is important to review and assess its efforts to provide sufficient, timely, and predictable funding for the Department of Veterans Affairs (VA), particularly the health-care system. The actions of Congress reflect the highest highs and the lowest lows of the current funding process. Although the new leadership in Congress elevated veterans issues to the top of the priority list, Congress still faced a significant struggle to get its appropriations work done on time. Political wrangling continued to deadlock the federal budget process, and, in turn, complicate funding for veterans health care.

Despite recent historic funding increases, today's VA health-care budget process itself has basically paralyzed VA officials from more properly managing, planning, and operating the VA system. Not knowing when or what level of funding it would receive from year-to-year, or how Congress would deal with policy proposals directly affecting the budget, severely impairs VA's ability to recruit and retain staff, contract for services, procure equipment and supplies, and conduct planning and administrative matters. Congress can fully solve this problem only by enacting real reform that results in sufficiency, predictability, and timeliness of VA health-care funding.

For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations,[*] has advocated for reform in the VA health-care budget process. The Partnership has worked with both House and Senate veterans' leaders to craft legislation that would change VA's health-care funding process from a discretionary to a mandatory system. If enacted, such a change would be intended to guarantee that VA health-care funding would be sufficient, timely, and predictable. This would guarantee funding is available on time every year, with automatic adjustments to account for medical inflation and enrollment changes. However, despite the fact that legislation has been introduced in recent years to shift VA health-care funding to a mandatory status, to date Congress has not shown interest in moving this legislation forward.

As a result, the Partnership worked with the Senate and House Committees on Veterans' Affairs this year to develop an alternative proposal (S. 3527/H.R. 6939) that would change the VA's medical care appropriation to an "advance appropriation," guaranteeing funding for the health-care system up to one year in advance of the operating year. In fact, with bipartisan cosponsors, Senate VA Committee Chairman Daniel Akaka (D-HI) introduced S. 3527, and House VA Committee Chairman Bob Filner (D-CA) introduced H.R. 6939. Had this proposal already been in effect, Congress would have recently completed the FY 2010 appropriations bill for VA health care, and the FY 2009 appropriations for VA health care would already have been approved well in advance of the start of the fiscal year. This alternative proposal would ensure that the VA received its funding in a timely and predictable manner. Furthermore, it would provide an option *The Independent Budget* veterans service organizations (IBVSOs) believe is politically more viable than mandatory funding, and is unquestionably better than the current process.

Moreover, to ensure sufficiency, our advance appropriations proposal would require that VA's internal budget actuarial model be shared publicly with Congress to reflect the accuracy of its estimates for VA health-care funding, as determined by a Government Accountability Office (GAO) audit, before political considerations take over the process. This feature would add transparency and integrity to the VA health-care budget process.

Although members of both committees appear to have serious questions about how best to address the recurring funding problems for VA's health-care system, it is clear that the current process must be reformed in a manner that meets three key tests: *sufficiency, timeliness, and predictability*. Most important, as long as VA's health-care system remains part of the current annual discretionary funding process, it will remain vulnerable to unrelated budget and partisan politics that threaten the quality of care for veterans.

As in years past, the FY 2008 appropriations process was not a seamless and efficient process. The IBVSOs were very disappointed when, for the 14th time in the past 15 years, VA did not receive its appropriation prior to the start of the new fiscal year on October 1. Although the appropriations bill was eventually enacted, it included budgetary gimmicks that *The Independent Budget (IB)* has long opposed. The maximum appropriation available to VA would match or exceed the IB's recommendations; however, the vast majority of this increase was contingent upon the Administration making an emergency funding request for the additional money Congress approved. Fortunately, the Administration recognized the importance of this critical funding and triggered its release to VA. This emergency request provided VA with $3.7 billion more than the Administration had sought for VA in FY 2008.

The process leading up to FY 2009 was equally challenging. For the second year in a row, VA received historic funding levels that matched, and in some cases exceeded, the recommendations of the *IB*. Moreover, for only the second time in the past 21 years, VA received its budget prior to the start of the new fiscal year on October 1. However, this funding was provided through a combination continuing resolution/omnibus appropriations act. The underlying military construction and Veterans Affairs appropriations bill for FY 2009 was not actually completed by Congress in the regular order. While the House passed the bill in the summer, the Senate never brought its bill up for a floor vote. This fact serves as a continuing reminder that, despite excellent funding levels provided over the past two years, the larger appropriations process is completely broken.

Although significant strides have been made to increase the level of VA health-care funding during the past several years, the inability of Congress and the Administration to agree upon and enact veterans health-care appropriations legislation on time continues to hamper and threaten VA health care. When VA does not receive its funding in a timely manner, it is forced to ration health care. Much-needed medical staff cannot be hired, medical equipment cannot be procured, waiting times for veterans increase, and the quality of care suffers. Equally disturbing are reports that VA, following the close of FY 2008 is retaining as much as $800 million because VA was unable to spend it in time, despite the fact that thousands of veterans are waiting or unable to receive care.

Only through a comprehensive reform of the budget and appropriations process, such as advance appropriations, will Congress be able to ensure the long-term viability and quality of VA's health-care system. A review of the past two budget cycles makes it evident that even when there is strong support for providing sufficient funding for veterans medical care programs, the systemic flaws in the budget and appropriations process continue to hamper access to and threaten the quality of VA's health-care system.

On February 4, 2008, the President's budget submission for the Department of Veterans Affairs for FY 2009 was released, which included a total funding request of $41.2 billion for VA medical care, an increase of $2.1 billion over the FY 2008 funding level. This request included $38.7 billion in discretionary funding and $2.5 billion in medical care collections. *The Independent Budget for Fiscal Year 2009* recommended approximately $42.8 billion in total funding for medical care—an increase of $3.7 billion over the FY 2008 approved funding level and approximately $1.6 billion over the Administration's request. This funding recommendation would allow VA to reduce waiting times for medical services and keep up with the increasing demands placed on the system by returning and transitioning veterans.

In the end, Congress provided approximately $43 billion for total medical spending in VA. This included $40.5 billion in discretionary budget authority and an additional $2.5 billion in medical care collections. While the IBVSOs have long opposed the use of collections in establishing the operating budget of VA, we recognize that a significant amount of funding is available to VA each year due to these collections. However, we would urge Congress to review the actual collections rates that VA achieves each year if it continues to use collections to increase the VA's operating budget. Our own analysis suggests that VA has only collected about 79 percent of its estimated collections rates dating back to FY 2004. This would suggest that VA will likely only collect approximately $2 billion for FY 2009, even though VA will credit its estimate of $2.5 billion to offset budgetary needs.

The IBVSOs contend that despite the recent increases in VA health-care funding VA does not have the resources necessary to remove the prohibition on enrollment of Priority Category 8 veterans, who have been blocked from enrolling in VA since January 17, 2003. In response to this continuing policy, the Congress included additional funding to begin opening VA health-care system to some category 8 veterans. In fact, the final approved FY 2009 appropriations bill includes approximately $375 million to increase enrollment of category 8 veterans by 10 percent. This will allow the lowest income and uninsured category 8 veterans to begin accessing VA health care. *The Independent Budget* provided a cost estimate for the total cost to reopen VA's health-care system to all category 8 veterans. We estimated that such a policy change would cost approximately $1.4 billion in the first year, assuming that about 375,000 such veterans would enroll in and use the system. This cost estimate is a total cost that does not reflect the impact of medical care collections. We believe that it is time for VA and Congress to develop a workable solution to allow all eligible category 8 veterans to begin enrolling in the system.

In its FY 2009 VA budget submission, the Administration once again included policy proposals to increase prescription drug copayments from $8 to $15 for a 30-day supply and an enrollment fee for category 8 veterans that earn $50,000 or more annually that would range from $250 to $750. VA estimated that these proposals would generate $2.3 billion in receipts to the Treasury

over five years; however, there would have been no guarantee that the funds would be used to improve or expand the delivery of health-care services to veterans. *The Independent Budget* opposes proposals requiring veterans to pay more for their own care, particularly when such revenues may not even be used for veterans health care. As it had done numerous times in previous years, Congress roundly rejected these proposals this year.

Recommendation:

- Congress should reform VA's medical care appropriation to give it an advance appropriation status, to provide funding for veterans health care one year or more in advance of the operating year. This would ensure funding becomes timely and predictable, without converting it to mandatory status or requiring it to meet Congressional PAYGO rules for mandatory accounts.

- Congress should require VA's internal budget model to be shared publicly to provide accurate estimates for VA health-care funding, with the information audited by the GAO.

- The Administration and Congress must provide sufficient funding for VA health care to ensure that all eligible veterans are able to receive VA medical services without undue delays or restrictions. When VA has calculated the cost to reopen the system to all veterans, it should receive full funding to accommodate Priority Category 8 veterans who choose to use the VA system for their health-care needs.

***The Partnership for Veterans Health Care Budget Reform is made up of The American Legion, AMVETS, Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans of the USA, Military Order of the Purple Heart of the U.S.A., Inc., Paralyzed Veterans of America, Veterans of Foreign Wars of the United States, and Vietnam Veterans of America*.

CRITICAL ISSUE 2
The Challenge of Caring for Our Newest War Veterans

The Departments of Defense (DOD) and Veterans Affairs (VA) face unprecedented challenges in meeting the needs of a new generation of war veterans and their families, including those who suffer from post-combat deployment readjustment challenges and reveal cognitive impairments as a result of traumatic brain injury.

Since October 2001, approximately 1.7 million military service members have deployed to Iraq and Afghanistan in Operations Enduring and Iraqi Freedom (OEF/OIF). Because many service members participate in multiple deployments, they are subjected to a number of serious threats including mortar attacks, suicide bombs, and exposure to repeated blasts from improvised explosive devices (IEDs). Current studies indicate that multiple exposures to IED blasts and the stress of these deployments in general are exacting a toll on the fighting force resulting in a variety of seemingly "invisible" wounds, including post-traumatic stress disorder (PTSD), major depression, and cognitive impairments due to milder forms of traumatic brain injury (TBI). Military medicine has advanced to unprecedented levels of excellence that have resulted in a 90 percent survival rate among wounded veterans.[1] However, within the DOD and VA health-care systems, gaps remain in the recognition, diagnosis, treatment, and rehabilitation of these less-visible injuries.

The DOD and VA share a unique obligation to meet the health-care and rehabilitative needs of veterans who have been wounded during military service or who may be suffering from post-deployment readjustment problems as a result of combat exposure. Without question, both agencies have done an extraordinary job in treating those who have suffered the most grievous polytraumatic injuries. But these deployments are also causing heavy casualties in what are considered the invisible wounds of war—PTSD, depression, substance-use disorders, family disruptions and distress, and a number of other social and emotional consequences for those who have served. The DOD, VA, and Congress must remain vigilant to ensure that federal programs aimed at meeting the extraordinary needs of the newest generation of combat veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older veterans who served and were injured in earlier military conflicts. Congress must also remain apprised of how VA spends the significant new funds that have been provided and earmarked specifically for the purpose of meeting post-deployment mental health and physical rehabilitation needs.

The *Independent Budget* veterans service organizations (IBVSOs) are grateful that VA has adopted the principles of the President's New Freedom Commission on Mental Health. The commission's ultimate goal is the eradication of the stigma that surrounds mental health challenges and the opportunity for full recovery for people facing those challenges. The commission's framework for achieving this important goal should be the guiding beacon for VA

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[1] *Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan: Hearing before the House Committee on Veterans Affairs*, 110th Cong., 1 (2007) (Testimony of Matthew Goldberg, deputy assistant director for National Security, Congressional Budget Office).

mental health planning, programming, budgeting, and clinical care for veterans of OEF/OIF service and of all military service periods. Optimal recovery is also the goal for those with severe physical injuries.

The RAND Corporation Center for Military Health Policy Research recently completed a comprehensive study titled *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. RAND found that the effects of TBI are still poorly understood, leaving a gap in knowledge related to how extensive the problem is or how to handle it.[2] The study evaluated the prevalence of mental health and cognitive problems of OEF/OIF service members; the existing programs and services available to meet the health-care needs of this population; the gaps that exist in these programs and what steps need to be taken to improve these services; and the costs of treating or not treating these conditions.

The study found rates of PTSD, major depression, and probable TBI are relatively high when compared to the U.S. civilian population.[3] RAND estimated that approximately 300,000, of the 1.64 million OEF/OIF service members who had been deployed as of October 2007, suffer from PTSD or major depression, and that about 320,000 individuals experienced a probable TBI during deployment.[4] Additionally, about one-third of those previously deployed have at least one of those three conditions, and about 5 percent report symptoms of all three.

According to RAND, 57 percent of those reporting a probable TBI had *not* been evaluated by a physician for brain injury. About 53 percent of those who met the criteria for PTSD or major depression had sought help from a physician or mental health provider in the past year.[5] It was noted, however, that even when individuals sought care, too few received *quality* care—with only half having received what was considered minimally adequate treatment. A number of barriers to care were identified by survey participants as reasons for not getting treatment. RAND concluded that there is a need for increased access to confidential, evidenced-based psychotherapy and that the prevalence of PTSD and major depression will likely remain high unless efforts are made to enhance systems of care for these conditions.[6]

Finally, the study evaluated the costs of these mental health and cognitive conditions to the individual and society. Suffering from these conditions can impair relationships, disrupt marriages, affect parenting, and cause problems in children of veterans.[7] RAND determined the estimated financial costs associated with mental health and cognitive conditions related to OEF/OIF service would be substantial ($4 billion to $6 billion over a two-year period for PTSD

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[2] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research, at XX (T. Tanielian & L. Jaycox eds., 2008).

[3] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research , at XXI, (T. Tanielian & L. Jaycox eds., 2008)

[4] *Ibid.*

[5] *Ibid.*

[6] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research, at XXII (T. Tanielian & L. Jaycox eds., 2008).

[7] *Ibid.*

and major depression, and $591 million to $910 million for TBI within the first year of diagnosis).[8]

Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. However, DOD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of these powerful detonations. Symptoms can include chronic headache, irritability, behavioral disinhibition, sleep disorders, confusion, memory problems, depression, and other behavioral conditions.

Emerging literature (including the RAND study) strongly suggests that even mildly injured TBI patients may have long-term mental and physical health consequences. According to DOD and VA mental health experts, mild TBI can produce behavioral manifestations that mimic PTSD or other mental health conditions. Additionally, TBI and PTSD can be coexisting conditions in one individual. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI. The IBVSOs believe VA should conduct more research into the long-term consequences of brain injury and development of best practices in its treatment; however, we suggest that any studies undertaken include veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. The medical and social histories of previous generations of veterans could be of enormous value to VA researchers interested in the likely long-term progression of brain injuries. Likewise, such knowledge of historic experience could help both the DOD and VA better understand the policies needed to improve screening, diagnosis, and treatment of mild-to-moderate TBI in combat veterans of the future.

The VA's Office of the Inspector General (OIG) issued an initial report on July 12, 2006, focused on the *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*. The report found that better coordination of care between DOD and VA health-care services was needed to enable veterans to make a smooth transition. The OIG Office of Health Care Inspections conducted follow-on interviews to determine changes since the initial interviews conducted in 2006. OIG concluded that three years after completion of initial inpatient rehabilitation many veterans with TBI continue to have significant disabilities and—although case management has improved, it is not uniformly provided to these patients.[9]

Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, and progress is being made, gaps in services are still troubling. The authors of *The Independent Budget* remain concerned about whether VA has fully addressed the long-term emotional and behavioral problems that are often associated with TBI, and the devastating impact on both veterans *and* their families.

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[8] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research , at XXIII, (T. Tanielian & L. Jaycox eds., 2008).

[9] *Follow Up Health Care Inspection: Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation,* VA Office of Inspector General Report No. 08-01023-119 at 8, (2008).

While a miraculous number of our veterans are surviving what surely would have been fatal wounds in earlier periods of warfare, most now survive but some grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal supports. Eventually most of these veterans will be able to return to their families, at least on a part-time basis, or be moved to an appropriate therapeutic residential setting—but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them substitute for the dramatic loss of physical, mental, and emotional capacities as a consequence of their injuries. Immediate families of newly and severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical and emotional problems of the severely injured veteran, deal with the complexities of the systems of care that these veterans must rely on, while struggling with disruption of their family life, interruptions of personal goals and employment, and often the dissolution of other "normal" support systems most people take for granted.

The IBVSOs believe that a strong case management system is necessary to ensure a smooth and transparent handoff of severely injured and ill veterans and their family caregivers between DOD and VA programs of care. This case management system should be held accountable to ensure uninterrupted support as these veterans and family caregivers return home and attempt to rebuild their lives. A severely injured veteran's spouse is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. Spouses must often give up their personal plans (resign from employment, withdraw from school, etc.) to care for, attend, and advocate for the veteran. They often fall victim to bureaucratic mishaps in the shifting responsibility for conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation) that they must rely upon for subsistence in absence of other personal means. For many younger, unmarried veterans who survive their injuries, their primary caregivers remain their parents, who have limited eligibility for military assistance and have virtually no current eligibility for VA benefits or services of any kind.

Both the DOD and VA health-care systems have limited authorization or capacity to provide mental health and relationship counseling services to family members—an important component of the rehabilitation process for veterans and their families. However, the IBVSOs have been informed by a few local VA officials that they are providing a significant amount of training, instruction, counseling and other services to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the possible absence of legal authority to provide these services, and that scarce resources are being diverted to these needs without recognition of their cost within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are penalizing themselves in doing so, but they clearly have recognized the urgency and validity of this need.

The Independent Budget veterans service organizations believe Congress should authorize, and VA should provide, a full range of psychological counseling and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum this benefit should include relationship and marriage counseling, family counseling, and related assistance for the family coping with the stress and continuous burden of caring for a severely

injured and permanently disabled veteran. Also, we believe VA should establish a new national program to make periodic respite services available to all severely injured veterans.

Another issue having an impact on service members, veterans, and their families is substance use disorder. There are multiple consistent indications from both the DOD and VA that the misuse of alcohol and other substances will continue to be a significant problem for many OEF/OIF service members and veterans. An untreated substance use disorder can result in a number of health consequences for the veteran and family, including a marked increase in health-care expenditures, additional stresses on families, social costs from loss of employment and additional, avoidable costs to the legal system. We urge VA and the DOD to continue research into this critical area and to identify the best treatment strategies to address substance abuse and other mental health and readjustment issues collectively.

Over the past decade VA drastically reduced its substance use treatment and related rehabilitation services; however, it now appears some progress is being made in restoring them in the face of increased demand from veterans returning from OEF/OIF. We urge VA to closely monitor the implementation phase of its newly approved Uniform Mental Health Services policy to ensure a full continuum of care for substance use disorders and include additional screening in all its health-care facilities and programs—and especially in primary care. Congress must provide continued oversight to ensure these specialized programs are fully restored, readily accessible, and focused on meeting the unique needs of this population.

The IBVSOs are pleased that VA has developed a comprehensive strategy to address suicides and suicidal behavior in the veteran population, but we encourage Congress to provide oversight to ensure proper focus and attention are paid to this issue. It is clear that without proper screening, diagnosis, and treatment, post-deployment mental health problems can lead distressed individuals to attempt to take their own lives. Ready access to robust mental health and substance abuse treatment programs, which must include screening and early intervention, are critical components of any effective suicide prevention effort.

VA operates a network of more than 190 specialized PTSD outpatient treatment programs throughout its system of care, including specialized PTSD clinical teams and/or a PTSD specialist at each VA medical center. Additionally, Vet Centers, which provide readjustment counseling in 232 community-based centers, have reported rapidly growing enrollments in their programs. Although VA has announced plans to increase the number of Vet Centers, the IBVSOs believe that currently operating Vet Centers must also bolster their staffing to ensure that all the centers can meet the expanding caseload—now including not only traditional counseling but outreach, bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma.

The numbers of women now serving in our military forces are unprecedented in U.S. history. Today, women are playing extraordinary roles in the conflicts in Iraq and Afghanistan. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, and military police officers and serve in other military occupational specialties that expose them to the risk of injury and death. To date, more than 100 women have been killed in action, and women have suffered grievous injuries including multiple amputations. The current rate of enrollment of

women in VA health care constitutes the most dramatic growth of any subset of veterans. According to VA, since 2002, 41 percent of women who deployed in OEF/OIF and have since discharged from military service have enrolled in VA health care.

Because of the expanded roles of women in the military and their broadened exposure to combat, as well as the potential for them to carry the dual burden of combat experience and sexual assault, and given the sheer numbers of women enrolling in VA health care, we encourage VA to continue to address, through its growing treatment programs and expanded research initiatives, the unique health-care needs of women veterans.

Recommendations:

- The DOD and VA must invest in research for individuals who suffer from post-deployment mental health challenges and TBI, to close information gaps and plan more effectively. Both agencies should conduct more research into the consequences of TBI and develop best practices in its screening, diagnosis, and treatment.

- VA should work more effectively with the DOD to establish a seamless transition of early intervention services to obtain effective treatments for war-related mental health problems, including substance use disorders, in returning service members.

- Congress should formally authorize, and VA should provide, a full range of psychological and social support services, including strong, effective case management, as an earned benefit to family caregivers of veterans with service-connected injuries or illnesses, especially for brain-injured veterans.

- The VA system must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.

- VA should initiate surveys and other research to assess the variety of barriers to VA care for OEF/OIF veterans, with special emphasis on reservists and guardsmen returning to veteran status after combat deployments, rural and remote veterans, and female veterans. These surveys should assess barriers among *all* OEF/OIF veterans—not only the subset who actually enroll or otherwise contact VA for health care or other services.

- The DOD and VA must increase the number of providers who are trained and certified to deliver evidenced-based care for post-combat PTSD and major depression.

- The DOD and VA should amend current policies to encourage service members and veterans to seek the care they need without fear of stigma.

- VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on new women veterans who have served in Iraq and Afghanistan.

- The President and Congress should sufficiently fund the DOD and VA health-care systems to ensure these systems *adapt* to meet the unique needs of the newest generation of combat service personnel and veterans, as well as continue to address the needs of previous generations of veterans with PTSD and other combat-related mental health challenges.

CRITICAL ISSUE 3
Maintain VA's Critical Medical Facilities Infrastructure

The Independent Budget ***veterans service organizations (IBVSOs) are concerned that the Department of Veterans Affairs (VA) has made attempts to back away from the capital infrastructure blueprint laid out by the CARES process and that its plans to begin widespread leasing of inpatient services through the "Health Care Center Facilities" program might not serve the best interests of veterans.***

With the completion of the Capital Assets Realignment for Enhanced Services (CARES) process, VA had a clear blueprint for the future—a comprehensive listing of necessary projects, including renovations and new construction that would bring VA infrastructure into the 21st century. So far, VA has completed 5 of those projects, with another 27 under construction.

Despite this progress, challenges remain. These projects, as well as the CARES-identified projects in the planning stage, still require at least $2.2 billion in future funding. At a March 24, 2008, briefing to several veterans service organizations, VA officials explained that between FY 2003 and FY 2009, the difference in the department's capital needs and what Congress had appropriated was a shortage of nearly $5 billion. Further, VA estimated that its future capital needs would be approximately $2 billion per year over the next five years.

Given this fundamental mismatch between VA's infrastructure demands and funding, VA has begun studying the feasibility of establishing the "Health Care Center Facilities" (HCCF) program. In its HCCF study of replacing facility construction with leasing, VA may be signaling a push to circumvent the traditional construction process. VA's FY 2008 Asset Management Plan describes the HCCF studies as a "means of improving both the access and environment of care for its veterans. These studies will assist in determining whether VA should lease space in lieu of seeking construction funding to address the current and future *health-care* needs of veterans."

From a list of 75 potential projects, VA has narrowed down the number of sites that it would consider for this program to 22, and the FY 2008 Asset Management Plan explains that VA expects to have the site analysis finished during FY 2009, allowing the department to move forward on a pilot program shortly after that point. VA claims it retains the authority to conduct this program within the context of its existing leasing authority, and without specific authorization by Congress to initiate the program.

On the face of it, having VA lease space is not necessarily a bad idea. It has the advantage of being able to be done quickly, especially when compared to the drawn-out major construction process. It also allows VA flexibility, and it has been particularly valuable in establishing community-based outpatient clinics (CBOCs) and Vet Centers.

Our concern with the HCCF model is that it is leasing in lieu of VA providing essential inpatient capacity. The leased VA facility would provide extensive outpatient services, including primary and specialty care services. Inpatient services, however, would be provided by local contract

through an agreement with an affiliate or with a community hospital, privatizing many services that the IBVSOs believe VA should continue to provide.

When combined with the recent trend of VA medical centers dropping inpatient services, the IBVSOs are becoming increasingly concerned. In Salisbury, North Carolina, the Hefner VA Medical Center is terminating inpatient, emergency, and surgical services. Michigan's Iron Mountain VA Medical Center has stopped performing inpatient surgeries and downgraded the emergency services it provides. There is suggestion that VA will contract out for some inpatient services at the Beckley, West Virginia, facility as well. Other still-unidentified facilities may follow this pattern.

One example of what can go wrong when VA abandons its inpatient services can be found in Grand Island, Nebraska. In 1997, the Grand Island VA Medical Center closed its inpatient facilities, contracting out with a local hospital for these services. Recently, the contract between the local facility, St. Francis Hospital, and VA was canceled. Veterans needing VA inpatient services can no longer receive care locally. They must travel great distances to other VA facilities including the Omaha VA Medical Center. In some cases, when Omaha is unable to provide the necessary specialized care, VA is flying patients at its expense to other VA facilities, including to the St. Louis and Minneapolis medical centers.

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

The IBSVOs also have increasing concern over the changing of plans for the Denver VA Medical Center. The initial plans for the replacement Denver center were part of the 2004 CARES Commission recommendations. Congress authorized and appropriated funding for the project, but in April 2008 VA unveiled a revised plan that would dramatically change the size and scope of the project, taking it away from the blueprint CARES had laid out. Although VA has not identified it as one of its HCCF projects, it shares the characteristics of those proposals. VA's new proposal would shift its inpatient services to a shared facility built and maintained by the University of Colorado. VA would be responsible for a scaled-back outpatient clinic at the fringes of the Fitzsimons campus.

One example of the problems with the proposal in Denver pertains to the spinal cord injury/dysfunction (SCI/D) center. The new proposal inexplicably splits the SCI/D center into two separate buildings with the outpatient clinic providing 18 beds and the university's inpatient tower providing another 12 beds. These two facilities are separated by a distance of close to a mile—making coordination of care between the two locations difficult, especially given the mobility problems these patients have and harsh winter weather conditions in the Rocky Mountains. Worse, the design splits support spaces for these beds. With separate locations, VA will need to duplicate support services at each facility, but with half the space VA originally

determined was required. With regard to VA requirements, efficient staffing for an SCI/D unit dictates a unit with a minimum of 30 contiguous beds. If a SCI/D center is to function properly, it must be colocated with a full-service hospital and an SCI/D outpatient clinic.

Paralyzed Veterans of America has traditionally had a strong working relationship with VA in developing these SCI/D centers, providing guidance and recommendations to optimize the care provided in a setting that is comfortable and efficient for the paralyzed patients VA serves. With regard to the planned change in the Denver project, veterans have not had a voice; therefore, VA may be making a major strategic error in establishing a suboptimal facility for this critical population of veterans.

We have a number of other questions regarding this project, many of which would apply to other potential HCCF projects. How would governance be handled, especially with respect to the large numbers of non-VA employees who would be treating veterans? How would the non-VA facility deal with VA directives and rule changes that govern health-care delivery and that ensure safety and uniformity of the quality of care? Will VA's space planning criteria and design guides be applied to non-VA facilities? How will VA's critical research activities, most of which improve the lives of all Americans and not only veterans, be affected if they are being conducted in shared facilities, and not a traditional part of VA's first-class research programs? What would this change mean for VA's electronic health record, which many have rightly lauded as the standard that other health-care systems should aim to achieve? Without the electronic health record, how would VA maintain continuity of care for a veteran who moves to another area?

The IBVSOs would like to see some justification for the changes in the scope of this project. The CARES study used comprehensive demographic and health utilization data to support its recommendations. We would like to know what other information was used to develop this revised plan, especially in light of Congress's recent reauthorization of the project and its appropriation of an additional $20 million in FY 2009. The IBVSOs believe the Denver project must immediately move forward as initially envisioned.

CARES provided a sound data-driven assessment of VA's infrastructure needs, and VA seems to be backing away from it toward a model that includes much more privatization of care. The IBVSOs will be watching the process carefully and insist that VA provide us specific information and reasons for any changes in plans that deviate from the CARES blueprint. Also, we believe Congress should examine VA's new HCCF plan to determine whether VA retains the legal authority to proceed without specific Congressional authorization.

Recommendations:

- VA must not move to a wide-scale leasing program that replaces critical inpatient capacity with contract or fee-basis care.

- VA must immediately move forward with the initial plans for the Denver VA Medical Center, as the IBVSOs believe that the revised blueprint would not serve the needs of veterans, especially with respect to the split SCI/D center.

- Congress must carefully examine VA's HCCF program and exercise its oversight authority to ensure that VA is caring for veterans in the best possible way.

CRITICAL ISSUE 4
Improvements Needed in the Claims Process

In order to make the best use of newly hired personnel resources, Congress must focus on the claims process from beginning to end. The goal must be to reduce delays caused by superfluous procedures, poor training, and lack of accountability.

During the past couple of years, the Department of Veterans Affairs (VA) hired a record number of new claims adjudicators. Unfortunately, as a result of retirements by senior employees, an increase in disability claims, the complexity of such claims, and the time required for new employees to become proficient in processing claims, VA has achieved few noticeable improvements.

The claims' process is burdensome, extremely complex, and often misunderstood by veterans and many VA employees. Numerous studies have been completed on claims processing delays and the backlog created by such delays, yet the delays continue. The following suggestions would simplify the claims process by reducing delays caused by superfluous procedures, inadequate training, and little accountability. Other suggestions will provide sound structure with enforceable rights where current law promotes subjectivity and abuses rights.

The subjectivity of the claims process results in large variances in decision-making, unnecessary appeals, and claims overdevelopment. In turn, these problems contribute to the duplicative, procedural chaos of the claims process. Congress and the Administration should seek to simplify, strengthen, and provide structure to the VA claims process.

In order to understand the complex, procedural characteristics of the claims process, and how these characteristics delay timely adjudication of claims, one must focus on the procedural characteristics and how they affect the claims process as a whole. Whether through expansive judicial orders, repeated mistakes, or variances in VA decision-making, some aspects of the claims process have become complex, loosely structured, and open to the personal discretion of individual adjudicators. By strengthening and properly structuring these processes, Congress can build on what otherwise works.

These changes should begin by providing solid, nondiscretionary structure to VA's "duty to notify." Congress meant well when it enacted VA's current statutory "notice" language. It has nonetheless led to unintended consequences that have proven detrimental to the claims process. Many Court of Appeals for Veterans Claims (Court) decisions have expanded upon VA's statutory duty to notify, both in terms of content and timing. However, with the recent passage of P.L. 110-389, the "Veterans Benefits Improvement Act of 2008," Congress, with the Administration's support, took an important step to correct this problem. However, *The Independent Budget* veterans service organizations (IBVSOs) believe VA can do more.

The VA's administrative appeals process has inefficiencies. The delays caused by these inefficiencies force many claimants into drawn-out battles for justice that may last for years. Delays in the initial claims development and adjudication process are insignificant when compared to delays that exist in VA's administrative appeals process. The IBVSOs believe VA

can eliminate some of the delays in this process administratively, and we urge VA to do so. For example, VA can amend its official forms so that the notice VA sends to a claimant when it makes a decision on a claim includes an explanation about how to obtain review of a VA decision by the Board of Veterans' Appeals (Board) and provides the claimant with a description of the types of reviews that are available.

Another problem that seems to plague the VA's claims process is its apparent propensity to overdevelop claims. One possible cause of this problem is that many claims require medical opinion evidence to help substantiate their validity. There are volumes of Veterans Appeals Reporters filled with case law on the subject of medical opinions, i.e., who is competent to provide them, when are they credible, when are they adequate, when are they legally sufficient, and which ones are more probative, etc.

There is ample room to improve the law concerning medical opinions in a manner that would bring noticeable efficiency to VA's claims process, such as when VA issues a Veterans Claims Assistance Act (VCAA) notice letter. Under current notice requirements and in applicable cases, VA's letter to a claimant normally informs the claimant that he or she may submit a private medical opinion. The letter also states that VA may obtain a medical opinion if VA decides to do so. However, these notice letters do not inform the claimant of what elements render private medical opinions adequate for VA rating purposes. To correct this deficiency, we recommend to VA that when it issues proposed regulations to implement the recent amendment of section 5103 that its proposed regulations contain a provision that will require it to inform a claimant, in a VCAA notice letter, of the basic elements that make medical opinions adequate for rating purposes. We believe that if a claimant's physician is made aware of the elements that make a medical opinion adequate for VA rating purposes, and provides VA with such an opinion, then, VA no longer needs to delay making a decision on a claim by obtaining its own medical opinion. This would reduce the number of appeals that result from conflicting medical opinions—appeals that are ultimately decided in an appellant's favor—more often than not. If the Administration refuses to promulgate regulations that incorporate the foregoing suggestion, then Congress should amend VA's notice requirements in section 5103 to require that VA provide such notice regarding the adequacy of medical opinions.

Congress should consider amending title 38, United States Code, section 5103A(d)(1) to provide that when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request such evidence from a department health-care facility. Some may view this suggestion as an attempt to tie VA's hands with respect to its consideration of private medical opinions. However, it does not. The language we suggest adding to section 5103A(d)(1) would not require VA to accept private medical evidence if, for example, VA finds that the evidence is not credible and therefore not adequate for VA rating purposes.

We also believe that other procedures add unnecessary delays to the claims process. For example, we believe that VA routinely continues to develop claims rather than issue decisions even though evidence development appears complete. These actions result in numerous appeals and unnecessary remands from the Board and the Court. Remands in fully developed cases do nothing but perpetuate the hamster-wheel reputation of veterans law. In fact, the Board remands

an extremely large number of appeals solely for unnecessary medical opinions. In FY 2007, the Board remanded 12,269 appeals to obtain medical opinions. Far too many were remanded for no other reason but to obtain a VA medical opinion merely because the appellant had submitted a private medical opinion. Such actions are, we respectfully submit, a serious waste of VA's limited and shrinking resources.

The suggested rulemaking actions and recommended changes to sections 5103 and 5103A(d)(1) may have a significant effect on ameliorating some problems. But to further improve these procedures, Congress should amend 38 U.S.C. § 5125. Congress enacted section 5125, for the express purpose of eliminating the former title 38, Code of Federal Regulations, section 3.157(b)(2), requirement that a private physician's medical examination report be verified by an official VA examination report before VA could award benefits. However, Congress enacted section 5125 with discretionary language. This discretionary language permits, but does not require, VA to accept medical opinions from private physicians. Therefore, Congress should amend section 5125 by adding new language that requires VA to accept a private examination report if the VA determines that the report is: (1) provided by a competent health-care professional, (2) probative to the issue being decided, (3) credible, and (4) otherwise adequate for adjudicating the claim.

The IBVSOs have consistently maintained that VA must invest more in training adjudicators and decision makers, and should hold them accountable for higher standards of accuracy. The VA has made improvements to its training programs in the past few years; nonetheless, much more improvement is required in order to meet quality standards that disabled veterans and their families deserve.

Training has not been a high enough priority in VA. We have consistently asserted that proper training leads to better quality decisions, and that quality is the key to timeliness of VA decision-making. VA will only achieve such quality when it devotes adequate resources to perform comprehensive and ongoing training, and imposes and enforces quality standards through effective quality assurance methods and accountability mechanisms.

The VA's problems with accountability are not isolated to the claims process. In fact, they begin in the VA training process. Essentially, there is no distinction between VA's claims process and its training program when distinguishing unsatisfactory performance and outstanding performance. Both processes place too much emphasis on quantity rather than quality. It is simply the numbers game in full swing.

The Administration and Congress should require mandatory and comprehensive testing designed to hold trainees accountable. This requirement should be the first priority in any plan to improve training. VA should not advance trainees to subsequent stages of training until they have successfully completed such testing.

In addition to training, accountability is a key to quality and therefore to timeliness. However, almost everything in VA is production driven. VA should base personnel awards as equally on quality as it places on production. Therefore, VA must implement stronger accountability measures for quality assurance.

Congress should require the Secretary to report on how the Department will establish a quality assurance and accountability program that will detect, track, and hold responsible those employees who commit errors. VA should generate the report in consultation with veterans service organizations most experienced in the claims process.

VA can engineer an effective accountability system that holds each employee responsible for his/her work as a claim moves through the system while it simultaneously holds all employees responsible. As errors are discovered, employees responsible for such errors must be held accountable. The IBVSOs recommend that this accountability be enforced by forfeiture of work credit.

Such a cumulative accountability system would eliminate potential abuse of the system through the proverbial "good-old-boy's" club. One employee is far less likely to cover for errors or look the other way from errors committed by a fellow employee if he or she knew his or her performance measurement was equally at risk. This type of system will ensure personal accountability at every stage in the claims process without seriously disrupting or dismantling VA's current performance measurement system.

Recommendations:

- VA should amend its notification forms to inform claimants of the procedures that are available for obtaining review of a VA decision by the Board of Veterans' Appeals along with providing an explanation of the types of reviews that are available to claimants.

- VA should issue proposed regulations to implement the recent amendment of 38 U.S.C. § 5103 as quickly as possible. The VA's proposed regulations should include provisions that will require VA to notify a claimant, in appropriate circumstances, of the elements that render medical opinions adequate for rating purposes.

- Congress should amend section 5103A(d)(1) to provide that when a claimant submits a private medical opinion that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request another medical opinion from a Department healthcare facility.

- Congress should amend title 38, United States Code, section 5125, insofar as it states that a claimant's private examination report "may" be accepted. The new language should direct that the VA "must" accept such report if it is: (1) provided by a competent health-care professional, (2) probative to the issue being decided, (3) credible, and (4) otherwise adequate for adjudicating such claim.

- VA should undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence. In addition, to complement recent improvements in its training programs, VA should require mandatory and comprehensive testing of the claims process and appellate staff. To the extent that VA fails to provide adequate

training and testing, Congress should require mandatory and comprehensive testing and under which VA will hold trainees accountable.

- Congress should require the Secretary to report on how the department will establish a quality assurance and accountability program that will detect, track, and hold responsible those VA employees who commit errors. VA should generate the report in consultation with veterans service organizations most experienced in the claims process. As errors are discovered, employees responsible for such errors must be held accountable by forfeiture of work credit percentage.

CRITICAL ISSUE 5
Seamless Transition from the DOD to VA

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

As service members return from the conflicts in Afghanistan and Iraq, the DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service to successfully integrate into the civilian community as veterans. Though improvements have been made, the transition from DOD to VA continues to be a challenge for newly discharged veterans. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The problems with transition from the DOD to VA were never more apparent than during the controversy that occurred at Walter Reed Army Medical Center in 2007. While much of the media coverage misrepresented the problems at Walter Reed as a problem with care for injured service members, the real problems reflected many of the administrative difficulties associated with transitioning from the DOD to VA.

The Independent Budget continues to stress the points outlined by the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report released in May 2003, and reinforced by the President's Commission on Care for America's Returning Wounded Warriors in September 2007, as well as four other major studies[10] regarding transition of service members to veteran status. One of the 20 recommendations made by the PTF and those made by the President's Commission was for increased collaboration between the DOD and VA for the transfer of personnel and health information. Great progress has been made in this area by VA, however, this recommendation remains only partially implemented. A September 2008 Government Accounting Office (GAO) report noted that the DOD and VA are not sharing all electronic health information and that information is still being captured in paper records at many DOD facilities.

Health Information

The IBVSOs believe the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and bidirectional, allowing for a two-way real time electronic exchange of health information and occupational and environmental exposure data. Such an accomplishment could increase health information sharing between providers, laboratories,

[10]Veterans Disability Benefits Commission, DOD Task Force on Mental Health, Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, Task Force on Returning Global War on Terror Heroes.

pharmacies, and patients; help patients transition between health-care settings; reduce duplicative and unnecessary testing; improve patient safety by reducing medical errors; and increase our knowledge and understanding of the clinical, safety, quality, financial, and organizational value and benefits of health information technology (IT). Lessons learned from previous wars also indicate that the DOD must continue collecting medical and environmental exposure data electronically while personnel are still in theater and we applaud the DOD for doing so. But it is equally important that this information be provided to VA. Electronic health information should also include an easily transferable electronic DD214 forwarded from 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 Joint Electronic Health Records Interoperability (JEHRI) plan as agreed to by both DOD and VA through the Joint Executive Council and overseen by the Health Executive Council is a progressive series of exchanges of related health data between the two departments culminating in the bidirectional exchange of interoperable health information. While this has occurred at several levels, the current need is for a common standard. In May 2007, the DOD established a Senior Oversight Committee (SOC), chartered and cochaired by the deputy secretaries of the DOD and VA with the goal to identify immediate corrective actions and to review, implement, and track recommendations from a number of external reviews. Due to the recognized need, one of the lines of action (LOA) identified to be addressed was DOD-VA data sharing. The SOC approved initiatives to ensure health and administrative data are made available. The September 2008 GAO report indicates that the DOD and VA have agreed to numerous common standards and are working with federal groups to ensure adherence and alignment with emerging standards.

For example, the DOD and VA are sharing selected health information at different levels of interoperability such as pharmacy and drug allergy data on nearly 19,000 patients that seek care from both agencies. Such information is computable to warn clinicians of a possible drug allergy with a to-be prescribed medication. The Laboratory Data Sharing Interface Project is a short-term initiative that has produced an application used to electronically transfer laboratory work orders and retrieval of results between the departments in real time. Nonetheless, questions remain regarding the extent to which the DOD and VA will achieve full interoperability by next year when both departments have not yet articulated an interoperability goal.

According to the GAO[11], the DOD-VA Information Interoperability Plan recently completed by the departments is supposed to address these and other issues, including the establishment of schedules and benchmarks for developing interoperable health record capability. However, although an important accomplishment, on preliminary review the plan's high-level content provides only a limited basis for understanding and assessing the department's progress towards full interoperability by the September 30, 2009 date mandated by the National Defense Authorization Act for Fiscal Year 2008. Moreover, when fully established, a new interagency program office is to play a crucial role in accelerating efforts. Unfortunately, this office is not expected to be fully operational until the end of this year, and some milestones in the office's plan for achieving interoperability have yet to be determined.

[11]GAO-08-954.

Care Coordination

Severely injured service members and veterans whose care and rehabilitation is being provided by both DOD and VA, or who are transferring from one health-care system to the other, must have a clear plan of rehabilitation and the necessary resources to accomplish its goals. In response to the provisions of VA's Office of Inspector General (VAOIG) recommendations in a 2006 report examining the rehabilitation of OEF/OIF veterans suffering from Traumatic Brain Injury (TBI), the under secretary for health stated, "…case managers will provide long-term case management services and coordination of care for polytrauma patients and will serve as liaisons to their families." In October 2007, the DOD and VA partnered to create the Federal Recovery Coordination Program to improve care management by identifying and integrating care and services between DOD and VA health-care systems and subsequently served to satisfy provisions of the Wounded Warrior Act, title XVI of Public Law 110-181. With such resources as the newly developed Federal Individual Recovery Plan, National Resource Directory, Family Handbook, MyeBenefits, and Veterans Tracking Application, the IBVSOs are cautiously optimistic that these coordinators will be able to provide greater oversight for the seamless transition of severely injured service members. Although there are only eight federal recovery coordinators serving about 120 severely injured service members across military treatment facilities,[12] and one newly assigned at Dwight D. Eisenhower Army Medical Center, the President's Commission on Care of America's Returning Wounded Warriors reported that more than 3,000 seriously wounded veterans might need the assistance of these coordinators.

For those service members and veterans whose injuries allow for more outpatient recovery and rehabilitation, a more extensive network has been created spanning the entire VA health-care system.[13] VHA has assigned part-time and full-time social workers to major Military Treatment Facilities (MTF) to serve as VHA liaisons between the MTF and VHA facilities. Each VHA facility has selected a point of contact (POC) and alternate who work closely with the VA-DOD social work liaisons detailed to MTFs and the Veterans Benefits Administration (VBA) representatives to ensure a seamless transition and transfer of care. While this initiative pertains primarily to military personnel returning from Afghanistan and Iraq having served in Operation Enduring Freedom and Operation Iraqi Freedom, it also includes active duty military personnel returning from other combat theater assignments. It does not include active duty military personnel who are serving in noncombat theaters of operation.

Moreover, VA introduced the concept of transition patient advocates in March 2007 to focus specifically on the needs of severely wounded veterans from operations in Iraq and Afghanistan. VAOIG then issued a follow-up report (May 1, 2008, to assess the extent to which VA maintains involvement with service members and veterans who had received inpatient rehabilitative care in

[12]Walter Reed Army Medical Center, Bethesda National Naval Medical Center, Brooke Army Medical Center, Naval Medical Center Balboa, as of this writing.

[13]VHA Directive 2006-017 April 3, 2006.

VA facilities for TBI. According to the report, VA case management was determined to have improved, while long-term case management is not uniformly provided for these patients, and significant needs remain unmet.

Disability Evaluation

The Independent Budget likewise concurred with the President's Commission recommendation that the DOD and VA implement a single comprehensive medical examination, and we believe that this must be absolutely done as a prerequisite of promptly completing the military separation process. However, we would like to reiterate our belief that if and when a single separation physical becomes the standard, VA should be responsible for handling this duty as VA simply has the expertise to conduct a more thorough and comprehensive examination as part of its compensation and pension process. Moreover, the inconsistencies with the Physical Evaluation Board (PEB) process from the different branches of the service can be overcome with a single physical administered from VA's perspective, and not DOD's. A pilot project launched by the DOD and VA in November 2007 for service members from Walter Reed Army Medical Center, National Naval Medical Center at Bethesda, and Malcolm Grow Medical Center has more than 200 participants and is a step toward developing this single separation physical. While this separation physical is targeted primarily at those considered for medical discharge from the military, it should be considered for all separations. According to the GAO, the DOD and VA have not finalized their criteria for expanding the pilot project beyond the original sites. The IBVSOs believe the DOD and VA need to expand the pilot to more sites in preparation to fully implement the program.

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

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

complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their situations and then seek answers prior to discharge.

The TAP and DTAP programs continue to improve, but challenges continue at some local military installations, at overseas locations, and with services and information for those with injuries. Disabled service members who wish to file a claim for VA compensation benefits and thus, other ancillary benefits, are dissuaded by the specter of being assigned to a medical holding unit for an indefinite period. Furthermore, there still appears to be disorganization and inconsistency in providing this information. Though individuals are receiving the information, the haphazard nature and quick processing time may allow some individuals to fall through the cracks. This is of particular risk in the DTAP program for those with severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center despite still being on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. DTAP has not had the same level of success as TAP and it is critical that coordination be closer between the DOD, VA, and VETS to improve this disparity.

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

In October 2008, the DOD released a new "Compensation and Benefits Handbook for Seriously Ill and Injured Members of the Armed Forces." This handbook is designed to help service members who are wounded, ill, and injured, as well as their family members, navigate the military and veterans disability system. The IBVSOs applaud this informative booklet as one more method for service members to understand the transition, but now it will be critical for DOD to ensure it gets into the hands of transitioning service members.

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

have earned. This can only be accomplished by ensuring that the DOD and VA improve their coordination and information sharing to provide a seamless transition.

Recommendations:

- The DOD and VA must ensure that service members have a seamless transition from military to civilian life.

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

- The DOD and VA must fully establish the Joint Interagency Program Office with permanent staff and clear lines of responsibility and finalize the draft implementation plan with appropriate milestones and timelines for defining requirements to support interoperable health records.

- The DOD and VA must outline the requirements for assigning new or additional federal recovery coordinators to military treatment facilities caring for severely injured service members in concert with tracking workload, geographic distribution, and the complexity and acuity of injured service member's medical conditions.

- The DOD and VA must develop a clear plan of rehabilitation for severely injured service members and veterans receiving care and must receive the necessary resources to accomplish these goals.

- In accordance with the recommendation of the FY 2008 National Defense Authorization Act and the recommendation of the President's Commission, the DOD and VA must implement a single comprehensive medical examination as a prerequisite of promptly completing the military separation process. Moreover, VA should be responsible for handling this duty.

- Congress and the Administration must provide adequate funding to support the TAP and DTAP programs managed by DOL-VETS to ensure that active duty, as well as National Guard and Reserve, service members do not fall through the cracks while transitioning.

CRITICAL ISSUE 6
Human Resource Challenges Facing the Department of Veterans Affairs

The Department of Veterans Affairs (VA) must strengthen, energize, and expand programs to recruit and retain highly qualified VA employees, particularly in the Veterans Health Administration (VHA), and must redouble its efforts to advance succession plans to welcome the next generation of VA employees.

Addressing human resource issues within VA has never been more urgent than today with the ongoing conflicts in Afghanistan and Iraq and the aging of both the veteran population and the "Baby Boomer" generation. Service members are returning from conflicts abroad and seeking services from VA, and, at the same time, veterans from previous wars, particularly veterans from the Vietnam era, are aging and their need for medical services and other VA benefits is steadily increasing. In this environment, sufficient staffing becomes more essential to ensuring that veterans receive adequate VA care.

VA's ability to sustain a full complement of highly skilled and motivated personnel will require aggressive and competitive employment hiring strategies that will enable it to successfully compete in the national labor market. VA's employment success within the VHA and Veterans Benefits Administration (VBA) will require constant attention by the very highest levels of VA leadership. Additionally, Members of Congress must understand the gravity of VA personnel issues and be ready to provide the necessary support and oversight required to ensure VA's success.

VA must prepare for future personnel challenges by refining human capital policies and procedures, specifically in the areas of recruitment, retention, and succession planning. The average age of a VA employee is nearly 50 years, and 41 percent of VA employees will be eligible for retirement by the year 2013. The estimated U.S. veteran population is 23,816,000, and 39 percent of the veteran population is 65 years of age or older. VA must create and implement a strategy that will focus on hiring, training, and retaining personnel to offset the changing demographics of the veteran population and the VA workforce. VA must work to ensure efficient, safe, and productive work environments that attract high caliber professionals to successfully execute the VA mission, caring for America's veterans.

Veterans Health Administration

The facilities of VA, like many other American health-care providers, are facing a looming and potentially dangerous shortage of available health-care personnel to meet the growing demands of sick and disabled veterans. The current documented national shortage of physicians, nurses, pharmacists, therapists of all disciplines, psychologists, and practitioners in several other professional disciplines is bound to impact the effectiveness of VA's recruitment and retention programs. VA estimates that 163,308 new hires will be needed to handle attrition and maintain VHA's workforce to 2013. VA must anticipate the effects of the national health-care workforce

shortage and work to provide competitive employment packages and a more preferred workplace to ensure veterans continue to receive high quality and effective VA health care in the future.

The dwindling supply of trained and qualified health-care professionals cannot keep pace with the national growth in demand for health care. VA has recognized that the employment market is extremely competitive for some positions and is working to provide innovative professional development opportunities and programs to attract some of the new employees it will need to care for veterans. However, recruitment, retention, and succession planning can be fully successful only with sufficient, timely, and predictable funding from Congress for VA's overall health-care mission. After years of reacting to the current erratic funding process, achieving effective health-care budgetary reform can provide VA the confidence it needs to more effectively recruit, develop, and retain its health-care workforce to meet the needs of our nation's veterans.

With regard to registered nurses (RNs) within the VA system, the United States is experiencing an unprecedented nursing shortage that is expected to continue well into the future.[14] The Health Resources and Services Administration (HRSA) projected in 2007 that the nation's nursing shortage will grow to more than 1 million nurses by the year 2020 and that all 50 states will experience shortages of nurses in varying degrees by the year 2015. According to projections from the U.S. Bureau of Labor Statistics (BLS) in the November 2005 *Monthly Labor Review*, 1,203,000 new RNs will be needed by 2014 to meet job growth and replacement needs. According to the July 2006 Aging Workforce Survey conducted by the Nursing Management organization, 55 percent of surveyed nurses reported the intention to retire between 2011 and 2020.[15] In addition to the need for 30,211 RNs by 2013, the VHA turnover rate for registered nurses in 2006 was 8.5 percent (full and part-time positions, not including trainees). VA must develop a recruitment strategy that provides employment incentives that attract and encourage nursing students and new nurse graduates to commit to VA employment. More specifically, VA must work to recruit and retain nurses that provide care in VA's specialized service programs, such as spinal cord injury/disease (SCI/D), blind rehabilitation, mental health, and brain injury using compensatory benefits, such as specialty pay.

With respect to VA physicians, at present, 130 VA medical centers have affiliations through which physicians represent half of approximately 100,000 VA health profession trainees. VA estimates that medical residents equate to approximately one-third of the total VA physician workforce. About 2,500 (16 percent) of VA physicians are currently eligible for voluntary retirement, and it is projected that by 2012, this number will grow to 2,909 (17 percent).[16] Notably, a 2007 survey assessed the impact of VA health profession training on VA physician recruitment. Prior to exposure to training in VA facilities, 21 percent of medical students and 27 percent of medical residents indicated they were "very" or "somewhat" likely to consider post-graduate VA employment. Following training at VA, these positive responses grew to 57 percent

[14] Auerbach, Buerhaus, & Staiger, 2007.

[15] www.nursingmanagement.com.

[16] Department of Veterans Affairs, Veterans Health Administration Workforce Succession Strategic Plan FY 2008–2012.

of medical students and 49 percent of medical residents. Although current resignation rates among VA physicians remain stable, VA projects the number of voluntary retirements will rise over time. Thus through its training programs VA is well positioned to take advantage of a ready source of physician recruitment.

In 2004, Congress passed Public Law 108-445, the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004. The act is partially intended to assist VA in both recruiting and retaining VA physicians (including scarce subspecialty practitioners) by authorizing VA to offer highly competitive compensation to full-time physicians oriented to VA careers. In the intervening years, VA has implemented the act, but *The Independent Budget* veterans service organizations believe the act may not have provided VA the optimum tools needed to ensure that veterans will have available the variety and number of physicians needed in their health-care system. For example, a recent review of offered VA physician position vacancies on usajobs.gov revealed the following: Bay Pines VA Medical Center is recruiting an orthopedic surgeon at a maximum salary of $175,000 while the national average income of orthopedists is $459,000. Indianapolis VAMC was seeking an emergency room physician at a maximum of $175,000 while the national average for this category is $216,000. The Greater Los Angeles VA system was offering a maximum of $270,000 for an anesthesiologist while the average income for anesthesiologists is $311,000. We urge Congress to provide further oversight and to ascertain whether VA has adequately implemented its intent or if VA may need additional tools to ensure full employment for qualified VA physicians as it addresses its future staffing needs.

Given the VHA's leadership position as a health system, it is imperative that VA aggressively recruit health-care professionals as well as emphasize the attractive opportunities within the VHA and work within established relationships with academic affiliates and community partners to recruit new employees. In order to make gains on these needs, VA must update and streamline its human resource processes and policies to adequately address the needs of new graduates in the health sciences, recruits, and current VA employees. Today's health-care professionals and other staff who work alongside them need improved benefits, such as competitive salaries and incentives, childcare, flexible scheduling, and generous educational benefits. VA must actively address the factors known to affect current recruitment and retention, such as fair compensation, professional development and career mobility, benevolent supervision and work environment, respect and recognition, technology, and sound, consistent leadership, to make VA an employer of choice for individuals who are offered many attractive alternatives in other employment settings.

VA Human Resources Policies Are Outmoded

VA must work aggressively to eliminate outdated, outmoded VA personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment. It is reported that, on average, from the time a vacancy announcement is posted, appointment of a new employee within the VHA consumes 90 days. In some professional occupations (especially physicians and nurses), many months can pass from the date of a position vacancy until the date a newly VA-credentialed and privileged professional caregiver is on board and providing clinical care to veterans. Its lack of ability to make employment offers and confirm them in a timely manner, especially to new graduates VA has helped train,

unquestionably affects VA's success in hiring highly qualified employees and has the potential to diminish the quality of VA health care. Hiring delays depress current workforce morale and lead to overuse of mandatory overtime for nurses and others, greater workplace stress and staff burnout. At all levels the VHA (especially including local facility managements) must be held accountable for improving human resources policies and practices. Congress should require VA to report its efforts to improve recruiting, retention, and environmental/organization practices to assure veterans that VA will be a preferred health-care provider in the future and will continue to provide veterans an effective health-care system to meet their specialized needs.

Succession Planning Needs Improvement

Improving VA recruitment and retention efforts and more focused succession planning could help offset the inevitable loss of VA's experienced personnel. The VHA has identified the top 10 occupations which make up approximately 44 percent of the future new hires needed to stem attrition between FY 2007 and FY 2013. VA must implement an energized succession plan in VA facilities that utilizes the experience and expertise of current employees, as well as to improve existing human resources policies and procedures to bring the next generation of VA caregivers onboard.

As employees exit VA employment over the next few years, it is imperative for the department to conduct exit surveys without regard to time in service or reason for resignation. However, the opposite seems to be the case today. In 2007, the VHA exit survey rate dropped from 27 percent to 20 percent, the lowest in three years. Exit surveys in the top 25 critical VA occupations are particularly important to evaluate employees leaving these positions. With thorough surveys VA management can secure pertinent data to help refill positions as quickly as possible and to determine whether conditions of employment, human resources policies or other contributing factors to early departures of valued staff need revision. Exit surveys also provide valuable insight and information on the VA work environment and organizational culture. These are key elements to both retaining and recruiting high quality personnel in VA health care.

Existing VA loan repayment and scholarship programs were established by Congress to provide individuals interested in VA nursing with the financial support they need to enter and stay in the field. Both a recruitment and retention tool, the centrally funded Employee Incentive Scholarship Program (EISP)[17] pays up to $32,000 for health care–related academic degree programs, with an average of $12,000 paid per scholarship. Since its inception in 1999 through 2007, approximately 7,000 VA employees have received scholarship awards for educational programs related to Title 38 and "hybrid" Title 5-Title 38 VA occupations. About 4,000 employees have graduated from academic programs under these auspices. Scholarship recipients include registered nurses (93 percent), pharmacists, physical therapists, and other allied health professionals. A five-year VA analysis of program outcomes demonstrates this program's impact on VA employee retention. For example, turnover of nurse scholarship participants is 7.5 percent compared to a nonscholarship nurse turnover rate of 8.5 percent. Also, less than 1 percent of

[17] 38 U.S.C. §§ 7671–7675. Established by Public Law 105-368, Title VIII, the Department of Veterans Affairs Health Care Personnel Incentive Act of 1998, and amended by Public Law 107-135, Department of Veterans Affairs Health Care Programs Act of 2001.

participating nurses left VHA employment during their service obligation period (from one to three years after completion of degree).[18]

The VA Education Debt Reduction Program (EDRP) provides tax-free reimbursement of existing education debt of recently hired Title 38 and hybrid employees. Centrally funded, the EDRP is the Title 38 equivalent to the Student Loan Repayment Program (SLRP) administered by the Office of Personnel Management (OPM) for Title 5 employees. More than 5,600 VA health-care professionals have participated in EDRP. The maximum amount of an EDRP award is limited by statute to $44,000 in exchange for five years of service. As education costs have risen, the average award amount per employee has increased over the years from about $13,500 in FY 2002 to more than $27,000 in FY 2007. While employees from 33 occupations participate in the program, 77 percent are from three mission critical occupations—RN, pharmacist, and physician. The rate of losses from resignation of EDRP recipients is significantly less than that of nonrecipients, as determined in a 2005 study. For physicians the study found the resignation rate for EDRP recipients was 15.9 percent compared to 34.8 percent for non-EDRP recipients.[19]

Both the ESIP and EDRP initiatives need to be strengthened and expanded to new VA occupations, in particular among the 25 critical occupational categories that will be increasingly competitive as the health manpower shortage worsens. These programs have proven themselves to be cost-effective recruitment tools and to provide strong incentives for individuals to remain in VA employment rather than to go elsewhere.

Veterans Benefits Administration

Over the past two years, and with Congressional authorization, the Veterans Benefits Administration has hired a record number of new claims adjudication staff. Unfortunately, as a result of senior VBA officials retiring in the interim, an increase in disability claims received, rising complexity of such claims, and the time required for new employees to become proficient in processing accurate claims, VA has achieved little noticeable improvement in its claims work. The VBA has a major challenge ahead in completing complex training required to gain full productivity of several thousand new staff.

With the influx of these new benefits personnel, it is difficult for the IBVSOs, as observers, to predict that ongoing challenges faced by the VBA are still the result of staffing shortages. In fact, such is the size of the claims backlog that it would be naïve to expect an immediate reduction in the VBA workload. Such an expectation is defeated merely by the time required for new employees to gain necessary experience, and the drain on experienced employees who provide much of the current training to them. In order to make the best use of new resources, the VBA must focus on improving training and accountability while simplifying the claims process itself.

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[18] April 8, 2008, testimony of Marisa Palkuti, M. Ed., director, VA Health Care Retention and Recruitment Office.

[19] *Ibid.*

Many of the core human resource systems problems documented primarily for the VHA in this critical issue also pertain to the VBA. As VA approaches solutions to its human resource challenges in the VA health-care system, it should also incorporate those solutions where applicable in the human resource policies and practices of the VBA.

Recommendations:

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

- VA must implement an energized succession plan in VA medical and regional office facilities that utilizes the experience and expertise of current employees, as well as to improve existing human resources policies and procedures.

- VA facilities must fully utilize recruitment and retention tools, such as relocation and retention bonuses, a locality pay system for VA nurses, and education scholarship and loan payment programs as employment incentives, in both the VHA and VBA.

- VA must conduct improved exit surveys as employees terminate employment to secure pertinent data that will help refill positions in a timely manner and to determine if conditions of employment, human resources policies, or other contributing factors need revision.

- Congress must provide further oversight to ensure adequate implementation of Public Law 108-445.

- Congress should implement a title 38 specialty pay provision for VA nurses providing care in VA's specialized services areas, such as spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury.

- VA must develop a more aggressive recruitment strategy that provides employment incentives that attract and encourage affiliated health professions students, and new graduates in all degree programs of affiliate institutions, to commit to VA employment.

- Congress should improve the provisions of VA's Employee Incentive Scholarship Program (ESIP) and Education Debt Reduction Program (EDRP) and make them available more broadly to all VA employees. VA must become more flexible with its work schedules to meet the needs of today's health-care and benefits professionals and must provide other employment benefits, such as childcare, that will make VA employment more attractive.

CRITICAL ISSUE 7
The National Cemetery Administration

The National Cemetery Administration must ensure that burial in a national or state veterans cemetery is an option available for all veterans and their family members and must provide a dignified setting with perpetual care that honors veterans and exhibits evidence of the nation's gratitude for their military service.

The Department of Veterans Affairs (VA) National Cemetery Administration (NCA) maintains more than 2.8 million gravesites at 125 national cemeteries and 33 additional installations in 39 states and Puerto Rico. Currently there are more than 17,000 acres within established NCA installations. Just more than half of this land is undeveloped. Including available gravesites and the undeveloped land there is a potential to provide more than 4 million resting places. In addition to the maintenance of these facilities, the NCA administers four programs: the State Cemetery Grants Program, the Headstone and Marker Program, the Presidential Memorial Marker Program, and Outer Burial Receptacle reimbursements.

The purpose of the national cemetery is to honor the memory of America's servicemen and -women. Many of our nation's cemeteries are steeped in history, and the monuments, markers, and memorials that stand represent the very foundation of our country. Our nation's burial grounds are a national treasure deserving of the utmost care and protection. To achieve this high standard of preservation, the NCA faces serious challenges. The increase in the demand for interment and the need for continuous gravesite maintenance, including the repairs, upkeep, and other labor-intensive tasks involved in operating a cemetery, continue to rise. To meet these challenges, the NCA must have adequate funding to ensure it remains a world-class system that honors our veterans and recognizes their contribution and service to our nation. Therefore, *The Independent Budget* recommends a budget for the NCA that will both meet the growing demand and allow every man and woman who has worn the uniform of the United States armed forces to be treated with dignity and respect.

The NCA has done an exceptional job of providing burial options for 90 percent of all veterans who fall within the 170,000 veterans within a 75-mile radius threshold model. However, under this model, no new geographical area will become eligible for a National Cemetery until 2015. St. Louis, Missouri, will at that time meet the threshold due to the closing of Jefferson Barracks National Cemetery in 2017. Analysis shows that the five areas with the highest veteran population will not become eligible for a National Cemetery because they will not reach the 170,000 threshold.

The NCA has spent years developing and maintaining a cemetery system based on a growing veteran population. In 2010 our veteran population will begin to decline. Because of this downward trend, a new threshold model must be developed to ensure more of our veterans will have reasonable access to their burial benefits. Reducing the mile radius to 65 miles would reduce the veteran population that is served from 90 percent to 82.4 percent, and reducing the radius to 55 miles would reduce the served population to 74.1 percent. Reducing the radius alone to 55 miles would only bring two geographical areas into the 170,000 population threshold in 2010, and only a few areas into this revised model by 2030.

Several geographical areas will remain unserved if the population threshold is not reduced. Lowering the population threshold to 110,000 veterans would immediately make several areas eligible for a national cemetery regardless of any change to the mile radius threshold. A new threshold model must be implemented so more of our veterans will have access to this earned benefit.

In addition to the day-to-day operations to develop, maintain, and improve the NCA cemeteries, the NCA run State Cemetery Grants Program is vital in establishing and maintaining veterans' gravesites in areas in which the NCA cannot fully respond to the burial needs of veterans. This program assists states, by providing grant money to ensure veterans' burial needs are met in areas where there are no national cemeteries or the area is underrepresented due to the number of veterans who live in a given area. It is imperative that the State Cemetery Grants Program be funded at a level that ensures the states can continue to meet the needs of veterans who want to be buried closer to their homes and that meets the challenge of growing interest by states in providing burial services in areas not currently served.

In 1973 the NCA established a burial allowance that provided partial reimbursements for eligible funeral and burial costs. The current payment is $2,000 for burial expenses for service-connected death, $300 for nonservice-connected deaths, and $300 for plot allowance. At its inception, the payout covered 72 percent of the funeral cost for a service-connected death, 22 percent for a nonservice-connected death, and 54 percent of the burial plot cost. In 2007, these benefits eroded to 23 percent, 4 percent, and 14 percent, respectively. It is time to bring these benefits back to their original value.

To ensure the National Cemetery Administration's capability to maintain our national cemeteries in a dignified and respectful manner, a comprehensive effort must be made to greatly improve the condition, function, and appearance of these cemeteries. To assist in restoring the national cemeteries *The Independent Budget* recommends to Congress the establishment of a five-year, $250 million "National Shrine Initiative" to restore the character of NCA cemeteries.

The NCA honors veterans with a final resting place that commemorates their service to the nation. Each Memorial Day and Veterans Day we honor the last full measure of devotion our veterans gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans—they are hallowed ground to those who died in our defense and a memorial to those who survived.

Recommendations:

- Congress must provide adequate resources to ensure that the NCA remains a world-class operation that honors veterans and recognizes their contributions and service to the nation.

- Congress must fund the State Cemetery Grants Program at a level that ensures that states can meet the needs of veterans who want to be buried closer to their homes.

- Congress should increase burial benefits to cover the cost of burial more adequately and expand 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.

- The NCA must continue to identify sites for the addition of new national cemeteries in areas that remain underserved.

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