

**MILITARY CONSTRUCTION AND VETERANS
AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2006**

TUESDAY, MARCH 15, 2005

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 2:32 p.m., in room SD-138, Dirksen Senate Office Building, Hon. Kay Bailey Hutchison (chairman) presiding.

Present: Senators Hutchison, Craig, Feinstein, Byrd, and Murray.

DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF THE SECRETARY

STATEMENT OF HON. R. JAMES NICHOLSON, SECRETARY

ACCOMPANIED BY:

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OPENING STATEMENT OF SENATOR KAY BAILEY HUTCHISON

Senator HUTCHISON. Our meeting will come to order. I will say that this is our first hearing for the Veterans Affairs Department for our new subcommittee. I am very pleased to be able to work with the Department of Veterans Affairs. Of course, I have known the Secretary for a long time and have worked with the previous Secretary for this important Department. We are delighted that we now have this jurisdiction.

I want to first tell you that we have votes starting at 3 o'clock, five votes. So I am going to dispense with my opening statement because I want to hear from you, and then I want to have time for questions. I think what we will do is get as far as we can until the vote starts, and then we will see where we are and perhaps have to take a small recess and come back. But I will dispense with my opening statement and put it in the record.

Welcome to you.

Let me call on my distinguished ranking member with whom I work very closely. It is a great relationship. I think it is safe to say we are both very happy to have the Veterans Affairs Department in this subcommittee. With that, Senator Feinstein.

STATEMENT OF SENATOR DIANNE FEINSTEIN

Senator FEINSTEIN. Thank you very much, Madam Chairman. I echo your comments. I am delighted to work with you. It has been many years, and I do not think we have had a problem yet. So that is the good news.

Additionally, I would ask that you allow me to join you in welcoming the lady and gentlemen assembled before us. I particularly want to welcome Secretary Nicholson. We look forward to working with you in this appropriation effort.

This is a new chapter for the Military Construction Committee because we will be taking on the Veterans Affairs matters, and I think between the chairman and me, we represent two of the three States with the largest population of veterans in America. So we have a very unique opportunity to work on these challenges and opportunities.

That said, I do want to let you know where I am coming from. I am very disappointed in the President's fiscal year 2006 budget request for the Department of Veterans Affairs. This budget assumes savings of over \$1 billion by doubling prescription drug co-payments and imposing a \$250 enrollment fee on middle income veterans, many of whom are struggling to make ends meet as it is on incomes as low as \$26,000 a year. More than 200,000 veterans would be adversely affected by these proposals. I think they are unrealistic assumptions. Congress has rejected them in the past and I hope we will continue to reject them.

We are a Nation at war. The military has discharged more than 244,000 veterans from Iraq and Afghanistan, and the VA has already treated nearly 49,000 of those returning troops. Yet, this budget turns a blind eye to the increasing demands on the VA health care system caused by the influx of new veterans, as well as the aging population of veterans from earlier wars. Instead of reaching out to veterans, this budget proposes to shut more veterans out of the health care system by charging enrollment fees, by hiking co-pays on prescription drug benefits, and by limiting long-term nursing home care.

This is not how we should be treating America's veterans. I know that money is tight, but the administration should not try to balance the books by forcing veterans to shoulder a greater share of the burden of health care costs.

I know these are tough times, Mr. Secretary, but they must be addressed. My goal as the ranking member of this subcommittee is to do everything in my power to see that we keep the promises we made to our veterans and, in so doing, make the highest and best use of taxpayer dollars.

Now, Madam Chairman, I look forward to working with you on this aspect of the budget. I also very much look forward to our taking over the mantel of the VA/HUD Subcommittee which I think did an excellent job in terms of appropriating for veterans and veterans affairs. Thank you very much.

Senator HUTCHISON. Thank you.
Senator Murray.

STATEMENT OF SENATOR PATTY MURRAY

Senator MURRAY. Madam Chairman, thank you. It is a delight to join you on this committee.

Mr. Secretary, it is an honor to be in front of you again. We have seen each other I believe on three occasions now. I serve on the Veterans Committee, Budget, and Appropriations. I appreciate and understand the difficult task that is before you.

Madam Chair, I know that you are short on time because of the votes, and I will submit my statement for the record.

But let me just say this. I share the concerns of Senator Feinstein. I do not believe that we have budgeted for the care of our soldiers who are returning from war, nor for the ones that are already in long waiting lines. You have heard me before. You know that I am deeply concerned of the thousands of members who are coming home who will be discharged but will not have access to health care, particularly our Guard and Reserve members. We know that you are talking about community outreach clinics, but they are already turning poor patients away in our States. So they cannot take up the burden of this.

Increasing co-pays, enrollment fees, closing our long-term care facilities is the wrong thing to be doing at a time when we have so many men and women who are serving us overseas.

So I will submit my statement for the record, but I feel very strongly about this and will continue in any way I can to help us increase the budget for our veterans because I believe it is a promise that we have not kept and we need to follow up on.

Senator HUTCHISON. Senator Byrd.

STATEMENT OF SENATOR ROBERT C. BYRD

Senator BYRD. Thank you, Madam Chairman, and I thank those Senators who have preceded me. I wish to associate myself with their remarks.

Mr. Secretary, during this time of war, few matters could be more important than the care that our Nation gives to our veterans. West Virginians are extremely proud of our veterans. Those men and women who have chosen to serve our Nation are owed an enormous debt. It is a moral responsibility that the United States carries, as President Lincoln said, "to care for him who shall have borne the battle and for his widow and his orphan."

But the funding priorities outlined by President Bush in his budget undermine our country's commitment to America's veterans. The President proposes to double the co-payment for prescription drugs, impose a new \$250 annual user fee for certain veterans, and continue a policy of turning away hundreds of thousands of veterans from VA hospitals because they are classified as low priority. According to the Congressional Research Service, continuing this policy on low-priority veterans will deny a staggering 522,000 veterans care from VA hospitals by the end of this year.

The American people must be told how many veterans will suffer under the President's budget proposal. The more than 190,000 veterans in West Virginia receiving health care from VA medical cen-

ters in the Mountain State are threatened by these significant hikes in fees and co-payments. The expected wave of combat veterans from the Iraq and the Afghanistan wars will add to the stress on our VA facilities.

Yet, instead of strengthening the VA medical system, the Bush administration weakens it. The Nation's three largest veterans organizations, the American Legion, the Veterans of Foreign Wars, and the Disabled American Veterans, have called the President's proposals the most tight-fisted, miserly budget for veterans programs. And they are right.

I note that the President's \$81.9 billion emergency supplemental does not include a single dime for veterans health care. Tax cuts and corporate giveaways are helping the super-rich to get further ahead, but the President's budget leaves veterans health care far behind. For this Senator, "support the troops" means taking care of veterans after they come home. Our brave fighting men and women deserve much more from the White House than sloganeering and health care on the cheap.

Thank you, Mr. Secretary. Thank you, Madam Chairman.

Senator HUTCHISON. Thank you, Senator Byrd.

Senator Craig, who is the distinguished chairman of the Veterans Affairs Committee and a member of our subcommittee.

STATEMENT OF SENATOR LARRY CRAIG

Senator CRAIG. Well, thank you, Madam Chairman, and again, congratulations on chairing this newly structured committee and the authority within. Also, let me congratulate Senator Feinstein on her new position as ranking on this structure.

To all of you from the Veterans Administration, Mr. Secretary, welcome before this most important committee. I have had the privilege, Madam Chairman, of being in each one of these lady's and gentleman's departments. I will go back better understanding the operations of the Veterans Administration. It is critically important for all of us to understand what it does and the role it plays as we work with this very difficult budget.

Just this past week—I have held hearings now with all the veterans service organizations. The traditional joint hearings between the House and the Senate were obviously well attended and we heard from all of these marvelous organizations of their concern for veterans and the urgency of much of the service provided.

I think it is also noteworthy that over the last 4 years, we have done more to improve veterans services than ever in the history of our country, tremendous commitments of resources, a 9.4 percent average increase on an annualized basis. For that, we can all be proud.

We are now debating a budget that is different than what the President proposed by a substantial amount. We have a budget before us that does not have any of the co-pays in it, does not have any of the new fees in it. In fact, it is a straight plus-up of nearly \$1 billion without any reconciliation instructions in it, Madam Chairman. That is a significant improvement that serves the veterans of our country the way we would want them to be served.

Does it serve every veteran who once bore the uniform of a service of this country? It does not. Nor can we be expected as a coun-

try to serve those who are not service-connected, who are the 7's and 8's, who may well have their own health care insurance, but now, because of the phenomenal work that the Veterans Administration has done to improve the quality of health care delivery within the system, we have created a system that is now sought after by all, in large part because if they can gain access through the front door, they gain free health care, even though they may be among the most wealthy in our country, but they have simply borne the uniform.

That is a question that we have to ask ourselves in a fundamentally and fiscally responsible way, and that is the question that is now before us on the floor of the Senate. I do believe, Madam Chairman, we are going to be given a budget by the Budget Committee and instructions to this subcommittee that we can work with, that we can hand them to these administrators who sit before us in a way that does meet most, if not all, of the challenges, that addresses the concerns of Senator Murray, as I have, that we have a lot of new, incoming veterans with extraordinary needs because of the character of warfare today and because of the character of health on the front lines and medicine on the front lines of this war.

So there are a lot of challenges out there that I trust, Madam Chairman, you and the ranking member can work with and work with those of us in the authorizing committees to make happen in defense of America's veterans. That is our charge. It is our responsibility.

Thank you.

Senator HUTCHISON. Thank you, Mr. Chairman.

And now, Mr. Secretary, we would be pleased to hear from you.

STATEMENT OF THE HONORABLE R. JAMES NICHOLSON

Secretary NICHOLSON. Thank you, Madam Chairman and members of the committee. Good afternoon.

Allow me, if you would, to start by introducing those experts that I have here and people who are far more experienced at the Veterans Affairs Department than I at this point. I would like to start on my far left with Tim McClain, who is the General Counsel. My immediate left is Dr. Jonathan Perlin, who is the Acting Under Secretary for Health. My far right is the Acting Under Secretary for Memorial Affairs, Dick Wannemacher. In the middle here on this side is Admiral Dan Cooper, who is the Under Secretary for Benefits, and my immediate right is Ms. Rita Reed, who is the Deputy Assistant Secretary for Budget.

I would ask, Madam Chairman, if I could have my complete, comprehensive written statement be submitted for the record, but that I would be allowed to offer some highlights here of the President's proposal before we take your questions.

Senator HUTCHISON. Without objection.

Secretary NICHOLSON. Madam Chairman, President Bush is requesting a record \$70.8 billion for the Department of Veterans Affairs in fiscal year 2006: \$37.4 billion for entitlement programs and \$33.4 billion for discretionary programs. This total represents a 2.2 percent increase over the fiscal year 2005 enacted level. The discretionary funding level would represent an increase of \$880 million,

or 2.7 percent, over the enacted level for 2005. The proposed mandatory spending level represents a \$639 million, or 1.7 percent, increase over 2005. This budget represents a total increase of 47 percent with a 44 percent increase in discretionary funding since the beginning of the Bush administration.

The President's 2006 proposal will allow us to meet the health care and benefit needs of all newly separated veterans of the conflicts in Iraq and Afghanistan to maintain the high standards of health care quality, for which VA is now nationally recognized while treating 5.2 million patients. It will allow us to follow through on an historic realignment of our health care infrastructure through the CARES process, to reduce the backlog of disability compensation and pension claims, and to continue the largest expansion of the national cemetery system since the Civil War.

In the area of health care, in recent years the Department's successes in delivering top-notch health care have been stunning. I can brag about this because I had nothing to do with it. But this is really a magnificent organization of dedicated, competent, compassionate people. The VA exceeds the performance of private sector and Medicare providers for key health care quality indicators for which comparable data are available. A recent RAND Corporation study also shows that patients in VA's health care system are significantly more likely to receive recommended care than our private sector patients.

This is all the more impressive when you consider the explosive growth in VA health care usage. In 2006, the VA will treat about 1 million more patients than were treated in 2001. The President's budget will ensure there is no slippage in our high level of performance, even at these elevated patient levels. Ninety-four percent of the primary care appointments are scheduled within 30 days of the patient's desired date, and 93 percent of the specialty care appointments are also scheduled within that time frame.

The President's 2006 budget asks that you enact two important provisions affecting only priority 7 and 8 veterans: an annual enrollment fee of \$250 and an increase in pharmacy co-payments from \$7 to \$15 for a 30-day supply of drugs.

The proposed enrollment fee is similar to the fee paid by career military retirees enrolled in the TRICARE system and some would argue even more justified. As you know, most TRICARE enrollees have served on active duty for at least 20 years and are former enlisted personnel with modest retirement incomes. The proposed enrollment fee would apply to those veterans who may have served as few as 2 years and who have no service-connected disability and who do have reasonable incomes.

In addition, those veterans who are in priority group 8 have incomes above the HUD geographic means test.

I would like to turn to long-term care. This budget provides all long-term care needs for veterans who are 70 percent or more service-connected. It also provides for patients requiring short-term care subsequent to a hospital stay and those needing hospice or respite care and those with special needs such as ventilator dependence or spinal cord injury.

To ensure fairness and consistency, the VA proposes similar eligibility criteria across all institutional, long-term care venues, VA,

contract community, and State nursing homes. The Department would continue to expand access to non-institutional long-term care with an emphasis on community-based and in-home care. In many cases this approach allows veterans to receive these services in the comfort and familiar settings of their homes surrounded by their families.

In order to be more prepared to care for our veterans returning from Iraq and Afghanistan, the VA's 2006 medical care request includes \$1.2 billion for the prosthetics program, which is \$100 million over the fiscal year 2005 enacted level. This will support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life.

The budget will also provide \$2.2 billion, or \$100 million over the 2005 level, to standardize and further improve access to mental health services across the system, including PTSD.

We are also proposing a number of program enhancements to cover out-of-pocket costs for emergency care for eligible veterans in non-VA facilities, to exempt former POW's from co-payments for VA extended care and exempt veterans from co-payments for hospice care delivered in hospitals or at home.

We have projected increased health care management efficiencies of 2 percent in 2006 which will yield about \$600 million in savings.

The \$750 million requested for CARES in 2006 brings the total 3-year investment to \$2.15 billion. At its core CARES means greater access to higher quality care for more veterans closer to where they live. Its impact is already being felt in Chicago where the proceeds from an enhanced use lease of VA's Lakeside Hospital property are being reinvested at VA's Westside facility. This will lead to a new modern bed tower for Chicago's veterans.

Finally, the \$786 million proposed in support of VA's medical and prosthetic research program would fund about 2,700 high-priority research projects to expand knowledge in areas critical to veterans health care needs. The combination of VA appropriations and funding from other sources would bring our 2006 research budget to nearly \$1.7 billion.

Veterans benefits. The President's request includes \$37.4 billion for the entitlement costs associated with all benefits. Our request includes \$1.26 billion for the management of the Department's benefits program, which is 6.6 percent over the 2005 level. Veterans Benefits will continue to address an increased volume of compensation claims from separating service members and older veterans who had not previously submitted claims and from current recipients.

The VA has made significant improvements to the claims decision process, but clearly more must still be done. VA takes seriously its obligation that every veterans claim must be treated fairly and equitably, regardless of the locality. We will and must be consistent. To address the issue of consistency, the IG is performing an independent system-wide review.

Also, Veterans Benefits leadership is looking at training, medical exams, and other aspects of the system to ensure we clearly are working toward a consistent, fair, and equitable case-decision process for all veterans.

The President's request would also permit us to continue the Benefits Delivery at discharge program. This program enables active duty service members to file disability compensation claims with VA staff at military bases, complete physical exams, and have their claims evaluated before their military separations or soon thereafter.

Burial benefits. The 2006 budget includes \$290 million in discretionary funding for VA's burial program, including operating and maintenance expenses for the National Cemetery Administration, capital programs, the administration of mandatory burial benefits, and the State cemetery grants program. This total is nearly \$17 million, or 6.4 percent, over the 2005 level.

It includes \$90 million for cemetery construction projects. We are requesting \$41 million in major construction funding for land acquisition for six new national cemeteries and \$32 million for the State cemetery grants program. These resources would enable us to increase to 82 percent, the percentage of veterans having a veterans cemetery burial option within 75 miles of their homes.

Madam Chairman, I would be remiss if I did not note that last year's VA National Cemetery Administration earned the highest rating ever achieved by a public or private organization in the 2004 American Customer Satisfaction Index, a rating of 95 on a scale of 100.

PREPARED STATEMENT

So in closing, Madam Chairman, despite the many competing demands for Federal funding, the President continues to make veterans benefits and services a top priority of his administration. Our veterans deserve no less.

We are now prepared to take your questions. Thank you.
[The statement follows:]

PREPARED STATEMENT OF R. JAMES NICHOLSON

Madam Chairman and members of the Committee, good afternoon. I am happy to be here and I am deeply honored that the President has given me the opportunity to serve as Secretary of Veterans Affairs. My service in the United States Army was the defining experience of my life and instilled me with a strong sense of duty and esteem for my fellow veterans. I look forward to working with you and the thousands of dedicated employees who are carrying out the compelling mission of the Department of Veterans Affairs (VA) by ensuring the timely delivery of high-quality benefits and services to those veterans in need of same earned through their sacrifice and service in defense of freedom.

In his February 2 State of the Union Address, the President underscored the need for America to restrain spending in order to sustain our economic prosperity. As part of this restraint, it is important that total discretionary and non-security spending be held to levels proposed in the 2006 budget. The budget savings and reforms in the budget are important components of achieving the President's goal of cutting the budget deficit in half by 2009. This budget gives VA what it needs to accomplish our priority mission and we urge the Congress to support it. The 2006 budget includes more than 150 reductions, reforms, and terminations in non-defense discretionary programs. The Department wants to work with the Congress to achieve these savings.

I am pleased to be here today to present the President's 2006 budget proposal for VA. The request totals \$70.8 billion—\$37.4 billion for entitlement programs and \$33.4 billion for discretionary programs. Our budget request for discretionary funds represents an increase of \$880 million, or 2.7 percent, over the enacted level for 2005, and a 47 percent increase since the beginning of the Bush Administration.

With the resources requested for VA in the 2006 budget, we aim to build upon many of the Department's achievements that have dramatically improved benefits

and services to veterans and their families since the President came to office. The most noteworthy accomplishments are that VA:

- provides health care to about 1 million more patients
- improved the quality of patient care that sets the national standard of excellence for the health care industry
- dramatically lowered the backlog of rating claims for disability compensation and pension from a high of 432,000 to 321,000 (for all claims the backlog peaked at over 600,000)
- reduced the average length of time to process compensation and pension claims from a high of 230 days to approximately 160 days
- continued the largest expansion of the national cemetery system since the Civil War to honor veterans with a final resting place and lasting memorial that commemorates their service to our country.

With strong support from the President, VA has made excellent progress in sharpening its focus on more effectively meeting the needs of those veterans who count on us the most—veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs. I fully support this strategy and am committed to ensuring that our health care resources continue to be concentrated on care for veterans most in need of the Department's services. As an integral part of this focused strategy, we will make it a top priority to provide ongoing benefits and services to the servicemen and women who served in Operation Enduring Freedom and Operation Iraqi Freedom. VA's goal is to ensure that every seriously injured or ill serviceman or woman returning from combat receives priority treatment and consideration. We will continue to work closely with the Department of Defense (DOD) to develop ways by which to move records more efficiently between the two agencies, share critical medical information electronically, protect the health of troops stationed in areas where environmental hazards pose threats, process benefit claims as one shared system, and in every way possible, ease their transition from active duty to civilian life.

MEDICAL CARE

The President's 2006 request includes total budgetary resources of \$30.7 billion (including \$750 million for construction and \$2.6 billion in collections) for the medical care program, an increase of 2.5 percent over the enacted level for 2005, and more than 47 percent above the 2001 level. The \$750 million in construction will be devoted to the Capital Asset Realignment for Enhanced Services (CARES) program, bringing the total Department investment to \$2.15 billion over 3 years.

Given the current fiscal environment, it is more important than ever that VA concentrate its resources, policies, and strategies on those veterans identified by Congress as high priority. The President's 2006 budget request includes policies and strategies used successfully during the last few years to focus VA health care resources on veterans with service-connected disabilities, those with lower incomes, and veterans needing our specialized services. In particular, this budget assumes continued suspension of enrollment of new Priority 8 veterans, as this has proven to be the most effective vehicle through which to focus our health care resources on our highest priority patients.

But maintaining the current enrollment policy will not in itself ensure us sufficient resources for the care of those who need us the most. The President's 2006 budget asks that you enact two important legislative proposals—an annual enrollment fee of \$250 and an increase in pharmacy co-payments from \$7 to \$15 for a 30-day supply of drugs, both pertaining to only Priority 7 and 8 veterans. This fee and the increase in co-payments pertain only to veterans who have no compensable service-connected disabilities and do have the means to contribute modestly to the cost of their care. This budget asks these veterans to assume a small share of the cost so that we may adequately care for high-priority veterans.

The proposed enrollment fee is very similar to the fee the law requires retired career service members to pay in order to participate in TRICARE, and is arguably even more justified. As you know, TRICARE enrollees generally must have served on active duty for at least 20 years, and many of them are former enlisted personnel with modest retirement incomes. The proposed enrollment fee would apply to those veterans who may have served as few as 2 years and who have no service-connected disability. In addition, some of these veterans (those in Priority Group 8) have incomes above the HUD geographic means test.

I recognize that Congress has not supported either of these proposals during the past 2 years. However, these two legislative proposals are consistent with the priority health care structure Congress enacted several years ago, and will help us meet the needs of our highest priority veterans. In addition, past utilization of VA's

health care services has demonstrated that veterans with higher incomes (Priority 7 and 8 veterans) rely less on VA for delivering their health care and usually have other health care options, including third party insurance coverage and Medicare. An annual enrollment fee of \$250 and an increase in co-payments for pharmacy benefits from \$7 to \$15 would give higher income, non-disabled Priority 7 and 8 veterans the option of sharing a small portion of the cost of their care or utilizing other health care options. Our high-priority patients typically do not have other health care options, so we must act decisively to protect their interests by making sure that sufficient resources are available to handle their health care needs.

With medical care resources of \$30.7 billion, we project that we will treat more than 5.2 million patients. Those in Priorities 1 to 6 will comprise 78 percent of the total number of veteran patients in 2006. This will represent the third consecutive year during which our high-priority veterans will increase as a percentage of all veterans treated. In addition, about 9 of every 10 medical care dollars in 2006 will be devoted to meeting the health care needs of those veterans who count on us the most.

Even with an increasing patient workload among our highest priority veterans, we will continue our steadfast commitment to providing high-quality and accessible health care that sets the national standard of excellence for the health care industry. Our two primary measures of health care quality—clinical practice guidelines index and prevention index—focus on the degree to which VA follows nationally recognized guidelines and standards of care that the medical literature has proven to be directly linked with improved health outcomes for patients and more efficient care. Our performance on the clinical practice guidelines index, which focuses on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to hold steady at the current high performance level of 77 percent. As an indicator aimed at primary prevention and early detection recommendations dealing with immunizations and screenings, the prevention index is projected to remain at its existing high rate of performance of 88 percent. VA continues to exceed the performance of private sector and Medicare providers for all 15 key health care quality indicators for which comparable data are available. These indicators include cancer screening for early detection, and immunization for influenza and pneumonia. In addition, they cover disease management measures such as compliance with accepted clinical guidelines in managing diabetes, heart disease, hypertensive disease, and mental health.

The Department has greatly improved access to our health care services during the last few years by opening additional outpatient clinics, applying information technology strategies to streamline administrative, business, and care delivery processes, and implementing pay policies and human resource management practices to facilitate hiring and retain sufficient health care workers to meet capacity demands across the full continuum of care. These initiatives have helped VA raise the percent of primary care appointments scheduled within 30 days of the patient's desired date to 94 percent and the percent of specialty care appointments scheduled within 30 days of the patient's desired date to 93 percent. By continuing these types of strategies, improving clinical efficiencies, and effectively utilizing the resources requested in our 2006 budget, VA will maintain these high performance levels.

The Department's record of success in health care delivery is substantiated by the results of the 2004 American Customer Satisfaction Index (ACSI). Conducted by the National Quality Research Center at the University of Michigan Business School, the most recent ACSI survey found that customer satisfaction with VA's health care system was markedly above the satisfaction level for Federal Government services as a whole. Results released in December 2004 revealed that inpatients at VA medical centers recorded a satisfaction level of 84 out of a possible 100 points, while outpatients at VA clinics registered a satisfaction score of 83. Both of these are well above the government average of 72.

While VA is excelling compared to its private sector counterparts, we are committed to doing even better in the future. The results of a recent study conducted by the RAND Corporation revealed that patients in VA's health care system were more likely to receive recommended care than private-sector patients. Quality of care was better for VA patients on all measures except acute care, for which care was similar for both patient groups. RAND researchers examined the medical records of nearly 600 VA patients and about 1,000 non-VA patients with similar health problems. They compared the treatment received by both groups to well-established standards for medical care for 26 conditions. They found that 67 percent of VA patients received care that met the latest standards of the health care profession compared with 51 percent of non-VA patients. For preventive care, such as vaccination, cancer screening, and early disease detection and treatment, 64 percent of VA patients received the appropriate care compared to only 44 percent in the pri-

vate sector. The RAND researchers attributed the difference in patient care to technological innovations, such as VA's computerized patient records, and to performance measurement policies holding top managers accountable for standards in preventive care and the treatment of long-term conditions.

As another means by which to ensure sufficient resources are available to address the health care needs of those veterans who count on us the most, VA is proposing to revise the eligibility criteria for long-term care services to focus on the following groups of veterans:

- those injured or disabled while on active duty, including veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom
- those catastrophically disabled
- patients requiring short-term care subsequent to a hospital stay
- those needing hospice or respite care.

These eligibility criteria would be applied to VA-sponsored long-term care services, including VA, community, and State nursing homes. This long-term care strategy will save approximately \$496 million that will be redirected toward meeting the health care needs of veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs.

In 2006 the Department will continue to expand access to non-institutional long-term care services to all enrolled veterans with an emphasis on community-based and in-home care. In many cases this approach allows VA to provide these services to veterans where they live and to care for them in the comfort and familiar setting of their home surrounded by their family. During 2006 VA will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 35,500. This total is over 50 percent above the number of patients receiving this type of care in 2001. Funding for non-institutional long-term care in 2006 will be about 67 percent higher than the resource level devoted to this type of health care service in 2001.

VA's 2006 medical care request includes \$1.2 billion (\$100 million over the 2005 enacted level) to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. VA is already providing prosthetics and sensory aids to many military personnel who served in Operation Enduring Freedom and Operation Iraqi Freedom and the Department will continue to provide them as needed.

The President's 2006 budget includes \$2.2 billion (\$100 million over the 2005 level) to continue our effort to improve access to mental health services across the country. These funds will help ensure VA provides standardized and equitable access throughout the Nation to a full continuum of care for veterans with mental health disorders. The Department will place particular emphasis on providing care to those suffering from post-traumatic stress disorder as a result of their service in Operation Enduring Freedom and Operation Iraqi Freedom.

We have included a management efficiency rate of 2 percent which will yield about \$600 million in 2006. We continue to monitor and emphasize the need for performance that results in minimizing unit costs where possible, and eliminating inefficiency in the provision of quality health care. To that end, we have included within this savings target, \$150 million that will be achieved through implementation of improved contracting practices with medical schools and other VA affiliates for scarce medical specialties. This is a long-standing issue for which the Department is aggressively implementing management changes to ensure fair pricing for the services provided by our affiliates.

As a result of continual improvements in our medical collections processes and the policy changes presented in this budget request, we expect to collect about \$2.6 billion in 2006 that will substantially supplement the resources available from appropriated sources. This figure is \$635 million (or 32.5 percent) above the 2005 estimate, with two-thirds of the increase due to the two important legislative proposals (the \$250 enrollment fee and the increase in pharmacy co-payments), and is more than 48 percent higher than the 2004 collections total. VA has an expanded revenue improvement strategy that focuses on modeling industry best performance by establishing industry-based performance and operational metrics, developing technological enhancements, and integrating industry-proven business approaches, including the establishment of centralized revenue operation centers. There are two electronic data initiatives underway that will add efficiencies to the billing and collections processes. The electronic and insurance identification and verification project is providing VA medical centers with an automated mechanism to obtain veterans' insurance information from health plans that participate in this electronic data exchange. We are pursuing enhancements which will provide additional insurance information stored by other government agencies. Our second initiative will result in

electronic outpatient pharmacy claims processing to provide real-time claims adjudication.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

The President's budget request includes \$750 million in 2006 to continue the CARES program that renovates and modernizes VA's health care infrastructure and provides greater access to higher quality care for more veterans, closer to where they live. About \$50 million of this total relates to the sale of assets and enhanced use proceeds of the Lakeside hospital in Chicago. The budget request provides a 3-year (2004–2006) investment total of \$2.15 billion committed to this historic transformation of our health care system. These resources will be used to address our prioritized list of major capital investments. The proposed projects for 2006 will advance the CARES program by providing construction funding for five projects for which design work has already started, as well as two additional projects to be initiated in 2006. All of these capital projects support the recommendations included in the CARES Decision report. About half of the CARES funding requested for 2006 will be devoted to three major construction projects:

- Las Vegas, Nevada, New Medical Facility—\$199 million to complete phase two construction, providing up to 90 inpatient beds, a 120-bed nursing home care unit, ambulatory care center, and administrative and support functions, all of which will expand capacity and increase the scope of health care services available; VA is working with DOD to ensure mutual needs are met
- Cleveland, Ohio, Cleveland-Brecksville Consolidation—\$87.3 million to complete phase two construction; this project will consolidate and co-locate all clinical and administrative functions of a two-division medical center at the Wade Park VA Medical Center, leading to annual cost savings of more than \$23 million and enhancing the quality of care
- Pittsburgh, Pennsylvania, Consolidation of Campuses—\$82.5 million to complete phase two construction; this project will consolidate a three-division health care delivery system into two divisions which will improve patient care by providing a state-of-the-art health care environment and reducing operating expenses.

Our capital investment planning process and methodology involve a Department-wide approach for the use of capital funds and ensure all major investments are based upon sound economic principles and are fully linked to strategic planning, budget, and performance measures and targets. All CARES projects have been reviewed using a consistent set of evaluation criteria that address service delivery enhancements, safeguarding assets, support of special emphasis programs and services, capital portfolio goals, alignment with the President's Management Agenda, and financial priorities.

MEDICAL AND PROSTHETIC RESEARCH

The President's 2006 budget includes \$786 million to support VA's medical and prosthetic research program. This resource level will fund nearly 2,700 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of aging, acute and traumatic injury, the effects of military and environmental exposures, mental illness, substance abuse, cancer, and heart disease.

The requested level of funding for the medical and prosthetic research program will position the Department to build upon its long track record of success in conducting research projects that lead to clinically useful interventions that improve veterans' health and quality of life. Examples of some of the recent contributions made by VA research to the advancement of medicine are:

- development of an artificial nerve system that enables a patient with upper-limb paralysis to grasp objects
- creation of a new collaborative model for treating depression in older adults, the application of which potentially saves lives, reduces patients' level of pain, and improves their overall functioning
- the finding that proper intake of cereal fiber and vitamin D are among the best ways to prevent serious colon polyps that may lead to colorectal cancer
- development of an oral drug that halts the deadly action of the smallpox virus.

In addition to VA appropriations, VA researchers compete and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2006. Through a combination of VA resources and funds from outside sources, the total research budget in 2006 will be nearly \$1.7 billion.

VETERANS' BENEFITS

The Department's 2006 budget request includes \$37.4 billion for the entitlement costs mainly associated with all benefits administered by the Veterans Benefits Administration (VBA). This total includes an additional \$812 million for disability compensation payments to veterans and their survivors for disabilities or diseases incurred or aggravated while on active duty. Recipients of these compensation benefits are projected to increase to 3 million in 2006 (2.7 million veterans and 0.3 million survivors, or 400,000 more than when the President came to office).

The President's budget request includes \$1.26 billion for the management of the following benefits programs—disability compensation; pension; education; vocational rehabilitation and employment; housing; and life insurance. This is \$77 million, or 6.6 percent, over the 2005 level. As a result of the enactment of the Consolidated Appropriations Act, 2005 (Public Law 108-447), an additional \$125 million will be made available to VBA (through a transfer of funds from medical care) for disability benefits claims processing. Of this total, \$75 million will be used during 2005 and the remaining \$50 million will be used in 2006. The overwhelming majority of these funds will be used to address the increased volume of compensation claims from both separating service members and older veterans who had not previously submitted claims.

As a Presidential initiative, improving the timeliness and accuracy of claims processing remains the Department's top priority associated with our benefits programs. Last year the timeliness of our compensation and pension claims processing improved by 9 percent (from 182 days in 2003 to 166 days in 2004). While we were successful in reducing the time it takes to process claims for compensation and pension benefits, we were not able to improve timeliness as much as we had projected at the beginning of the year. Entering 2004, VA was well positioned to meet our performance goals pertaining to the timeliness of processing claims. However, a September 2003 decision by the Federal Circuit Court in the case of the *Paralyzed Veterans of America et. al. v. the Secretary of Veterans Affairs* required VA to keep veterans' claims open for 1 year before making a decision to deny a claim. As a result, decisions on over 62,000 claims were deferred, many for as much as 90 days. While the President signed correcting legislation in December 2003, the impact of the court decision in the early portion of 2004 was substantial, as the number of pending claims had grown dramatically. VA made significant progress during the last half of the year, but we were not able to fully overcome the negative effects from this court decision on our claims processing timeliness.

We have had to revise our claims processing timeliness goals for the next 2 years due, in part, to the lingering effect of the Federal Circuit Court decision. Also having an impact on the timeliness of processing is the increasing volume of disability claims and the complexity of the claims. In addition, VA will continue to face the retirement of staff members highly experienced in processing claims. While we have established a sound succession plan, the new employees we are hiring will require both extensive training and substantial claims processing experience in order for them to reach the productivity level of those leaving the Department.

During 2005 we expect to reduce the average number of days to process compensation and pension claims to 145 days, an improvement of 12.7 percent from the 2004 performance level. With the resources requested in the 2006 budget, we will be able to maintain this improved timeliness in support of this Presidential initiative. In addition, we will reduce the number of pending claims for compensation and pension benefits to 283,000 by the end of 2006, a reduction of 12 percent from the total at the close of 2004.

We will increase our efforts to ensure the consistency of our disability evaluations from one regional office to another. VA has made significant improvements in both the accuracy and consistency of its benefit entitlement decisions due to increased quality assurance efforts and more focused training of claims adjudicators. However, more must be done to ensure the Department meets its commitment to treating every veteran's claim fairly and equitably regardless of locality. A system-wide review of the rating program for disability compensation is underway. In addition to this independent review, the Veterans' Disability Benefits Commission has been established to carry out a study of the statutory benefits that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service. This commission is expected to examine and make recommendations concerning the appropriateness of these statutory benefits, the appropriateness of the level of the benefits, and the appropriate standard or standards for determining whether a disability or death of a veteran should be compensated. VA's efforts to improve the consistency of disability evaluations are supported in the 2006 budget by a request for \$1.2 million for skills certification testing and \$2.6 mil-

lion for continued development of computer-based training tools. These initiatives will complement other ongoing efforts supported by our budget that address the issue of consistency and accuracy. Among these are:

- revision of all of the regulations that govern the compensation and pension programs in plain language to ensure that the rules can be applied consistently and fairly
- in-depth data analysis of benefit decisions to identify potential areas of inconsistency, increasingly possible with our new information technology applications and tools
- centralized processing of appeals remanded by the Board of Veterans' Appeals, and ongoing quality reviews of appealed claims decisions.

An important and successful component of VA's vision for providing a seamless transition for service members separating from active duty is the Benefits Delivery at Discharge (BDD) program. The BDD program enables active duty service members to file disability compensation claims with VA staff at military bases, complete physical exams, and have their claims evaluated before, or closely following, their military separation dates. Transitioning service members benefit greatly from the BDD program, which has been a vital part of the Department's strategy for improving timeliness and accuracy of disability compensation claims processing.

We believe the BDD program provides opportunities to not only benefit transitioning service members through timely and accurate claims processing, but also to bring new processing improvements and efficiencies to the system through consolidation of claims evaluation activities. An initiative is currently underway to consolidate disability compensation rating and authorization actions on all BDD claims to two sites nationwide. VA staff will continue work with transitioning service members at military bases to establish claims and arrange for timely medical exams, thereby retaining these successful aspects of the BDD program.

In support of the education program, the 2006 budget proposes \$7.8 million for continued development and implementation of the Education Expert System. The requested funds will be used to first transition education processing to VBA's corporate environment, followed by the development and deployment of a processing system that receives application and enrollment information electronically and processes that information in the new corporate environment without human intervention. While it will be a number of years before this system is fully deployed, it will ultimately lead to substantial improvements in education claims processing timeliness.

In April 2004 the Department's Vocational Rehabilitation and Employment Task Force released its report containing more than 100 recommendations on how to improve service to disabled veterans. The focus of the report was on development and implementation of a new, integrated service delivery system based on an employment-driven process. In response to the task force's recommendations, VA is including \$4.4 million in the 2006 resource request to be used for establishing a job resource lab in each regional office. These labs will include all of the necessary equipment, supplies, and resource materials to aid VA staff and veterans in conducting comprehensive analyses of local and national job outlooks, developing job search plans, preparing for interviews, developing resumes, and conducting thorough job searches. These self-service job resource labs will assist veterans in acquiring suitable employment through the use of a comprehensive on-line employment preparation and job-seeking tool.

In order to make the delivery of VA benefits and services more convenient for veterans and more efficient for the Department, we are requesting \$4.4 million for the collocation and relocation of some regional offices. This effort may involve collocations using enhanced-use authority, which entails an agreement with a private developer to construct a facility on Department-owned grounds and then leasing all or part of it back to VA. At the end of these long-term lease agreements, the land and all improvements revert to VA ownership.

BURIAL

The President's 2006 budget includes \$290 million in discretionary funding for VA's burial program, which includes operating and maintenance expenses for the National Cemetery Administration, capital programs, the administration of mandatory burial benefits, and the State Cemetery Grants program. This total is nearly \$17 million, or 6.4 percent, over the 2005 enacted level.

The 2006 request includes \$167 million in administrative funding for VA's burial program, an increase of \$7.3 million (or 4.6 percent) from the 2005 enacted level. Within this total, \$156 million is for the operations and maintenance of VA's national cemeteries and \$11 million is for the administrative processing of claims for

burial benefits. The additional funding will be used to meet the growing workload at existing cemeteries, primarily by increasing staffing and contract maintenance. The growth in workload is a direct result of the aging of the veteran population. The annual number of veteran deaths continues to rise and VA projects an increase in interments of about 4 percent a year for the next several years.

Our budget request for the burial program includes \$90 million for construction projects. Of this total, \$65 million is for major projects and \$25 million is for minor projects. Consistent with the provisions of the National Cemetery Expansion Act of 2003, we are requesting \$41 million in major construction funding for land acquisition for six new national cemeteries in the areas of Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Sarasota, Florida; and southeastern Pennsylvania. The 2006 request also includes funding to develop an annex for the expansion of Fort Rosecrans National Cemetery in Miramar, California. In addition, this budget provides \$32 million for the State Cemetery Grants program.

Our resource investments in the burial program produce positive results in service delivery to veterans and their families. We will expand access by increasing the percent of veterans served by a burial option within 75 miles of their residence to 82.2 percent in 2006, which is 6.9 percentage points above the 2004 figure. While our 2004 performance was extremely high in several key areas, we will continue to improve our performance in 2006. We have established the following performance goals for 2006:

- increase to 96 percent (from 94 percent in 2004) those who rate the quality of service provided by the national cemeteries as excellent
- increase to 99 percent (from 98 percent in 2004) those who rate national cemetery appearance as excellent
- increase to 89 percent (from 87 percent in 2004) the proportion of graves in national cemeteries marked within 60 days of interment.

These performance improvements will further enhance the outstanding reputation of VA's National Cemetery Administration which, in 2004, earned the highest rating ever achieved by a public or private organization in the American Customer Satisfaction Index (ACSI). These results demonstrated that the Department's national cemeteries produced a customer satisfaction rating of 95 out of a possible 100 points. This is two points higher than the last survey conducted in 2001 when VA's national cemeteries also ranked number one among Federal agencies in customer satisfaction.

MANAGEMENT IMPROVEMENTS

VA continues to aggressively pursue a variety of initiatives aimed at ensuring we apply sound business principles to all of the Department's operations. Two of our most successful management improvement efforts during the last year focus on the strategic management of human capital and capital asset management.

As an integral component of our succession planning activities, we released a state-of-the-art "VA Recruitment" CD-ROM in September 2004 promoting the Department as an employer of choice. We distributed this to colleges and universities, military transition centers, veterans organizations, and VA vocational rehabilitation centers, offices, and medical centers. This initiative creates a corporate recruitment marketing approach that will give VA a competitive edge in attracting highly-qualified career applicants. The CD-ROM uses graphics and video streaming to present a wide spectrum of career opportunities and describes VA's goals and services, occupations, and the benefits of working for the Department. We will continue to focus on creative marketing initiatives and outreach to prospective applicants.

VA has also launched a Capital Asset Management System (CAMS) which is an integrated, Department-wide system that enables us to establish, analyze, monitor, and manage our portfolio of diverse capital assets through their entire lifecycle from formulation through disposal. CAMS provides a strategic view of existing, in-process, and proposed asset investments across all VA program offices and capital asset types. All offices now use this shared system to collect and monitor real property and capital asset information. In addition, VA has been approached by numerous agencies, including the Departments of Defense, Homeland Security, Commerce, and Interior to explore the replication of CAMS in their organizations.

VA's progress in this area places it in the forefront of other Federal agencies in terms of its ability to meet the real property performance measures and guidelines that were recently finalized by the newly created Federal Real Property Council.

We are currently in the process of fully evaluating all of the information gathered during the operational tests of the Core Financial and Logistics System (CoreFLS) conducted last year. This year we will complete a comprehensive analysis of the

product and any existing configuration gaps, examine lessons learned from the pilot tests, and reevaluate our business processes. This will provide us with the information needed to refine the system as well as develop improved change management, training, and implementation procedures that are critical to successful deployment. In anticipation of an enhanced financial management system moving forward to full deployment at VA facilities nationwide, the Department's 2006 budget includes \$70.1 million for this project.

In support of one of the primary electronic government initiatives for improving internal efficiencies and effectiveness, the Department's 2006 budget provides \$8 million to continue the migration of VA's payroll services to the Defense Finance and Accounting Service (DFAS). This initiative will consolidate 26 Federal payroll systems down to 2 Federal payroll provider partnerships. VA is working with DFAS on all required tasks to ensure successful migration.

CLOSING

In summary, Madam Chairman, our 2006 budget request of \$70.8 billion will provide the resources necessary for VA to:

- provide timely, high-quality health care to more than 5.2 million patients; 78 percent of all veteran patients will be veterans with service-connected disabilities, those with lower incomes, or veterans with special health care needs
- maintain the 2005 performance level of 145 days, on average, to process compensation and pension claims
- increase access to our burial program by ensuring that more than 82 percent of veterans will be served by a burial option within 75 miles of their residence.

I look forward to working with the members of this committee to continue the Department's tradition of providing timely, high-quality benefits and services to those who have helped defend and preserve freedom around the world.

That concludes my formal remarks. My staff and I will be pleased to answer any questions.

Senator HUTCHISON. Thank you very much, Mr. Secretary.

I would like to have a 5-minute round. Each of us can have one round and then we will definitely have a second and maybe a third.

First of all, Mr. Secretary, I certainly agree with the Veterans Administration's principle that we should focus on care for priority 1 through 6 veterans. I think everyone would agree that that should be our highest priority. Do you agree that we must have full funding for those priority 1 through 6 veterans, whatever else happens?

Secretary NICHOLSON. Yes, Madam Chairman. This budget reflects that. We have a mandate to take care of those veterans who need us the most, and that is those veterans who have been injured as a result of their service or become ill, including mental illness as a result of that service, those that are down and out, the poor, indigent, and those in need of unique, special care, and that is those categories.

Senator HUTCHISON. This is my question. If the policy provisions regarding 7's and 8's with the added enrollment fees and co-payments were not enacted, would there still be full funding in this budget for priorities 1 through 6?

Secretary NICHOLSON. Yes, Madam Chairman, there would. We would still be able to take care of those priorities.

Senator HUTCHISON. Thank you.

THIRD PARTY COLLECTIONS

Along that line, I understand that you have the authority to collect payments from private health insurance for the cost of treating veterans' non-service-connected disabilities. So when we are looking at the priority 7's and 8's, which have become really the growth area for the medical care for veterans, according to the GAO your

present collection rate is only 41 percent and your fiscal year 2006 budget submission sets a target of only 41 percent. I wondered why this collection target seems low and if you are looking at trying to improve that collection rate and perhaps a different way to get more income from the 7's and 8's to make sure that we are doing the best we can with what we have.

Secretary NICHOLSON. Let me respond in part, Madam Chairman, and then I am going to ask Dr. Perlin to comment. It is 6 weeks today that I have been Secretary, so there are just one or two things that I do not know yet.

Senator HUTCHISON. We understand totally and we are not expecting perfection until next year.

Secretary NICHOLSON. It is a very important question. You will note that in this budget proposal it shows collections being up by 15 percent over last year. I will say that I think the VA has shown a commendable transformation in its culture, going from virtually no collections, a no-collection culture habit mandate, to in a very short time, collecting a significant amount of money. But it is still a work in process. It is very important.

I will ask Dr. Perlin if he would comment further.

Senator HUTCHISON. Dr. Perlin.

Dr. PERLIN. Thank you, Madam Chairman. The Secretary is absolutely right in terms of our Veterans Health Administration learning how to collect, and the progress has been substantial. In fact, in 2001, our collections were on the order of \$700 million. Today they will approach in the 2006 budget on the order of \$2.1 billion. That budget builds in an 11 percent increase, or collections of \$211 million additional.

I think the 41 percent is important because we need to keep moving up, but I would note that it is unadjusted for Medicare. As you know, we cannot collect for Medicare, but the figure actually reflects the funds that we are not able to collect. So actually it is artificially deflated. We do benchmark against private sector, and we have been using gross days revenue outstanding, and I am pleased to say that we are closing in on setting aggressive targets. But your point is well taken. We will continue to push the aggressive collections.

[The information follows:]

The Department of Veterans Affairs (VA) is not allowed (by law) to bill and collect from Medicare. The unadjusted billing to collection ratio of 41 percent reflects the large number of over-65, Medicare-eligible population that VA serves which cannot be billed or collected. VA maintains an adjusted billing to collection ratio which accounts for the Medicare-eligible population and this ratio has been in the 75 percent range for fiscal year 2004 and fiscal year 2005 and provides a more realistic measure of performance.

To improve the collections to billings Medicare-adjusted ratio, VA is taking the following actions:

—*Metric Calculation.*—Collections to billings calculation attempts to quantify net billings by projecting net amounts due from third parties and secondary payors. The current calculation utilizes national data and does not fully reflect VISN differences in population compositions (veterans older and younger than 65) and Health Maintenance Organization (HMO) penetration that impacts this performance metric.

—*Action.*—The Veterans Health Administration (VHA) is working to enhance the metric calculation for fiscal year 2006 to incorporate population variations and HMO penetration differences that could impact overall results. Also, full implementation of the e-MRA (Medicare-equivalent remittance advice) system

throughout VHA will improve the specificity of predicting these net realizable amounts.

—*Denial-Management Tracking System.*—The private sector approaches aggressively the identification, tracking, and resolution of third-party denials. VHA is presently establishing several best-practice denial-management initiatives at the Veterans Integrated Service Network (VISN) level.

—*Action.*—VHA is working to compile the best practices from the VISN pilots and roll out a comprehensive national denial-management strategy in the upcoming months.

—*Formalized Managed-Care Contracts.*—The private sector has the ability to project net billings with great specificity due to established contract rates with managed-care payors, which can easily be loaded into their systems to track deviations due to over- and under-payments.

—*Action.*—VHA has established a National Payor Compliance Office (NPCO) to assist VISNs in addressing negotiations strategically with managed-care payors. As this process matures, VHA will be able to track expected reimbursements better, similar to the private sector.

—*Enhanced Development of Revenue-Cycle Productivity Tools.*—The private sector has invested considerable time and effort to ensure that the necessary staff and resources are dedicated to the revenue cycle. VHA actively monitors monthly performance of its facilities through use of a web-based system (POWER) that reports performance using a stop-light color-coded approach. This system is considered a best practice when compared to private-industry standards. The VISNs have also adopted monitoring tools to measure productivity and to ensure that appropriate resources are dedicated to the revenue-cycle collection process.

—*Action.*—VHA is taking a leadership role to extend nationally the best practices identified at the VISN level to improve overall effectiveness in the collection process.

Senator HUTCHISON. I guess that would be my point. Would you continue to look for ways where there is an outside insurer, a private insurer, that we would make as many of those collections as absolutely possible to offset costs?

My time is up, and I would like to give my colleagues a chance to have a first round of questions before this vote starts. Senator Feinstein.

Senator FEINSTEIN. Thanks very much, Madam Chairman. I appreciate that.

GRANTS FOR STATE EXTENDED CARE FACILITIES

Mr. Nicholson, the President's fiscal year 2006 budget request for the VA suspends grants for the State extended care facilities. Could you explain to us why it is necessary to impose a 1-year moratorium on grants for construction of long-term extended care facilities when there is such a need for VA homes throughout this Nation? How would this affect the current priorities list for funding under this program? Do you anticipate altering this list in fiscal year 2007?

California, my State, with three homes and 2.3 million veterans is one of two States classified under great need in regard to home funding. The State plans to request \$125 million in fiscal year 2007 under this grant program to fund its largest project to date which is the greater Los Angeles, Ventura County home which includes three separate facilities. How would the 1-year moratorium impact funding for this project?

So there are essentially three questions in one. If you want me to go one by one, I will.

Secretary NICHOLSON. Thank you, Senator. It is an important area. Let me address the suspension of the grants. In this budget,

I think it would reflect a reduction of just over \$100 million for this coming fiscal year 2006. I am going to ask Dr. Perlin if he would address the specifics as to California.

Dr. PERLIN. Thank you, Senator. Let me start with the piece of the question you asked about the 2005 commitments. The commitments are proceeding as was planned. I would have to get back to you with the specific information on California.

Senator FEINSTEIN. And how will this affect 2007?

Dr. PERLIN. I think I would be unable to speculate in terms of the future.

Senator FEINSTEIN. All right. So what you are telling me then is you do not know about California. You do not know about the future, and it is a 1-year moratorium essentially.

Could you tell me what the rationale for a 1-year moratorium is when the needs are so great?

[The information follows:]

The fiscal year 2006 VA budget proposes a 1-year moratorium on new grants to States for construction and renovation of extended care facilities. This will permit VA to complete an assessment of its nationwide institutional long-term care infrastructure and ensure that future construction aligns with the areas of greatest projected need. Grants that have already been awarded will not be affected by the 1-year moratorium.

VA has already committed to all planned fiscal year 2005 projects on the current Priority List. The States are currently completing the requirements for fiscal year 2005 grant awards. VA has committed the maximum fiscal year 2005 appropriations and the remaining fiscal year 2004 carryover funds to these projects.

The Priority List is revised annually, as of August 15th. All new and existing pending projects are ranked and included in the annual list. Once approved by the Secretary, the list is used to identify ranked projects and commit funding for projects for that fiscal year award or to finalize conditionally approved projects. For fiscal year 2007, VA would follow the same procedures and commit funds available at that time to the projects in rank order. VA cannot predict at this time how the California project will be ranked in fiscal year 2007 or whether there will be sufficient appropriations to fund it.

Secretary NICHOLSON. Well, I can address the issue in brief, Senator. If you take a look at the VA as a whole, it has gone through a major transformation from being a hospital-centered medical care provider to a clinical-centered provider and more outreach and moving out more to where the veterans are.

The same philosophy is operating in extended care. We are finding that it is very often both more efficient and effective to treat institutional care people or what used to be institutionalized people in a non-institutionalized setting using the new tools that are available of telemedicine, telehealth, social workers, people being allowed to remain in their homes or closer to their homes.

Senator FEINSTEIN. I think I see where you are going, and correct me if I am wrong. Is this then an effort to begin to phase out long-term care for veterans and sort of go to an outpatient treatment process?

Secretary NICHOLSON. Well, I think there are certainly some people that will need long-term care. There are some people who are not candidates for the new capabilities that we have for extended non-institutionalized care. So no, I do not think it is a path toward the end of them, but it is a trend and one that is finding a lot of satisfaction among the people being treated that remain at home. They have a social worker come there and provide them with care and bathing. With the electronics that we have now, we can take

blood pressure, get their blood sugar, and all that on-line daily with a medical mentor talking to them in their home. If they need care, we can then move them.

Senator FEINSTEIN. Let me just, if I might, say a word on behalf of the 2.2 million veterans in my State. California is a very high cost-of-living State. The extended care facilities are very expensive for the most part, particularly if an individual does not have Medicaid or Medicare. I guess what I hope is that this is just not an effort to absolve us of the Federal responsibility to take care of veterans in later years who cannot take care of themselves and push it onto the State because I think the veterans are not then going to be well cared for. So I will leave you with that.

Senator CRAIG.

Senator CRAIG. Well, thank you very much. I think we are going to run out of time rapidly here, Senator Feinstein, as it relates to a vote that is now underway.

Mr. Secretary, from my initial visit with you and our initial hearing on your budget, we have proposed a variety of changes, somewhat different from what you proposed, which we think will offer a little more flexibility in funding and still meet all of the needs that you have projected are out there and the savings that you have projected are out there.

PER DIEM PAYMENT POLICY TO STATE HOMES

There are many that concern me and I think concern all of us, but the State home program, by most accounts, has been a very successful partnership between the Federal and State governments for the care of aging veterans, and yet VA proposed to modify this past per diem payment policy, a change in policy the VA says would reduce the number of State beds by more than 50 percent. We have, obviously, disagreed on that and are proposing not to do so.

Why does VA want the States to reduce the number of State home beds? I guess that would be the first question. Even if VA does not want to provide institutional care for the non-service-connected, why does it want to discourage States from attempting to meet that need?

Secretary NICHOLSON. Well, one of the things operating here, Senator Craig, is a goal of getting in uniform conformance with the law from the VA's perspective, which is that those people eligible for long-term institutional care are those that are 70 percent disabled or more. The goal, as I have stated to Senator Feinstein, of—you know, realizing the benefits of the care more in the community where the people are.

I am not sure that the VA is desirous of the States getting out of the long-term institutional care.

Senator CRAIG. I guess then the question, does VA believe that it has the legal authority to simply stop paying per diem payments to the States for the care of veterans VA does not define as a priority?

Secretary NICHOLSON. No, I do not think so. I think there would be a legislative piece needed. I could also say that this budget does not contemplate that a veteran that is in a facility who really needs to be there would be moved from that bed.

Senator CRAIG [presiding]. Well, I am going to run out of time, and I need to go vote. So I am going to put the committee at recess until the chairman returns. So with that, the committee will stand in recess.

Thank you all very much for being here today.

Senator HUTCHISON [presiding]. I am going to call the committee back to order. We will try to finish the questions.

TRANSITIONAL PHARMACY BENEFIT PILOT PROGRAM

Let me ask you about the transitional pharmacy benefit pilot program. Last year the Department implemented the transitional pharmacy benefit pilot program to allow veterans on the waiting list to have their privately written prescriptions filled at the VA without seeing a VA physician. I think this makes great sense, and tying up VA doctors just to write a prescription when someone can get one outside probably is not the best use of their time.

I understand the pilot did achieve its goal of improving access to VA prescription drugs, but there were implementation errors reported by the Inspector General. I am concerned that maybe the errors did not give an accurate assessment of whether this type of program should be continued. So I wanted to ask you what is the status of that pilot program and is it something that you are going to implement as a policy?

Secretary NICHOLSON. Madam Chairman, this budget does not contemplate that. There was that pilot program and it encompassed 48,000 people. What was most notable I think about that was that approximately half of those prescriptions that were presented for filling by the VA pharmacies were requesting pharmaceuticals that did not meet the formulary inventory of the VA. So it caused difficulties for people on both sides of that transaction, as well as the need then for VA functionaries who were very dutiful to call the prescriber, if they could find them, to see if they could prescribe a comparable for the patient that was in our formulary holding.

I will ask Dr. Perlin, who was there and has been through that test, if he would like to elaborate.

Dr. PERLIN. Madam Chairman, thank you for your interest in this area. I know it has been positive that the substitution of the ability to fill pharmaceuticals might relieve some of the waiting when, in fact, a patient wants just a prescription.

By way of disclosure, I would need to indicate that we have learned from the transition pharmacy benefit a few facts. As Secretary Nicholson said, almost half of the prescriptions were off of our formulary. Even with negotiation, it was still a much, much higher rate of non-formulary, which meant that we did not achieve some of the efficiencies in terms of cost of the prescription that we would in our normal course of practice. So it is something that I think deserves further consideration, and I would want to consult with the Secretary in terms of his future thoughts on the topic.

Senator HUTCHISON. Well, I understand the point that was being made that perhaps it ends up not being a good tradeoff. You save the doctor's time, but you make it harder for the pharmacies and maybe more expensive. So I would like for you to look at it again just to see if it is worth continuing a pilot or if you determine that

the good does not outweigh the bad. It just seemed like a good concept.

Secretary NICHOLSON. So noted, Madam Chairman. It is something that we have discussed quite a bit actually in the few weeks that I have been there because on its face it does seem to have a lot of appeal, especially some of those prescribers have been Medicare paid doctors so the public is already paying for that service.

MEDICAL PROSTHETIC RESEARCH

Senator HUTCHISON. Let me ask you a question on the research budget. The budget request proposes a \$9.3 million cut to the medical and prosthetic research account. But I wanted to ask you if you feel that that is going to be enough.

Further, Secretary Principi had made a commitment of \$15 million a year for the Gulf War Syndrome research for a 4-year period for a total of \$60 million. That is something that is very important to me because I think our veterans got very short-changed when they came home with these symptoms, that in a previous administration, were sort of swept aside as, well, it was post-traumatic stress syndrome type thing, and it turns out that there is a causal connection between brain damage and exposure to chemicals. We, through the Veterans Administration under Secretary Principi, were on the road to making that a larger study, with the long-term goal of, of course, getting antidotes for that or trying to determine if someone is predisposed because of a brain deficiency—an enzyme deficiency, that is—to not send someone to an area where there might be chemical weapons.

My question is does this cut in the budget give you enough funding for your Department to do all of the things that are a priority and is Gulf War Syndrome research still going to get the full \$60 million commitment, in \$15 million increments, that Secretary Principi had said he would do?

Secretary NICHOLSON. Madam Chairman, this budget is \$1,653,000,000 for research in total. We are asking for an appropriation of \$786 million. That is sufficient to underwrite something like 2,700 different research projects.

As to your question, is there sufficient funding in here approved for the current year Gulf War illness research of \$15 million, the answer is yes.

We have had some discussion about the \$60 million, the 4-year program, and counsel to me is that it is not a hard commitment. That has been discussed. What I will say to you is that the \$15 million is absolutely in here, and the subsequent years, as I get more familiar with it, I will take a very serious look at this. But we will probably be back to you in discussion with this.

I think the answer to your question overall is that there is enough in this to do the research that we think should be done.

There is a \$100 million in this budget for prosthetics, and there is an increase of \$100 million for PTSD research and application.

Senator HUTCHISON. Could you clarify? You are saying that the \$60 million over the 4 years is not a commitment. So are you saying that \$15 million is in for this year but you are not making a commitment for future years?

Secretary NICHOLSON. Well, I am going to first ask the general counsel if he would address that from his perspective, and then I will respond.

Mr. MCCLAIN. Madam Chairman, we do have \$15 million in additional research funding for the Gulf War illnesses. That is for this particular year in unspecified projects but they will go toward Gulf War research. As far as future years, we really cannot speculate as to what might come out in future years for research dollars, but certainly we have been committed over several years now to putting additional resources toward Gulf War research.

Senator HUTCHISON. Mr. Secretary, do you consider that the Gulf War Syndrome is a legitimate area for research?

Secretary NICHOLSON. Yes, I do. I know something about that. I have been briefed by a team of doctors on that, and I think that is a very legitimate area to try to understand. So that is not an issue for me, but we have to do it legally.

I would like to ask Dr. Perlin, if I could, Madam Chairman, if he would comment a bit on the current status of the research.

Dr. PERLIN. Madam Chairman, this is an absolutely critical area. Right now we have 146 separate projects on environmental exposures at a cost of about \$35 million in the 2006 budget proposed.

In the area of Gulf War illnesses, VA has funded 111 projects since 1991 and currently there are 48 ongoing. VA's commitment to date has been \$73 million. The Federal commitment has been in excess of \$300 million. Of that \$15 million, I can tell you that right now \$5 million have been executed late this spring. There is a request for applications to make sure that we have the best research in that area.

I think one of the most promising endeavors this year, something that we worked hard with the Research Advisory Committee on Gulf War Illnesses to develop is a new center for the study of promising treatments for Gulf War illness. While we may not have full insight into the mechanisms of what causes these unexplained symptoms, we passionately feel the obligation to care for these veterans to treat their symptoms. This new center promises to help us align our best tools to understand what treatments may be promising.

Senator HUTCHISON. So you are not in any way saying it is not a priority. You will be saying that it is a priority. Is that what you are saying?

Secretary NICHOLSON. Yes, exactly.

DALLAS VA MEDICAL CENTER

Senator HUTCHISON. I wanted to talk about a couple of local issues. First of all, in November of 2004, your own Department ranked the Dallas Veterans Affairs Medical Center the worst VA hospital in the country. Of course, that was a revelation to many people in the Dallas area. I know improvements have been made. I know that the head of that hospital is no longer there. But I just wanted to ask you, Mr. Secretary, if you are satisfied that the changes being made there are bringing that VA hospital up to your standards.

Secretary NICHOLSON. Yes. That has been problematic. I noted that as soon as I began getting briefed for this job. As you noted,

some of the key management personnel have been replaced. There have been several reviews made of that internal. An accrediting association has looked at that. They found some deficiencies and have given recommendations to us to institute. I am satisfied that those corrective measures are underway. We have some good new people in place, but it is something that is very important and we are keeping an eye on.

Senator HUTCHISON. That is what I was going to follow up and ask. Is there a mechanism by which, when you have a hospital that gets this low a rating, you would go in and check more carefully and more frequently to assure that the changes are being implemented?

Secretary NICHOLSON. I am going to ask Dr. Perlin to answer that.

Dr. PERLIN. Thank you, Mr. Secretary.

Madam Chairman, absolutely. We are following up with objective evidence of improvement. We have the performance measurement system throughout the VHA. As our Inspector General noted, the performance was not where the citizens of Texas and Dallas deserved. That is changing already objectively on the basis of data. We can demonstrate that there is significant improvement.

In addition to a new director, Betty Brown, there is also a new associate director, Dan Heers, a new chief of staff, a new chief nursing executive. And my own calls to individuals down there tell me that the progress has been light-speed.

I would note to you that I plan to make a visit to Dallas in April to assure myself that what I am seeing on paper is actually represented as the best improvements.

I think it is important to note that while there have been some individuals who have been problematic, that part of my job is to encourage the 90 percent of the staff that really go above and beyond to give their best for the veterans. So I want to make sure that the message is complete, that we sanction and improve and hold accountable where we need to, but that we also encourage and support those individuals who really do give our veterans their best.

WACO AND BIG SPRING, TEXAS SITES

Senator HUTCHISON. Thank you. I would be very interested, after your visit, in hearing what your findings are.

There are two veterans sites that are in the 18 in the CARES plan that are cited as needing more study. One is in Waco. I have discussed this with you, Mr. Secretary.

The Waco facility is a campus. It is a beautiful campus. It is under-utilized, that is for sure. The care that it gives is excellent. The mental health care, from everything that we could tell, did a very solid, good job. But the plan now is for there to be a master plan for the Waco facility that is supposed to be put together with the city leaders in Waco and the consultants from the VA. I just wanted to ask you if we can expect that you would continue the commitment to look for a master plan for that site so that it can be efficiently used.

One of the things that I did not quite understand in the CARES Commission report is that they closed two smaller clinics and rec-

commended that there be a VA clinic built in Waco. It just seemed to me that with the facility there being under-utilized that perhaps having the clinic move to the long-term care facility that there might be an added benefit there and be the right thing for the veterans in the area as well as for the efficient operation that you would be seeking.

So do you have any status report on that, or can you just at least say that we will have the master plan moving forward and that the Department will work with the community leaders for that plan?

Secretary NICHOLSON. Absolutely I can say that, Madam Chairman. In fact, I am planning to go to Waco myself hopefully in April. I want to go down there and get on the ground and see the facilities, not to preempt the process but so that I know and have a feeling myself for the physical assets that are there. I know that the continued process out of the CARES process is underway, and I think that will run its course and have great community involvement. We are very committed and interested in that.

Senator HUTCHISON. Well, I certainly am pleased that you are going there. I hope I can join you. So I would like to call your office and see if we can do that together.

Secretary NICHOLSON. We will try to coordinate.

Senator HUTCHISON. There is a second facility at Big Spring. It is a hospital that I visited a few months ago. It is in a central location which is 40 miles from Midland, 60 miles from Odessa, 87 miles from San Angelo, and 110 miles from Abilene. The next closest VA hospital is 200 miles from any of those locations.

I had asked Secretary Principi to consider a public/private partnership between the Big Spring VA and Scenic Mountain Medical Center to increase the services to the veterans in that area. It is the area that all of those communities support the VA hospital because it is the most centrally located. As you know, we have two Air Force bases, one in Abilene and one in San Angelo, that feed into that veterans hospital, plus Midland and Odessa feeding in. And if you put it in any of the other places, it would be much farther from other population centers.

So I would ask that you also visit that one—it might be a good day to go to both of those at the same time—and look at the possibilities of, again, making your service more efficient but keeping it at the Big Spring facility where you already have a major investment.

Secretary NICHOLSON. I will try to do that, Madam Chairman. I am committed to Waco. I will see if we can make it work at Big Spring. I would like to. I can tell you, as you probably know, I think the first open forum of that advisory board for Big Spring is scheduled to meet, I think, April 7 for the first time with our consultant, Price Waterhouse.

ADDITIONAL COMMITTEE QUESTIONS

Senator HUTCHISON. Well, I know this is all pretty overwhelming and you have only been there a short time. But I would look forward to working with you to assure that the community has its input and that we can do the best for the veterans in the area. I think you will be pleased when you see both of those facilities.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR KAY BAILEY HUTCHISON

MAJOR CHALLENGES AND GOALS

Questions. I recognize you have been in office only a few weeks, but I would like to hear your preliminary observations about the Department.

Specifically, what do you see as the Department's main challenges?

As VA Secretary, what are the main goals you would like to achieve before the end of your tenure?

Answers.

Challenges

VA is a very large, multi-business organization requiring diverse management service delivery skills. More than 220,000 dedicated VA employees operate its 157 hospitals, 134 nursing homes, 860 outpatient clinics, 57 regional benefit offices, and 120 national cemeteries and receive pre-discharge claims for disability benefits at 139 military sites. They strive to provide world-class service to America's deserving veterans who seek (1) health care; (2) the benefits they have earned to restore their capability and ensure a smooth transition from active military service to civilian life; and (3) honor and fitting memorials in death.

Our single greatest challenge is making sure our veterans receive the highest return on the taxpayers' dollar. To do that, VA needs to make sure it operates with only the best business practices in place. This alone, will make it easier for our veterans to access the quality care and services we provide. We must continually improve our business practices, maximize sharing opportunities with DOD and others and focus our services on those most in need. I look forward to tackling the challenges of ensuring best practices in all areas of VA endeavor and building on today's successes for even greater achievements in the future.

Goals

—I want to ensure that timely access to medical care continues to improve for those who depend on VA the most, and I want to ensure that significant improvements in both accuracy and consistency of benefit entitlement decisions are a primary focus across regional offices.

—I want to achieve the right balance of informed, centralized policy decision-making with appropriate, responsible decentralized implementation at levels closest to the provision of day-to-day services to our veterans.

—I want to lead VA to the forefront of integrating accountability systems based on results. VA provides essential, life-saving and life-enhancing services for America's veterans, and I want the Department to be able to articulate, based on solid metrics, the incredible results that are achieved on an on-going basis for veterans, their dependents and survivors.

—I want to continue to build on the objective measures currently being used to assess maximum resource-allocation efficiency so that every dollar is invested wisely toward the outcome of improving veterans' lives.

—I want to sharpen this organization's focuses on improved information and knowledge management and human-capital development.

Madam Chairman, there is so much more I could address, but first and foremost, I want to ensure that all 220,000 employees of this Department strive every day to improve the lot of those heroic, selfless Americans we are privileged to serve—our Nation's veterans.

VETERANS RETURNING FROM IRAQ AND AFGHANISTAN

Question. There are concerns about VA's ability and capacity to treat all returning service members from Operations Enduring Freedom and Iraqi Freedom (OEF/OIF). Further, there have been media reports of some returning veterans who are falling through the cracks and experiencing such things as delayed benefits and medical care and homelessness.

For the record, do you have enough resources to meet the needs of all returning veterans from Iraq and Afghanistan for this current fiscal year 2005?

Answer.

Dr. PERLIN. Yes, VA has the necessary resources in fiscal year 2005 to continue meeting the needs of all returning veterans from Iraq and Afghanistan.

Admiral COOPER. VA has the resources, capacity, and systems in place to provide priority care and claims processing for all seriously injured veterans of Iraq and Afghanistan. We have the resources available to continue our highly successful Benefits Delivery at Discharge (BDD) program, through which service members are able to file disability compensation claims prior to their separation from service. Their claims are then processed expeditiously immediately upon the service members' separation from service. Last year claims filed through the BDD program were processed in an average of 55 days, compared to the national average for all disability determinations of 165 days. We have the resources to conduct briefings for separating members of the active components and specialized outreach to demobilized reserve component forces. In fiscal year 2004 we conducted benefit briefings for more than 88,000 members of the Guard and Reserve. VA will continue to meet its responsibilities to America's current returning war veterans while working to lower inventories, reduce claims processing times, and deal with high claims activity by veterans from earlier service periods.

Question. Does the budget request for fiscal year 2006 provide adequate funding to meet the needs of all returning OEF and OIF veterans?

Answer.

Dr. PERLIN. Yes, VA requested the necessary resources in fiscal year 2006 to continue meeting the needs of all veterans who have suffered injuries or diseases as a result of the conflicts in Iraq and Afghanistan.

Admiral COOPER. The funding request for 2006 is adequate and will enable us to continue the efforts described in the previous response.

Question. Has the VA exhausted all means to reach service members who may separate from active duty? Has the VA used public service announcements?

Answer. While there is always more that could be done to reach veterans and their families, VA has extensive outreach programs for returning service personnel, including Reserve/National Guard members.

News Releases.—Last year, VA produced a 30-second public service video entitled "Our Turn to Serve" which was distributed to domestic viewing markets near or at major military transition and separation bases. It was placed as a streaming video file on the VA Internet Web site and marketed electronically to other domestic TV station programmers in markets with large military populations. It is now about to run on AFRTS outlets serving military based overseas. A new VA outreach video program, "The American Veteran," is airing on the Pentagon Channel, which reaches military audiences at Department of Defense (DOD) installations, communities, and sites in this country and around the world. It is a half-hour video magazine featuring stories and information of interest to military personnel and veterans that focuses on their benefits and how they can access and use them. This is a continuing series of monthly programs that will be marketed domestically to cable systems, PBS stations, and community access cable.

Transition Assistance Program (TAP) and Other Military Services Briefings.—From October 2002 through January 2005, VBA military services coordinators conducted transition briefings and related personal interviews in the United States as reflected in the chart below. These briefings include pre- and post-deployment briefings for Reserve and National Guard members.

OVERALL BRIEFINGS

Fiscal year	Briefings	No. attendees	No. interviews
2003	5,368	197,082	97,352
2004	7,210	261,391	115,576
2005 ¹	2,263	79,105	34,106

¹ Through January 2005.

In addition to military services briefings in the U.S., VBA representatives conduct briefings overseas under arrangement with DOD. VBA provides two tours each year with 6 to 7 VBA representatives providing this service for each tour. Each is home-based at a major military site and provides services at the site and surrounding areas. The countries serviced are England, Germany, Japan, and Italy. Korea is serviced by staff from the Benefits Delivery at Discharge office in Yong San. A representative from the St. Petersburg Regional Office provides that service for Guantanamo Bay. We were recently requested by DOD to add Bahrain to our overseas schedule beginning with the May 2005 tour. The following chart reflects statistics regarding overseas briefings:

OVERSEAS BRIEFINGS

Fiscal year	Briefings	No. attendees	No. interviews
2003	472	12,943	12,947
2004	624	15,183	6,544
2005 ¹	36	1,278	464

¹ Through January 2005.

Briefings for Reserve/Guard Members.—Outreach to Reserve/Guard members is part of the overall VBA outreach program. In peacetime, this outreach is generally accomplished on an “on call” or “as requested” basis. With the activation and deployment of large numbers of Reserve/Guard members following the September 11, 2001, attack on America, and the onset of OEF/OIF, VBA outreach to this group has been greatly expanded. National and local contacts have been made with Reserve/Guard officials to schedule pre- and post-mobilization briefings for their members. Returning Reserve/Guard members can also elect to attend the formal three-day TAP workshops. The following data on Reserve/Guard briefings is a subset of the Overall Briefings data provided in the first chart:

RESERVE/GUARD BRIEFINGS

Fiscal year	Briefings	No. attendees
2003	821	46,675
2004	1,399	88,366
2005 ¹	531	32,448

¹ Through January 2005.

Briefings Aboard Ships.—VA provided TAP briefings aboard the USS Constellation, the USS Enterprise, and the USS George Washington on their return from the Persian Gulf to the United States. VBA will continue to support requests from the Department of the Navy for TAP workshops aboard ships.

Seamless Transition—Military Treatment Facilities (MTFs)

In 2003, VA began placing Veterans Service Representatives at key military treatment facilities (MTFs) where severely wounded service members from OEF/OIF are frequently sent. Representatives of the VBA Benefits Delivery at Discharge office in Germany work closely with the staff at the Landstuhl Army Medical Center to assist returning injured service members who are patients at that facility and family members temporarily residing at the Fischer House.

Since March 2003, a VBA OEF/OIF coordinator is assigned for each MTF. Full time staff is assigned to the Walter Reed Army Medical Center in Washington, D.C., and the Bethesda Naval Medical Center in Maryland. Similar teams work with patients and family members at three other MTFs serving as key medical centers for seriously wounded returning troops: Eisenhower, Brooke, and Madigan Army Medical Centers. Itinerant service is conducted at all other major military treatment facilities. As of January 2005, over 4,500 hospitalized returning service members were assisted through this program at Walter Reed, Bethesda, Eisenhower, Brooke, and Madigan. Since March 2003, each claim from a seriously disabled OEF/OIF veteran has been case managed for seamless and expeditious processing.

Web Page.—As part of the Seamless Transition effort, VBA created a new web page for OEF/OIF, directly accessible from the VA homepage. Information specific to Reserve/Guard members who were activated is included, as well as links to other Federal benefits of interest to returning service members. The web page has been accessed over 340,000 times since its activation in December 2003.

Benefits Delivery at Discharge (BDD).—VA’s BDD program operates in concert with the military services outreach program. Under BDD, service members can apply for disability compensation within 180 days before discharge. The required physical examinations are conducted and service medical records are reviewed prior to discharge. The goal is to adjudicate claims within 30 days following discharge. Upon receipt of the claimant’s DD Form 214 (Report of Release from Active Military Service), benefits are immediately authorized so that the recently separated veteran can receive his/her first disability check the month following the month of discharge or shortly thereafter. Currently, 141 military installations worldwide participate in this program, including two sites in Germany and three in Korea. Approximately 26,000 BDD claims were finalized in fiscal year 2003; 40,000 in fiscal year 2004; and 12,000 in fiscal year 2005 to date.

Recently-Separated Veterans

Veterans Assistance at Discharge System (VADS).—All separating and retiring service members (including Reserve/Guard members) receive a “Welcome Home Package” that includes a letter from the Secretary, a copy of VA Pamphlet 21–00–1, A Summary of VA Benefits, and VA Form 21–0501, Veterans Benefits Timetable, through VADS. Similar information is again mailed with a 6-month follow-up letter.

Secretary’s Outreach Letter to Returning Service Members.—Outreach letters from the Secretary of Veterans Affairs have been sent to approximately 240,000 returning service members who have separated/retired from active duty. Enclosed with the letters are copies of VA Pamphlet 21–00–1, A Summary of VA Benefits, and IB 10–164, A Summary of VA Benefits for National Guard and Reserve Personnel.

PRIORITY 7 AND 8 VETERANS

Question. Clearly, we must ensure full funding for Priority 1 through 6 veterans, but I am also concerned about our Priority 7 and 8 veterans.

Given the escalating costs of private health care insurance and cuts to other publicly funded programs, what is going to happen to the tens of thousands of uninsured Priority 7 and 8 veterans? Has the VA performed any analysis to project the outcomes of these veterans? Does the VA have a good understanding of who these veterans are, demographically, and what resources they may have in the event VA medical care is not available to them?

Answer. VA has health insurance coverage data on veterans from the fiscal year 2001 Survey of Veterans. VA also obtains health insurance coverage data for VA health care enrollees from the annual VHA Enrollee Survey. VA has also considered the impact of its proposed policies on uninsured veterans. For example, the cost-sharing policies (annual enrollment fee and increased pharmacy co-payments) in the fiscal year 2006 President’s budget will enable uninsured Priority 7 and 8 enrolled veterans to continue to have access to the VA health care system for a very modest amount of cost sharing. We expect that Priority 7 and 8 enrollees who are uninsured will pay the enrollment fee, while many Priority 7 and 8 enrollees who have other health care coverage are not expected to enroll because of their alternative sources of care.

MANAGEMENT EFFICIENCIES

Question. This year’s request estimates savings of some \$1.8 billion in management efficiencies—an increase of some \$590 million over the fiscal year 2005 level. I support efforts by the Department to improve its management practices, and clearly the Inspector General’s office has identified a number of areas where savings could be achieved. But we haven’t seen a lot of detail or reliable data to back up these savings projections.

For example, the budget projects saving \$150 million through improved contracting practices with medical schools and other VA affiliates for scarce medical specialties. Can you explain exactly how you will achieve this \$150 million in savings?

Answer. VA anticipates that \$150 million in savings will result from improved contracting practices. A new directive is about to be issued that encourages competitive contracting for services and provides contracting officers specific guidance on appropriate costs to include in a sole-source contract, when that vehicle is appropriate. In addition, there will be increased Office of Inspector General audits of sole source contracts with VA’s affiliates, which will result in further savings from originally negotiated rates.

Question. Can you provide the committee with details on how the Department will achieve its overall management savings goal of \$1.8 billion for fiscal year 2006?

Answer. The \$1.8 billion in management efficiencies is composed of recurring and anticipated new efficiencies in standardization of pharmaceuticals and supplies; inventory management; productivity; and administrative/clinical consolidations and VA/DOD sharing.

HOMELESSNESS

Question. By some accounts, homeless veterans number around 200,000; even some veterans returning from Iraq and Afghanistan are experiencing homelessness.

Can you explain why there continues to be such a large number of homeless veterans in this country?

Answer. While homeless veterans tend to be older and better educated than their non-veteran counterparts, they face the same vulnerabilities that increase their risk of homelessness. These liabilities include mental illness and substance use dis-

orders, lack of adequate social supports, disadvantages associated with past histories of incarceration, and poor employment prospects.

VA estimates that there may be 200,000 homeless veterans living on the streets or in shelters on any given day. Data from the National Survey of Homeless Service Providers and Clients conducted in 1996 indicates that the proportion of veterans among homeless men declined to 23 percent from an estimate of 34 percent identified in a similar study conducted in the mid 1980s. We believe that VA, working together with community-based and faith-based organizations, has put in place a wide range of services to address the needs of homeless veterans and this system of services is helping veterans move out of homelessness to independence and self sufficiency.

Question. Why are some of our OEF and OIF veterans experiencing homelessness?

Answer. From August through December of 2004, VA has reached out to 128 homeless OEF and OIF veterans, about 1 percent of all homeless veterans contacted through outreach during those months. Review of intake assessment information about these veterans suggests that, for the most part, these homeless veterans have problems similar to those of homeless veterans from other eras and periods of service. However, homeless OEF/OIF veterans are younger and appear to have fewer problems with substance abuse and they seem to have more short-term situational problems such as changes in family status (e.g. separation or divorce). These veterans are less likely to be chronically homeless, which gives us hope that they can return more easily to self sufficiency.

VISN STRUCTURE

Question. The President's Task Force (PTF) found that the VA's veterans integrated systems network (VISN) structure "resulted in the growth of disparate business procedures and practices." Further, the PTF's report stated that the "VISN structure alters the ability to provide consistent, uniform national program guidance in the clinical arena, the loss of which affects opportunities for improved quality, access, and cost effectiveness." Due to these findings, the PTF recommended "the structure and processes of VHA should be reviewed."

Do you agree with the PTF's findings? If so, what are your thoughts on altering the VISN structure? If not, what alternatives do you offer?

Answer. There is always a tension between centralization and decentralization, such as we find in the current VA network structure. A system that is too centralized is grossly ineffective and inefficient. On the other hand, a system that is too decentralized loses the integration and cohesiveness that defines it as a "system." Achieving the proper balance to avoid both too much centralization and too much decentralization requires continual monitoring and refinement where necessary. So to that extent, we agree that the structure and processes of the VISN structure require continual review. But continual review does not necessarily entail significant alterations. Nor is it clear that the VISN structure has impaired VA's ability to provide consistent, uniform national clinical guidance.

VA operates a large, integrated health care system that functions both efficiently and effectively. Improvements in quality, access, veteran satisfaction, and efficiency are measurable and have been widely recognized. Health care policy is established centrally in Washington and is expected to be executed uniformly throughout all 21 VISNs. I expect the VISNs to address the unique challenges of their respective environments, and we will hold management at all levels accountable for implementing national policy consistently. I am a firm believer in the benefits of performance measurement, and I will hold all VISN directors accountable for the same set of performance measures and goals. The individual means to achieve the goals set may vary somewhat from VISN to VISN, depending on their individual circumstances, but the requirement for implementation of overall national health care policies is immutable.

STATE HOME CONSTRUCTION

Question. The budget request proposes a 1-year moratorium on providing grants for construction of State nursing homes until the VA has completed a review of its long-term care needs.

Since State veterans' nursing homes account for more than half of VA's nursing home workload, to what extent will the moratorium impact veterans access to long term-care?

Answer. The proposed 1-year moratorium on grants for construction of State nursing homes will have a minimal effect on veterans' access to long-term care. Nationally, State Veterans Homes operate at approximately 85 percent capacity; consequently the existing capacity can accommodate additional veterans. Moreover,

construction projects that are already underway are anticipated to add more than 1,600 additional State Home beds nationally over the next 3–4 years.

Question. Are there State nursing home projects with established and documented need that will be delayed because of the funding moratorium?

Answer. There are nursing home projects for which the States have committed matching funds that will be delayed by the moratorium for 1 year. Because the Priority List is revised annually, VA cannot predict how many or which specific projects will be delayed. All new and existing pending projects are ranked as of August 15 and included in the annual list.

VA–DOD COLLABORATION

Question. For several years, there have been numerous efforts to promote health care collaboration between the Department of Defense and the VA. The fiscal year 2003 National Defense Authorization Act directed DOD and VA to establish a joint program to identify and provide incentives to implement, fund, and evaluate creative health care coordination and sharing initiatives between the two departments.

Can you give us a status and any initial findings on this new program?

Answer. Section 721 of Public Law 107–314, the fiscal year 2003 National Defense Authorization Act, requires that DOD and VA establish a joint incentives program through the creation of a DOD–VA Health Care Sharing Incentive Fund. The intent of the program is to identify, fund, and evaluate creative local, regional, and national sharing initiatives.

A DOD–VA Memorandum of Agreement (MOA), signed on July 8, 2004, assigned VA as administrator of the fund under the direction of the VA–DOD Health Executive Council (HEC). The HEC appointed the Financial Management Work Group to issue the calls for proposals, recommend the proposals to be funded, and monitor the projects selected. There is a minimum contribution of \$15 million by each Department (\$30 million total per year) each year for 4 years (fiscal year 2004–fiscal year 2007).

In fiscal year 2004, 12 proposals were approved. Those proposals require \$37.5 million in funding over 2 years. Approved proposals involve a wide range of services including various tele-health projects, women’s health services, a joint cardiac catheterization lab, a joint dialysis unit, and a joint clinic.

In fiscal year 2005, 56 proposals have been submitted, and they will compete for \$22.5 million in funding for the first year. VA and DOD are currently reviewing the projects submitted for the fiscal year 2005 awards cycle.

There has been a high level of interest by VA and DOD in submitting projects for funding. There have been many lessons learned in administering the program, such as allowing sufficient time to permit review up the chains of commands within both VA and DOD; the need for information technology projects to be consistent with the national level solutions being developed; and the need for projects to clearly identify a benefit to both Departments. The projects selected for funding in fiscal year 2004 have not been operational long enough to provide an individual project assessment of the results.

QUESTIONS SUBMITTED BY SENATOR LARRY CRAIG

SERVICES

Question. The 116th Calvary Brigade Combat Team of the Idaho Army National Guard are now stationed overseas in Iraq and fighting in Operation Iraqi Freedom. Like all National Guardsmen, when they return from active duty they will resume their duties of working under the command of the Governor of Idaho.

What will their eligibility be for VA services, including health care and benefits, when they separate from active duty service?

Answer. Army National Guard personnel activated by Federal declaration and who served on active duty in a theater of combat operations which includes Operation Iraqi Freedom are eligible for hospital care, medical services, and nursing home care. Public Law 105–368 amended title 38, United States Code, to authorize VA to provide combat veterans with care for conditions potentially related to their combat service for a 2 year period following discharge. Care is cost-free for conditions that cannot be disassociated from combat service. Care for other conditions is subject to applicable copayments. Veterans who enroll with VA under this authority retain enrollment eligibility, regardless of any enrollment restriction that may be in effect after this 2-year post discharge period. Combat veterans who choose not to enroll with VA during the 2-year period would be able to enroll in the future only if they are otherwise eligible to enroll.

In addition to health care benefits, they are also eligible for a full array of benefits offered through the Veterans Benefits Administration (VBA) to include:

- Disability Benefits
- Education and Training Benefits
- Vocational Rehabilitation and Employment
- Home Loans
- Life Insurance
- Burial Benefits
- Dependents' and Survivors' Benefits

Question. Does the Department have any programs in place that will continue to follow these Guardsmen after their completion of their combat mission and they return home to a civilian life?

Answer. Under 38 U.S.C. § 1710(e)(1)(D) and § 1710(e)(3)(C), OIF/OEF veterans may enroll in the VA health care system and, for a 2-year period following the date of their separation from active duty, receive VA health care without co-payment requirements for conditions that are or may be related to their combat service. After the end of the 2-year period, they may continue their enrollment but may be subject to any applicable co-payment requirements. For OIF/OEF veterans who do not enroll with VA during the 2-year post-discharge period, eligibility for enrollment and subsequent health care is, of course, subject to such factors as a service connected disability rating, VA pension status, catastrophic disability determination, or financial circumstances.

OIF and OEF veterans have sought VA health care for a wide-variety of physical and psychological problems. The most common health problems have been musculo-skeletal ailments (principally joint and back disorders); diseases of the digestive system (with teeth and gum problems predominating); and mental disorders (predominantly adjustment reactions). The medical issues we have seen to date are those we would expect to see in young, active, military populations, and no particular health problem stands out among these veterans at present. We will continue to monitor the health status of recent OIF and OEF veterans to ensure that VA aligns its health care programs to meet their needs.

Following is a brief description of VA initiatives that have been developed in response to the service needs of veterans from Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF). Many of these are brand new programs that were developed to meet these needs. All of them represent “lessons learned” from VA’s experiences responding to the health care and other benefits needs of veterans returning from the 1991 Gulf War and from the Vietnam War before that.

Immediate Health Care Needs for Combat Veterans.—In response to immediate health concerns for OIF and OEF veterans, on March 26 and 27, 2003, VA developed a program called “Caring for the War Wounded,” which was broadcast over the VA Knowledge Network satellite broadcast system. This program provided timely and relevant information about the anticipated health care needs of veterans of the current conflict in Iraq, included VA experts on treatments for traumatic injuries; chemical warfare agent health effects; infectious diseases; radiological health effects; and post-deployment readjustment health concerns, and was converted into a new Veterans Health Initiative (VHI) health care provider independent study guide, called “Caring for the War Wounded,” which is available online at vaww.va.gov/VHI/ and on the Internet at <http://www.appc1.va.gov/vhi/>.

New Clinical Guidelines for Combat Veteran Health Care.—In collaboration with DOD, VA developed two Clinical Practice Guidelines on combat veteran health issues, including one general guideline to post-deployment health, and a second dealing with unexplained pain and fatigue. The new clinical guidelines give our health care providers the best medical evidence for diagnoses and treatment. VA highly recommends these for the evaluation and care of all returning combat veterans, including veterans from OIF and OEF. The value of the guidelines in providing care to returning veterans is described in a video “The Epic of Gilgamesh: Clinical Practice Guidelines for Post-Deployment Health Evaluation and Management,” at www.va.gov/Gilgamesh.

New Specialized Combat Veteran Health Care Program.—In 2001, VA established two new War Related Illness and Injury Study Centers (WRIISCs) at the Washington, DC, and East Orange, NJ, VAMCs. Today, the WRIISCs are providing specialized health care for combat veterans from all deployments who experience difficult to diagnose but disabling illnesses. Concerns about unexplained illness are seen after all deployments including OIF/OEF, but VA is building on our understand of these illnesses. More information is available online at www.va.gov/environagents under the heading “WRIISC Referral Eligibility Information.”

Expanded Education on Combat Health Care for VA Providers.—In addition to the programs already described, VA has developed several Veterans Health Initiative

(VHI) Independent Study Guides relevant to veterans returning from Iraq and Afghanistan:

- “A Guide to Gulf War Veterans Health” was originally on health care for combat veterans from the 1991 Gulf War. The product, written for clinicians, veterans and their families, remains very relevant for OIF and OEF combat veterans because many of the hazardous exposures are the same.
- “Endemic Infectious Diseases of Southwest Asia” provides information for health care providers about the infectious disease risks in Southwest Asia, particularly in Afghanistan and Iraq. The emphasis is on diseases not typically seen in North America.
- “Health Effects from Chemical, Biological and Radiological Weapons” was developed to improve recognition of health issues related to chemical, biological and radiological weapons and agents.
- “Military Sexual Trauma” was developed to improve recognitions and treatment of health problems related to military sexual trauma, including sexual assault and harassment.
- “Post-Traumatic Stress Disorder: Implications for Primary Care” is an introduction to PTSD diagnosis, treatment, referrals, support and education, as well as awareness and understanding of veterans who suffer from this illness.
- “Traumatic Amputation and Prosthetics” includes information about patients who experience traumatic amputation during military service, their rehabilitation, primary and long-term care, prosthetic, clinical and administrative issues.
- “Traumatic Brain Injury” presents an overview of TBI issues that primary care practitioners may encounter when providing care to veterans and active duty military personnel.

All are available in print, CD ROM, and on the web at www.va.gov/VHI.

Outreach to Combat Veterans.—VA has many new products to offer combat veterans and their families.

- The Secretary of Veterans Affairs sends a letter to every newly separated OIF and OEF veteran, based on records for these veterans provided to VA by DOD. The letter thanks the veteran for their service, welcomes them home, and provides basic information about health care and other benefits provided by VA.
- In collaboration with DOD, VA published and distributed one million copies of a new short brochure called “A Summary of VA Benefits for National Guard and Reservists Personnel.” The new brochure does a tremendous job of summarizing health care and other benefits available to this special population of combat veterans upon their return to civilian life (also available online at www.va.gov/EnvironAgents).
- “Health Care and Assistance for U.S. Veterans of Operation Iraqi Freedom” is a new brochure on basic health issues for that deployment (also at www.va.gov/EnvironAgents).
- “OIF and OEF Review” is a new newsletter mailed to all separated OIF and OEF veterans and their families, on VA health care and assistance programs for these newest veterans (online at www.va.gov/EnvironAgents).
- “VA Health Care and Benefits Information for Veterans” is a new wallet care that succinctly summarizes all VA health and other benefits for veterans, along with contact information, in a single, wallet-sized card for easy reference (also at www.va.gov/EnvironAgents).

Special Depleted Uranium (DU) Program.—OIF veterans concerned about possible exposure to depleted uranium can be evaluated using a special DU exposure protocol that VA began after the 1991 Gulf War. This program offers free DU urine screening tests by referral from VA primary care physicians to veterans who have concerns about their possible exposure to this agent.

Combat Veteran Health Status Surveillance.—Today, we can monitor the overall health status of combat veterans very efficiently by using VA’s electronic inpatient and outpatient medical records. This surveillance summarizes every single visit by a combat veteran including all medical diagnoses. VA has developed a new Clinical Reminder (part of VA’s computerized reminder system) to assist VA primary care clinicians in providing timely and appropriate care to new combat veterans.

Question. What resources are being devoted this year to put into effect the co-location of the Boise VA Medical Center and Regional Office? What are projected for next year?

Answer. In fiscal year 2005, staff resources in VBA will accomplish the following:

- Secure a letter from the GSA initiating the transfer of the 2.13 acre parcel to VA and get VA Secretary’s signature accepting transfer and control of the property.
- Complete a concept paper for the business case for a project to construct a new office building for the Boise Regional Office on the subject property.

- Complete an Exhibit 300 business case application for a project to construct a new office building for the Boise Regional Office on the subject property.
- Select an Architect/Engineer (A/E) firm to prepare a preliminary design and a Request for Proposals (RFP) for a Design-Build contract for the construction of the new office building. Funds from the Minor Construction program will be allocated to this contract.
- Begin the preliminary design for the new office building.
- In fiscal year 2006, staff resources in VBA will accomplish the following:
 - Complete the preliminary design and the RFP for the Design-Build contract.
 - Work with the VHA contracting officer to prepare the solicitation for the Design-Build contract.
 - Advertise the project in the FedBizOps for a contract award in early fiscal year 2007.
 - Identify the necessary minor construction funds in the fiscal year 2007 budget for the construction contract.

PRESCRIPTION DRUGS

Question. Last year, Congress enacted the Medicare Modernization Act which, for the first time, provides Medicare beneficiaries with prescription drug coverage.

Has VA conducted any assessments of the impact this legislation will have on the number of veterans who rely on VA health care to provide prescription drug coverage? If so, what has this assessment shown?

Answer. Milliman, Inc., the private-sector actuarial firm that develops projections of veteran demand for VA health care, has advised VA that the impact of the new Medicare drug benefit on VA enrollment, utilization, and expenditures is expected to be minimal. The biggest impact is expected to come from reductions in employer-based prescription drug coverage. However, the impact may not become significant until as late as 2016 since the most recent cutbacks have been for future retirees only; those eligible for retirement (over age 55) have been grandfathered into employer's current plan. Based on recent estimates of retirees who could lose benefits, enrollment in VA health care could increase by an estimated 35,000 within the 10–15 year period following the start of the Medicare prescription drug benefit. VA currently treats about 5.2 million veterans per year.

Question. Does VA believe that there is a way VA can work in concert with Medicare on the provisions of prescription medications for Medicare-eligible veterans? If so, has VA leadership approached the leadership of the Centers for Medicare and Medicaid Services to discuss and proposals?

Answer. VA believes that VA and the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) can work together so that beneficiaries who chose to use both VA and CMS prescription benefits do so in a safe and cost-effective manner.

To that end, VA Pharmacy Benefits Management staff and staff from the Centers for Medicare and Medicaid Services (CMS) have had preliminary discussions about potential VA /CMS patient safety and electronic prescribing initiatives.

VA will continue to provide prescription medications to enrolled veteran patients who are also eligible for Medicare. VA will continue to provide this prescription coverage to Medicare eligible veterans who chose VA as their health care provider, even after Medicare Part D is fully implemented.

STATE HOME PER DIEM PROPOSALS

Question. The State Home program, by most accounts, has been a successful partnership between the Federal and State governments for the care of aging veterans. Yet VA proposes to modify its past per diem payment policies—a change in policy that VA says will reduce the number of State home beds by more than 50 percent.

Why does VA want the States to reduce the number of State home beds? Even if VA does not want to provide institutional care to the non-service-connected, why does it want to discourage States from meeting that need?

Answer. VA is not proposing that the States reduce the number of State Home beds. State Veterans Homes are owned, operated, and financed by the States. VA provides limited financial assistance to the States in the form of per diem payments for nursing home, hospital, domiciliary, and adult day healthcare. Only the nursing home per diem is affected by the fiscal year 2006 budget proposal. The cost of care in State Veterans Homes varies from State to State, as does the amount of assistance provided to the Homes by the State. Currently, costs not covered by the VA per diem payments are covered from various sources, including the veterans themselves and State and Federal programs such as Medicare and Medicaid. VA's proposal could increase the share of costs borne by the State, depending upon the

State's own policies for coverage of the costs of State Home care. State Homes will continue operations to the extent that individual States discharge their fiscal responsibility for the operation and management of the Homes. VA does not have information on the plans of individual States to respond to the change in VA policy.

The average daily census in State Veterans Homes on whose behalf VA pays a per diem payment would decrease from 17,328 to 7,217 from fiscal year 2004 to fiscal year 2006. Over the same period, however, VA is projecting a substantial increase in both workload and funding for the non-institutional programs it supports. The average daily census in these home and community-based care (HCBC) programs is projected to rise from 25,523 in fiscal year 2004 to 35,540 in fiscal year 2006 (a 39 percent increase). Funding is projected to increase from \$287.3 million in fiscal year 2004 to over \$400 million in fiscal year 2006 (also a 39 percent increase). The projected increases in HCBC programs will serve to offset some of the reductions in nursing home care. VA believes the proposals on long-term care in this budget provide an appropriate balance between congressionally mandated nursing home services and the national trend toward increased use of non-institutional home and community-based services in preference to nursing home care. HCBC is preferred by most patients and their families and is more cost effective than inpatient care.

Question. Does VA assume bed closures will occur when payments for non-priority veterans (those without a service-connection) cease? Does VA believe that it has the legal authority to simply stop paying per diem payments to States for the care of veterans VA doesn't define as a priority?

Answer. VA is seeking legislative authority to align VA per diem payments to State veterans homes with VA's revised long-term care eligibility policy. Enactment of this proposal would ensure fairness and consistency in how VA treats veterans needing long-term care across all venues, including VA nursing homes, community nursing homes, and State nursing homes. We are unable to comment on how the individual States would respond to this change in policy.

Question. It seems to me that VA encouraged the States to build long-term care capacity by offering them construction subsidies. Would a change in the "rules of the game" after these State homes have been built not break the bargain that the Federal Government has struck with the States?

Answer. The VA State Home Construction Grant Program assists States in construction and renovation costs for nursing homes, domiciliary facilities and adult day healthcare. The program does not require the state to participate in the State Veteran Home Per Diem Grant Program, or guarantee the ongoing subsidy of per diem payments. The law is separate for each of the programs.

QUESTIONS SUBMITTED BY SENATOR DIANNE FEINSTEIN

STATE EXTENDED CARE FACILITIES GRANTS PROGRAM

Question. Today I asked about the decision to impose a 1-year moratorium on funding for the State Extended Care Facilities Grants program. Specifically, I asked for the rationale behind the decision and if he could explain its impact on States, such as California, which critically need additional veterans homes. I also inquired about whether the moratorium was really a plan to ultimately phase out funding for State veterans homes.

Can you explain to this committee why it is necessary to impose a 1-year moratorium on grants for construction of long-term extended care facilities when there is such a need for VA homes throughout this Nation?

Answer. The fiscal year 2006 VA budget proposes a 1-year moratorium on new grants to States for construction and renovation of extended care facilities. This will permit VA to complete an assessment of its nationwide institutional long-term care infrastructure and ensure that future construction aligns with the areas of greatest projected need. Grants that have already been awarded will not be affected by the 1-year moratorium.

Question. How would this moratorium affect the current priorities list for funding under this program?

Answer. VA has already committed to all planned fiscal year 2005 projects on the current Priority List. The States are currently completing the requirements for fiscal year 2005 grant awards. VA has committed the maximum fiscal year 2005 appropriations and the remaining fiscal year 2004 carryover funds to these projects.

Question. Do you anticipate altering this priorities list for fiscal year 2007?

Answer. The Priority List is revised annually, as of August 15th. All new and existing pending projects are ranked and included in the annual list. Once approved

by the Secretary, the list is used to identify ranked projects and commit funding for projects for that fiscal year award or to finalize conditionally approved projects. For fiscal year 2007, VA would follow the same procedures and commit funds available at that time to the projects in rank order.

Question. Can you provide this committee a better sense of your plans going forward and how it would affect funding for future State veterans home projects?

Answer. VA will complete its assessment for our nationwide long-term care infrastructure and assess the construction grants program priority during the fiscal year 2007 budget deliberations.

Question. Is the Administration considering a plan to phase out grant funding for State veterans homes?

Answer. The Administration will reevaluate the funding for the State Extended Care Facilities Grant program during the fiscal year 2007 budget deliberations.

Question. I also know that the State of California plans to request \$125 million in fiscal year 2007 under this grant program to fund its largest project to date, the Greater Los Angeles-Ventura County Home, which includes 3 separate facilities. How would the 1-year moratorium impact funding for this project?

Answer. The fiscal year 2006 VA budget proposes a 1-year moratorium on new grants to States for construction and renovation of extended care facilities. This will permit VA to complete an assessment of its nationwide institutional long-term care infrastructure and ensure that future construction aligns with the areas of greatest projected need. Grants that have already been awarded will not be affected by the 1-year moratorium.

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MEDICAL CARE PROGRAMS

Question. The Administration's overall request for Medical Care Programs is \$30.8 billion. However, if you discount the collections that you anticipate through the Medical Care Collections Fund, as well as the new fees that would be imposed on thousands of veterans, you are left with a base appropriation request for Medical Care Programs of \$28.2 billion. Which is only 0.4 percent increase over last year's enacted level. This falls well below the standard compounded medical inflation rate of 3.9 percent.

Do you believe that this is sufficient funding given the number of veterans returning home from the Middle East?

Answer. Yes, VA requested the necessary resources in fiscal year 2006 to continue meeting the needs of all veterans who have suffered injuries or diseases as a result of the conflicts in Iraq and Afghanistan.

MEDICAL AND PROSTHETIC RESEARCH

Question. I am happy to see the fiscal year 2006 budget calling for \$1.2 billion for prosthetics and sensory aids, a \$100 million increase over fiscal year 2005, however, I am concerned about the cut to Medical and Prosthetic Research (from \$402 million in fiscal year 2005 to \$393 million in fiscal year 2006). As you know, 11,000 men and women of our Armed Forces have suffered injuries in Iraq and Afghanistan and to many of them functional and efficient prosthetics will make all the difference in the world. The VA has made tremendous progress in developing new, state-of-the-art prosthetics, but we should not stop there. We should continue to fund a robust prosthetic research program. None of us ever wants to have to explain to one of our soldiers who has lost a leg, that more could have been done.

Can you please explain why the fiscal year 2006 budget reduces money in this area?

Answer. The VA research program is funded by three funding sources—direct appropriation, private grant funding, and Federal grant funding. The overall estimated funding is expected to rise in fiscal year 2006 by \$49 million or 3.1 percent to \$1.7 billion. The total research program level of effort and number of projects for vet-

erans will be at a similar level to that of fiscal year 2005. VA, like other Departments across Government, must be a responsible partner in assisting to achieve many important, competing priorities. Reducing the deficit for the current and long-term strength of this country is very important. Therefore, tough choices had to be made in maximizing resource impact in a slower growth environment. Medical care for those who need VA the most and timely, consistent benefits delivery are also crucial services for veterans. A balanced approach in wisely investing resources was a guiding principle in the development of this budget. Research that enhances veterans' lives continues to be an important priority of the VA.

In terms of prosthetics research, VA is expanding its support of multidisciplinary research approaches and examination of enabling technologies that aim to ease the physical and psychological pain of veterans. The VA Office of Research and Development (ORD) is collaborating with clinical services to evaluate the delivery of care and help identify optimal utilization of all patient services including durable medical equipment for veterans. VA is also dedicated to the generation of the rigorous data required to formulate policy and establish clinical care guidelines.

In addition to evaluating existing practices, VA is expanding upon its long-standing support for advances in surgical approaches to primary amputation to include operative revision and limb lengthening procedures that can potentially aid in fitting prostheses and enhance function beyond what is now possible. VA is also aggressively examining other techniques such as osseointegration, a procedure that replaces missing limbs with titanium rods inserted directly into residual bone.

Examples of ongoing projects include:

- partnerships with the Department of Defense and Walter Reed Army Medical Center to investigate immediate concerns of returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans;
- trials of current prosthetic designs and improvements for future designs;
- use of telerehabilitation to prevent complications resulting from amputation;
- bio-hybrid limb projects using regenerated tissue, lengthened bone, internal and external titanium implants, and sensors that allow amputees to use brain signals and residual limb musculature to move their prostheses;
- new uses for sensory and implanted control devices and biological sensors for the detection of health and function including microelectro-mechanical or nanotechnologies;
- evaluation and updates of rehabilitation strategies; and
- examination of how best to implement research results and develop best practices across VHA.

MEFLOQUINE (LARIAM) USE

Question. As you may be aware, I have been concerned about the Department of Defense's (DOD) use of the anti-malarial drug mefloquine (Lariam) and its impact on our service members. In June 2004, I wrote your predecessor Secretary Principi with my concerns about the use of this drug, especially after hearing that several service members had been diagnosed with permanent brainstem and vestibular damage from mefloquine toxicity. Shortly thereafter, the Veterans Health Administration issued an Information Letter outlining the potential for serious complications associated with mefloquine.

The VA's health care system is likely to be the first line of treatment for service members who have returned from active duty. And the VA will bear much of the cost and burden of treatment and rehabilitation for service members with mefloquine toxicity.

Knowing that mefloquine was issued to active duty military in the wars in Afghanistan and Iraq, will you take steps to actively monitor the impact this drug has on these veterans' health conditions?

Answer. VA is actively monitoring the DOD studies of possible adverse effects of mefloquine and is following the medical literature and reported studies. At DOD's invitation, VA participated in a special meeting of DOD's Armed Forces Epidemiology Board that DOD charged with helping to plan studies on long-term health effects among OIF and OEF veterans from mefloquine. VA regularly participates in DOD briefings on the status of DOD's studies on this health issue. In addition, VA developed an Under Secretary for Health Information Letter that reviewed medical and scientific literature on known health effects from taking mefloquine (IL 10-2004-007), "Possible Long-Term Health Effects From The Malarial Prophylaxis Mefloquine (Lariam)," June 23, 2004). This information letter alerts VA health care providers to the range of possible long-term health effects from taking mefloquine. It is important to note that mefloquine is an FDA approved drug that is widely used in the civilian community and not just in the military.

Question. In the past, I have suggested that it is necessary for the Department of Defense (DOD) to immediately implement a program that will allow soldiers to report side effects and be evaluated, diagnosed and treated without fear of reprisal and that reporting such side effects not negatively affect their military service or careers. Would you be willing to implement such a program at the Department of Veterans' Affairs and will you work with DOD on such a program?

Answer. Mefloquine side effects begin while a person is actually taking the drug—in this case, while they were still on active duty. Side effects appearing while a service member was still on active duty may be recorded by DOD health care providers. Few if any veterans are still taking malaria prophylaxis after leaving active military duty and then enrolling for VA health care. VA's Information Letter on mefloquine side effects (IL 10-2004-007) is intended to alert VA health care providers to any side effects that may persist in veterans after they have separated from military service. Any relevant findings then may be entered into the veteran's health record. Moreover, no health problem identified by the VA would result in reprisals or harm to a veterans' career because of the strict confidentiality and professionalism within the VA health care system.

Question. As you may know, DOD is undertaking an investigation of the impact of mefloquine use by service members. What has the VA's role been in this investigation and has the Department participated in DOD's investigation?

Answer. VA has been briefed on this study and actively supports DOD's efforts. VA is actively monitoring the DOD studies of possible adverse effects of mefloquine and is following the medical literature and reported studies. At DOD's invitation, VA participated in a special meeting of DOD's Armed Forces Epidemiology Board that DOD charged with helping to plan studies on long-term health effects among OIF and OEF veterans from mefloquine. VA regularly participates in briefings on the status of various DOD studies on this topic.

ENROLLMENT FEES

Question. The budget submission assumes a \$250 enrollment fee on Priority 7 and 8 veterans.

How many veterans will have to pay the \$250 enrollment fee? How many veterans will leave VA if they have to pay this premium? AND How does the VA plan to collect this fee from veterans?

Answer. In 2006, 1.26 million Priority 7 and 8 veterans are expected to pay the \$250 annual enrollment fee. This policy is expected to reduce enrollment for Priority 7 and 8 veterans by 1.1 million and reduce the number of Priority 7 and 8 unique patients by 213,000.

VA will notify all Priority 7 and 8 enrolled veterans of the requirement to pay the enrollment fee by letter with appropriate payment guidance. Veterans will be provided a specified period of time to pay the entire fee or to agree to a quarterly payment schedule with payment of the first quarterly payment by a specified date. Payments will be processed through a central "lockbox" utility separate from, but similar to, existing processes used for receipt of veteran co-payments.

PHARMACY CO-PAY INCREASE

Question. The budget includes an assumption that the pharmacy co-payments for certain veterans will increase from \$7 to \$15.

How did VA choose \$15 as the amount for the prescription drug co-payment?

Answer. This and the other proposed policies in VA's 2006 President's budget were designed to ensure that VA is able to fulfill its core mission—providing timely access to high-quality health care to veterans with serviced connected disabilities, low incomes, and those with special needs. The \$15 pharmacy co-payment proposal and other cost-sharing proposals would only affect higher income, better-insured veterans in the lowest priorities and have been strategically priced to refocus the VA system on those veterans who need us most. The \$15 drug co-pay would more closely align VA with other private and public health care plans.

RETURNING TROOPS

Question. There are new challenges arising to ensure that returning troops are receiving their entitled benefits and services as veterans. The new challenges include reaching every veteran.

What steps is the VA taking to reach out to all of our returning troops from Iraq and Afghanistan?

Answer. Returning troops are provided information about VA benefits and services and assistance in applying for these benefits through the following VA outreach programs.

Transition Assistance Program (TAP) and Other Military Services Briefings.—From October 2002 through January 2005, VBA military services coordinators conducted transition briefings and related personal interviews in the United States as reflected in the chart below. These briefings include pre- and post-deployment briefings for Reserve and National Guard members.

OVERALL BRIEFINGS

Fiscal year	Briefings	No. attendees	No. interviews
2003	5,368	197,082	97,352
2004	7,210	261,391	115,576
2005 ¹	2,263	79,105	34,106

¹ Through January 2005.

In addition to military services briefings in the United States, VBA representatives conduct briefings overseas under arrangement with the Department of Defense (DOD). VBA provides two tours each year with 6 to 7 VBA representatives providing this service for each tour. Each is home-based at a major military site and provides services at the site and surrounding areas. The countries serviced are England, Germany, Japan, and Italy. Korea is serviced by staff from the Benefits Delivery at Discharge office in Yong San. A representative from the St. Petersburg Regional Office provides that service for Guantanamo Bay. We were recently requested by DOD to add Bahrain to our overseas schedule beginning with the May 2005 tour. The following chart reflects statistics regarding overseas briefings:

OVERSEAS BRIEFINGS

Fiscal year	Briefings	No. attendees	No. interviews
2003	472	12,943	12,947
2004	624	15,183	6,544
2005 ¹	36	1,278	464

¹ Through January 2005.

Briefings for Reserve/Guard Members.—Outreach to Reserve/Guard members is part of the overall VBA outreach program. In peacetime, this outreach is generally accomplished on an “on call” or “as requested” basis. With the activation and deployment of large numbers of Reserve/Guard members following the September 11, 2001, attack on America, and the onset of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF), VBA outreach to this group has been greatly expanded. National and local contacts have been made with Reserve/Guard officials to schedule pre- and post-mobilization briefings for their members. Returning Reserve/Guard members can also elect to attend the formal 3-day TAP workshops. The following data on Reserve/Guard briefings is a subset of the overall briefings data provided in the first chart:

RESERVE/GUARD BRIEFINGS

Fiscal year	Briefings	No. attendees
2003	821	46,675
2004	1,399	88,366
2005 ¹	531	32,448

¹ Through January 2005.

Briefings Aboard Ships.—VA provided TAP briefings aboard the USS Constellation, the USS Enterprise, and the USS George Washington on their return from the Persian Gulf to the United States. VBA will continue to support requests from the Department of the Navy for TAP workshops aboard ships.

Seamless Transition—Military Treatment Facilities (MTFs)

In 2003, VA began placing Veterans Service Representatives at key military treatment facilities (MTFs) where severely wounded service members from OEF/OIF are frequently sent. Representatives of the VBA Benefits Delivery at Discharge office in Germany work closely with the staff at the Landstuhl Army Medical Center to assist returning injured service members who are patients at that facility and family members temporarily residing at the Fisher House.

Since March 2003, a VBA OEF/OIF coordinator is assigned for each MTF. Full time staff is assigned to the Walter Reed Army Medical Center in Washington, D.C., and the Bethesda Naval Medical Center in Maryland. Similar teams work with patients and family members at three other MTFs serving as key medical centers for seriously wounded returning troops: Eisenhower, Brooke, and Madigan Army Medical Centers. Itinerant service is conducted at all other major military treatment facilities. As of January 2005, over 4,500 hospitalized returning service members were assisted through this program at Walter Reed, Bethesda, Eisenhower, Brooke, and Madigan. Since March 2003, each claim from a seriously disabled OEF/OIF veteran has been case managed for seamless and expeditious processing.

Web Page.—As part of the Seamless Transition effort, VBA created a new web page for OEF/OIF, directly accessible from the VA homepage. Information specific to Reserve/Guard members who were activated is included, as well as links to other Federal benefits of interest to returning service members. The web page has been accessed over 340,000 times since its activation in December 2003.

Benefits Delivery at Discharge (BDD).—VA's BDD program operates in concert with the military services outreach program. Under BDD, service members can apply for disability compensation within 180 days before discharge. The required physical examinations are conducted and service medical records are reviewed prior to discharge. The goal is to adjudicate claims within 30 days following discharge. Upon receipt of the claimant's DD Form 214 (Report of Release from Active Military Service), benefits are immediately authorized so that the recently separated veteran can receive his/her first disability check the month following the month of discharge or shortly thereafter. Currently, 141 military installations worldwide participate in this program, including two sites in Germany and three in Korea. Approximately 26,000 BDD claims were finalized in fiscal year 2003; 40,000 in fiscal year 2004; and 12,000 in fiscal year 2005 to date.

Recently-Separated Veterans

Veterans Assistance at Discharge System (VADS).—All separating and retiring service members (including Reserve/Guard members) receive a "Welcome Home Package" that includes a letter from the Secretary, a copy of VA Pamphlet 21-00-1, A Summary of VA Benefits, and VA Form 21-0501, Veterans Benefits Timetable, through VADS. Similar information is again mailed with a 6-month follow-up letter.

Secretary's Outreach Letter to Returning Service Members.—Outreach letters from the Secretary of Veterans Affairs have been sent to approximately 240,000 returning service members who have separated/retired from active duty. Enclosed with the letters are copies of VA Pamphlet 21-00-1, A Summary of VA Benefits, and IB 10-164, A Summary of VA Benefits for National Guard and Reserve Personnel.

Question. It is imperative for the Department of Defense and the Veterans Administration to work closely to ensure that troops returning from Iraq and Afghanistan receive the benefits and assistance to which they are entitled.

How do the VA and Department of Defense coordinate information on returning troops? Is the VA getting timely and accurate information from the Department of Defense on returning troops? In what manner is information on returning troops transmitted to the VA from DOD?

Answer. VA's Office of the General Counsel continues to negotiate with DOD to obtain the complete range of returning service member data VA needs for identification, tracking, and statistical/reporting purposes. A formal Memorandum of Agreement (MOA) between VA and DOD is still pending.

However, a preliminary agreement has been reached that will allow VA to receive a flow of basic data from DOD on a regular basis, thus facilitating a seamless transition of seriously disabled service members into the VA system. As part of this agreement, VA will begin receiving data on those disabled service members who are entering the Physical Evaluation Board process.

Question. What is VA doing to reach out to reservists and national guardsmen that were activated and deployed who are now returning home and are entitled to benefits?

Answer. See the response above to the question concerning outreach to all of our returning troops from Iraq and Afghanistan. Outreach to reservists and National Guard members is addressed in that response.

COLORECTAL CANCER

Question. Colorectal cancer is the second leading cause of cancer deaths in the United States, yet survival rates are greater than 90 percent among those whose cancer is detected early.

Roughly, what percentage of patients who receive their health care at a Veterans Administration facility undergoes routine screening for colon cancer?

Answer. Screening for colorectal cancer in the VA has increased significantly. In fiscal year 2004, 74 percent of the established veterans (those who received care from VA in the past 12 months) requiring colorectal screening received it. The percentage of veterans requiring colorectal screening has been increasing. In fiscal year 1996, the percentage was 34 percent; in fiscal year 2001, 60 percent; in fiscal year 2002, 64 percent; and in fiscal year 2003, 67 percent.

Question. Many patients resist colon cancer screening tests due to the anticipated discomfort and inconvenience. On the other hand, those who choose to be screened by colonoscopy—the most accurate of the current modalities—must often wait months for access to a surgical suite and trained gastroenterologist. On average, how long must veterans wait for a screening colonoscopy at veterans' hospitals and clinics?

Answer. Diagnostic colonoscopies (for patients with symptoms or positive findings) are scheduled as soon as possible with an average wait time of 32 days. Screening colonoscopies (for asymptomatic patients) are scheduled for the next available appointment. VA does not measure specifically for screening colonoscopies, but we are providing the following waiting time information for diagnostic colonoscopies and GI clinics (which includes upper endoscopies and colonoscopies).

VHA has completed 20,186 diagnostic colonoscopies for the first 4 months of fiscal year 2005 with an average wait time from the patient's desired appointment date (from the date appointment created if a new patient) of 32 days. Half the appointments were completed within 17 days (median wait time was 17 days).

VHA completed 55,933 appointments for the GI Endoscopy Clinic for the first 4 months of fiscal year 2005. The average wait time from the patient's desired appointment date (or the date the appointment created if a new patient) was 31 days. Half were completed within 7 days (median wait time was 7 days).

Question. In the fiscal year 2004 Omnibus Appropriation, Congress urged the VA to pursue aggressively new technologies available for diagnosing colorectal cancer that are less invasive, less expensive and provide equal or better evaluations than older methods. What has the Administration done in response?

Answer. VA is committed to improving the colorectal screening methods and overall percentage of screened veterans. In general, VA follows the evidence-based review of the U.S. Preventive Services Task Force (USPSTF) in screening for colon cancer, which is found online at <http://www.ahrq.gov/clinic/uspstf/uspscolo.htm>. As noted in their conclusion, "It is unclear whether the increased accuracy of colonoscopy compared with alternative screening methods (for example, the identification of lesions that FOBT [fecal occult blood test] and flexible sigmoidoscopy would not detect) offsets the procedure's additional complications, inconvenience, and costs." However, the Task Force also found insufficient evidence that newer screening technologies (for example, computed tomographic colography) are effective in improving health outcomes. VA is still looking for evidence to show benefit of the newer technologies and works closely with USPSTF.

VA offers screening for colon cancer using all recognized effective modalities. If a patient experiences symptoms or has positive findings on a screening by any other modality than colonoscopy, then a diagnostic colonoscopy is scheduled.

QUESTIONS SUBMITTED BY SENATOR TIM JOHNSON

MEDICAL HEALTH CARE

Question. Recently, I introduced the Assured Funding for Veterans Health Care Act (S. 331). This bill would ensure adequate veterans health care funding is available by making VA medical care mandatory spending. This legislation has been endorsed by all of the leading veterans organizations.

Do you support this legislation, and if not, why?

Answer. An analysis of your proposed legislation would need to be made in light of the President's fiscal year 2006 budget submission and overall guidance on the budget.

That said, however, VA has not supported similar legislation introduced in previous Congresses. While mandatory funding may appear to be an interesting approach to provide resources to America's veterans, VA has some serious concerns about its applicability to a very complex, highly dynamic and sophisticated health care delivery system such as the VA. A mandatory funding approach could inhibit VA's ability to appropriately react to rapid advances in medical science and technology and the development of new drugs and equipment have dramatically changed treatment modalities and the manner in which health care is delivered over the last decade. It could also fail to keep up with the demographic or health status changes

among veterans and possibly create a false impression that VA would have full funding to enroll all veterans. Therefore, a mandatory funding system based upon static or untimely fixed indices may not be the best way to ensure that adequate resources are available to maintain the high quality of care that VA has become renowned for to care for our Nation's veterans.

Former VA Secretary Principi testified that the VA needs at least a 13 percent-14 percent increase in medical funding each year just to maintain current health care services for veterans. The Bush Administration's fiscal year 2006 budget request for VA medical care does not include such an increase in funding.

Question. If the Administration's proposed VA health care funding levels were enacted would there be a decrease in any veterans health care services or was Secretary Principi incorrect in his analysis?

Answer. The Veterans Health Administration has received record budget increases over the last 4 years. With this budget proposal, the President, working in partnership with Congress, will have increased health care funding for veterans by more than 47 percent since fiscal year 2001.

In fiscal year 2006, VA plans to operate within the level of the President's Budget request of \$30.7 billion (including \$750 million for construction and \$2.6 billion for collections) for the medical care program, an increase of 2.5 percent over the enacted level of fiscal year 2005. With this funding level, VA will be able to treat more than 5.2 million patients and VA will focus its health care resources on veterans with service-connected disabled conditions, those with lower incomes, and veterans needing our specialized services. In 2006, nearly 80 percent of veteran patients are expected to be high priority—those veterans who count on VA the most.

The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans—a 15-member panel that was assembled to study the health care needs of our Nation's veterans—released their recommendations in a report on May 28, 2003. The report stated clearly that the most pressing problem facing the VA health system is that funding is not keeping pace with the need for care. While the panel encouraged greater cooperation between the VA and the Department of Defense's health care system, they recognized this would not address the fundamental problem. Instead, the panel recommended two solutions to the VA's funding problems: create an independent board which will set the level of VA health care spending each year, or establish a formula and provide a mandatory amount of funding for VA medical care.

Question. Do you plan to endorse or act on either of these recommendations from the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans?

Answer. Thank you for your question regarding the endorsement of mandatory health care funding for the Department of Veterans Affairs. We are most appreciative of your interest and concern to ensure that sufficient resources are available to provide high-quality health care to our Nation's veterans.

The discretionary legislative process currently in place has provided for substantial increases for the Department of Veterans Affairs health care budget over the past several years, nearly a 47 percent increase since 2001.

While mandatory funding may appear to be an interesting approach to provide resources to America's veterans, VA has some serious concerns about its applicability to a very complex, highly dynamic and sophisticated health care delivery system such as the VA. A mandatory funding approach could inhibit VA's ability to appropriately react to rapid advances in medical science and technology and the development of new drugs and equipment have dramatically changed treatment modalities and the manner in which health care is delivered over the last decade. It could also fail to keep up with the demographic or health status changes among veterans and possibly create a false impression that VA would have full funding to enroll all veterans. Therefore, a mandatory funding system based upon static or untimely fixed indices may not be the best way to ensure that adequate resources are available to maintain the high quality of care that VA has become renowned for to care for our Nation's veterans.

Since 2001 VA has been utilizing a professional actuarial model as a basis for the formulation of the budget. These actuarial forecasts also have been integrated into the VHA's capital and strategic planning processes. This demand model has contributed significantly to the achievement of VA's strategic goals and performance measures to provide enrolled veterans with access to timely, quality care. This has allowed decision makers to ensure that resources are available to meet the expected demand or develop policies to address any gap between the expected demand and available resources. This professional, businesslike approach to forecasting is similar to that employed by many large private-sector organizations such as major insurance corporations throughout our country. The model utilized is highly sophisticated

and is capable of predicting patient utilization, reliance, morbidity, etc. We continue to revise and update the model in order to assure that future projections will be as accurate as possible.

VA therefore strongly believes that the utilization of a highly professional, scientific, actuarial model is a much more professional, effective, and businesslike approach for budget formulation and forecasting than those like mandatory funding.

QUESTIONS SUBMITTED BY SENATOR MARY L. LANDRIEU

Question. In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. The PTF Task Force. This task force was charged to identify ways to improve health care delivery to VA and Department of Defense beneficiaries. One important recommendation of this task force was recently addressed in a letter sent to the VA Secretary and to Defense Secretary Rumsfeld. This recommendation directed the VA to develop electronic medical records that are interoperable and bi-directional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. These electronic medical records should also include an easily transferable electronic DD214 forwarded from the DOD to the VA. This would allow the VA to expedite the claims process and give the service member faster access to health care and benefits.

What progress has been made towards accomplishing this task which is necessary in order to ensure that servicemen and women have a seamless transition from military to civilian life?

Answer. The Defense Personnel Records Image Retrieval System (DPRIS) is currently operational between the Department of Veterans Affairs, Veterans Benefits Administration (over 3,000 users) and the Official Military Personnel File systems of the Army, Navy, and Marine Corps. DPRIS connects to the VA Personnel Information Exchange System (PIES) and allows VA users to electronically request and receive official military personnel documentation. The interface with the Air Force will be completed in June 2005, and the VA will be able to retrieve imaged copies of military personnel records from the Air Force by September 2005. All of these systems contain the DD214 and many additional military personnel documents that VA uses. The most commonly requested form is the DD214, and although the performance parameter for DPRIS is to return the requested documents to VA within 48 hours, it is currently operating in near real time. In addition to the interagency collaboration on DPRIS, DOD and VA are also collaborating on VA access to military personnel information that will be stored as data in the Defense Integrated Military Human Resources System (DIMHRS). VA requirements for military information have been an integral and on-going part of the requirements collection for DIMHRS, and the two departments are now moving into the technical integration phase which will determine the most efficient and expeditious way for VA to access information in DIMHRS when it comes on line in 2006. The electronic exchange of DD214 information will be fully implemented with DIMHRS.

Question. According to a New England Journal of Medicine study published on July 1, 2004, dealing with Mental Health Problems and Barriers to Care with respect to Service Members Returning From Combat Duty in Iraq and Afghanistan, 82 percent of veterans acknowledged a need for mental health treatment, however only 24 percent reported ever receiving any mental health treatment within 1 year after returning from combat. Among the concerns veterans reported after returning from combat, were depression, anxiety, post traumatic stress disorder and almost one third reported the misuse of alcohol. With thousands of service members returning from Iraq and Afghanistan this year, these numbers will increase significantly. As you know, often times symptoms of post traumatic stress do not manifest themselves for months or even years after returning from combat.

Given the importance of mental health issues and the impact that these concerns will have on not only the service member's entire quality of life, as well as the quality of life of his or her family and community, what programs has the VA in place at present to deal with these matters and what plans do you have to deal with the increased numbers who will require this type of health care?

Answer. Meeting the needs of our returning veterans and their families is among VA's highest priorities. VA has indeed anticipated and prepared for the increased numbers of those requiring mental health services. VA's approach toward the returning troops and their families emphasizes health promotion and preventive care principles. This approach is designed to identify and resolve problems in readjustment to civilian life, before they progress to problems requiring more intensive clin-

ical interaction. For those that require clinical interaction, VA provides state-of-the-art psychotherapy and psychopharmacology treatments.

Based on VA's experience and research we do not expect that a great majority of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans will suffer long-term consequences of their war zone experience. However, many likely will have some short-term reactions to the horrors of war. Of those who do develop mental/emotional problems, PTSD will not be the only problem to be addressed. VA provides comprehensive care for veterans with mental disorders through a continuum of services designed to meet patients' changing needs.

Major depression and substance abuse are two problems that can be anticipated, and these disorders carry with them significant risk for dangerous behaviors such as suicide and family violence. VA provides care through 144 specialized PTSD programs throughout the country along with 206 (soon to be 207) Readjustment Counseling Centers (RCS), often called Vet Centers. In addition, Outpatient Clinical PTSD Teams, Specialized Inpatient PTSD Programs, and Residential Treatment Programs are located across the Nation. There are PTSD programs in all States. VA's ongoing PTSD program evaluation indicates improvements in PTSD symptoms and functioning in patients treated by VA for PTSD. In fiscal year 2004, VA spent more than \$3 billion on the provision of treatment services (medical and psychiatric) to veterans with a mental illness.

The tasks for these teams are those of outreach, health promotion, consultation, and liaison. The working title for these programs is: Returning Veterans Outreach, Education and Care programs and there will be at least one program in every Veterans Integrated Service Network. VA's National Center for PTSD is creating an educational program entitled "PTSD 101" specifically for clinicians who will be hired into the new PTSD programs. There will be basic and advanced care modules. Linked to the concepts of the PTSD Clinical Practice Guideline and the Iraq Clinician War Guide, it will ensure the provision of the latest evidence-based care to veterans with PTSD and associated mental disorders.

Analysis of DOD data as of December 2004 shows that 244,054 troops had returned from Iraq, with 20 percent (48,733) receiving care in a VA medical center. Of those returned troops, 12,422 had a mental health diagnosis: 4,783 were previously diagnosed with PTSD, and 3,500 were diagnosed with a depressive disorder. An additional 2,082 veterans were diagnosed with PTSD at Vet Centers.

Readjustment Counseling Service takes the lead in providing outreach and counseling services through the 206 (soon to be 207) community-based centers throughout the United States. Fifty additional Global War on Terrorism counselors have been added to these centers to meet this need. In addition the Secretary has assigned authority to RCS to deliver bereavement counseling to those in need.

To position VA for future needs, we have allocated \$100 million in fiscal year 2005 to implement initiatives contained in the Department's Mental Health Strategic Plan. The President's fiscal year 2006 budget submission proposes an additional \$100 million for mental health initiatives in fiscal year 2006. These initiatives will benefit all veterans receiving mental health care from VA and include OEF/OIF outreach programs designed to provide preventive health services that should, in many instances, identify problems and address them before they require more extensive clinical intervention. These enhancements will also address increased clinical needs of returning veterans and existing veterans who come to VA for PTSD care.

Question. A core mission of the Department of Veterans Affairs is the provision of benefits to relieve the economic effects of disability upon veterans and their families. For those benefits to effectively fulfill their intended purpose the VA must process and adjudicate claims in a timely and accurate fashion. Rather than making headway and overcoming the chronic claims backlog and consequent protracted delays in claims disposition, the VA has lost ground to the problem, with the backlog of pending claims growing substantially larger. Historically, many underlying causes acted in concert to bring on this intractable problem. These dynamics acting in concert have been thoroughly detailed in several studies into the problem. While the problem has been exacerbated by lack of appropriate and decisive action, most of the causes can be directly or indirectly associated with inadequate resources.

What steps does the Veterans Administration plan to take by virtue of this recommended budget in order to improve the quality, proficiency, and efficiency within the Veterans Administration with respect to claims processing and adjudication?

Answer. The focus of the 2006 budget is to continue progress, in support of the President's initiative, to improve the timeliness and accuracy of claims processing. Recipients of compensation and pension benefits are projected to increase from 2.62 million in 2001 to 3.02 million in 2006, a 15.3 percent increase. The projected increase is due to a number of factors, including the current record levels of DOD active duty end strength resulting from the large number of activated reserve units.

- We continue to receive increasing numbers of claims. Between 2000 and 2004, the number of disability claims received annually rose from 674,000 to 771,000, or more than 14 percent. This budget conservatively estimates a 3 percent increase for 2005 and another 3 percent for 2006 in claims receipts. This increase is due to both the high active duty levels mentioned above, as well as an increase in the number of reopened claims due to various changes, including the addition of cardiovascular disease and residuals of stroke to the presumptive list for former Prisoners of War.
 - To address projected workload increases, this budget continues to ensure a sufficient workforce in our compensation and pension programs to meet our targets. The FTE in the compensation and pension programs will increase by 128 in 2006.
- This budget also continues VBA's goal to improve organizational designs and information technology investments to process claims as efficiently and accurately as possible. For example:
- In 2005 VBA will begin the consolidation of the disability determination aspects of the Benefits Delivery at Discharge Program into two rating activities located in Salt Lake City and Winston-Salem.
 - In 2006 VBA will complete implementation of the Cooperative Separation Process/Examination initiative at the local level. This is a joint VA and DOD initiative that streamlines the military discharge process for separating servicemembers with disabilities.
 - Funds are provided to continue reorganizing our field financial functions to reduce overhead and realign critical resources to our business processes directly serving veterans.
 - \$4.4 million is provided to begin implementation of the Vocational Rehabilitation & Employment Task Force recommendations to establish self-service job resource labs at each regional office to aid VR&E staff and veterans in comprehensive analyses of employment opportunities.
 - Over \$15 million has been allocated to support our highest priority IT initiative—VETSNET—and continue efforts in C&P, Education, and VR&E to move off the existing Benefits Delivery Network to the new corporate environment. VETSNET, when fully deployed, will greatly expand the information available to decision makers, reduce the number of times data must be entered both increasing efficiency and insuring that the same data is available throughout the Department.

In addition, the 2006 budget submission will enable VA to continue its efforts in skill certification. Skill certification is a core initiative of the Department to insure that claims processors in regional offices have tested and validated competencies in the essential aspects of their positions. We believe that skill certification directly addresses quality and proficiency.

VA will also continue its Benefit Delivery at Discharge (BDD) program. That program greatly simplifies the claims process and significantly reduces the amount of time required to process a claim.

Question. There are 119 State Veterans Homes in 48 States and Puerto Rico. For more than 100 years the Federal Government has provided support for our State Veteran's Homes in partnership with State governments. The Federal Department of Veteran's Affairs budget for fiscal year 2006 would change the eligibility for Federal support excluding for the first time whole priority groups of deserving veterans. As a result, up to 80 percent of veterans in many States may no longer qualify for partial Federal support through per diem payments. Budget assumptions reduce the VA Per Diem grant by \$293 million. The budget would also place a moratorium on Federal construction grants for renovations and new construction of State Veterans Homes. After decades of partnership with the States—during which State taxpayers across the country have contributed millions of dollars to build and maintain the State Veterans Homes—the President's budget reneges on this commitment to our State homes, State taxpayers, and worst of all, our honored veterans. The impact of the proposal would be devastating for the residents of the State Veterans Homes. Of veterans currently residing in the Homes, approximately 20 percent would continue to receive the Federal per diem payments.

What suggestions does the VA have for veterans who cannot afford to pick up these additional payments as a result of the per diem change and what plan do you have for Louisiana Veterans Homes which will be unable to meet their operating costs as a result of this massive blow?

Answer. State Veterans Homes are owned, operated, and financed by the States. VA provides limited financial assistance to the States in the form of per diem grants for nursing home, hospital, domiciliary, and adult day healthcare. Only the nursing home per diem is affected by the fiscal year 2006 budget proposal. The cost of care

in State Veterans Homes varies from State to State, as does the amount of assistance provided to the Homes by the State. Currently, costs not covered by the VA per diem payments are covered from various sources, including the veterans themselves and State and Federal programs such as Medicare and Medicaid. VA's proposal could increase the share of costs borne by the State, depending upon the State's own policies for coverage of the costs of State Home care. State Homes will continue operations to the extent that individual States discharge their fiscal responsibility for the operation and management of the Homes. VA does not have information on the plans of individual States to respond to the change in VA policy.

QUESTIONS SUBMITTED BY SENATOR ROBERT C. BYRD

Question. According to the Congressional Research Service, the 2003 decision by the Administration to suspend health care enrollments for the lowest priority veterans called Category 8 veterans will affect 522,000 veterans by the end of the current fiscal year.

Secretary Nicholson, how many Category 8 veterans in West Virginia are no longer eligible to enroll in the VA health care as a result of the 2003 decision?

Answer. As of the end of fiscal year 2004, VA estimates there were 78,688 veterans in West Virginia who were Priority 8 of which 24,649 were enrolled. VA projects there were 54,039 Priority 8 veterans in West Virginia who were not eligible to enroll with VA for health care.

Question. If this policy continues, as your budget proposes, how many Category 8 veterans in West Virginia will be affected in fiscal year 2006 and beyond? How many veterans will be affected nationally?

Answer. VA projects there are 9,818 Priority 8 enrollees residing in West Virginia who will pay the enrollment fee in fiscal year 2006 and another 8,789 who will choose not to pay. At the national level, 642,772 Priority 8 enrollees would pay the enrollment fee and 579,929 would not. These new collections will allow VA to continue to refocus resources on veterans that fall under VA's core medical care mission (those with service-related disabilities, lower incomes, and special health needs). The fees are more closely aligned with other public and private health plans.

PROPOSED BECKLEY VA MEDICAL CENTER NURSING HOME

Question. Mr. Secretary, I made your predecessors acutely aware of my very strong support for the construction of the proposed Beckley VA Medical Center Nursing Home, and I want to take this opportunity to familiarize you of my interest in this project, as well. The nursing home was authorized by the Veterans Programs Enhancement Act of 2000, with the sponsorship of Senator John D. Rockefeller, IV. The project was originally authorized at \$9.5 million. However, after further consultation with VA Headquarters officials, the estimates were reformulated, with a new total cost of approximately \$18 million for a 120-bed, 71,300 gross-square foot facility.

I have been supportive of this project since its inception. To aid in its development, I added \$1 million to the fiscal year 2001 VA-HUD Appropriations bill for the design of such a nursing home on thirteen acres of available space owned by the Beckley VA Medical Center, a site for which I secured \$100,000 several years ago in anticipation of increased demand for nursing home care in Southern West Virginia. Further, I have included language in the Senate reports accompanying the fiscal year 2002, 2003, 2004, and 2005 VA-HUD Appropriations bills to encourage that funds for the project be included in subsequent Administration budgets.

I understand that the project has undergone the Capital Asset Realignment for Enhanced Services (CARES) review process and that it has been included in the February 2005 VA Five-Year Capital Plan, 2005-2010, which lists the VA's highest priority major medical facility construction requirements over the next 5 years. While I am pleased that the proposed nursing home is on this list, I am disappointed that it is ranked #46 (out of 48 projects).

Mr. Secretary, is the VA adhering to its capital investment methodology by funding construction projects in priority order? Have there been any exceptions made? What are they?

Answer. The Department has adhered to the capital investment methodology when funding CARES projects. VA has only allowed projects to be funded out of order in extremely limited situations, based upon funding allocations, as described below.

The only exception being:

—*To Allow for Maximizing of the Utilization of Major Construction Funds.*—In fiscal year 2005 #29 San Diego, CA, \$48.3 million was funded prior to #28 Dallas,

TX. Clinical expansion at San Diego was funded since it was less expensive and within VA's funding allowance. This occurred again in fiscal year 2006 when the design for #6 project in Fayetteville, AR, was funded prior to other higher ranking projects because of the availability of funding.

Question. At the current level of funding and the current rank of the Beckley VAMC Nursing Home, when do you anticipate that funds will be included in the President's Budget for this project? What can be done to move Beckley up the list?

Answer. When Beckley will be included in the President's budget cannot be determined at this time as new projects are added (and some may drop out) to the review process each year. For example, for fiscal year 2006 two additional projects were reviewed as compared to the previous year. Existing projects which have not received CARES funding and new projects are rescored each year. Split funded projects that have received previous CARES funds (because of their higher score) retain their ranking.

Based on the current capital decision criteria, it will be difficult for a project like Beckley to compete with other medical projects that clearly provide more access to care, or have a life-safety component (such as seismic) and/or provide for special disability services (spinal cord injury). How well a project addresses these criteria leads to an improved score.

Question. Will the VA's highest major construction priorities be reevaluated in the future, providing an opportunity for the proposed Beckley Nursing Home to move up on the list?

Answer. The Department rescors and ranks major projects every year. In the next few months, VA will again review and rank major construction projects. The highest ranking will be included in the congressional budget submission for fiscal year 2007.

Question. Since the proposed Beckley Nursing Home has already been designed with funds that I added in fiscal year 2001 and the land is already owned by the VA, why can't this project be moved up on the list since it is ready to go to construction?

Answer. The ranked list of projects are developed based on how well each project specifically addresses each of the main criteria and sub-criterion used for ranking CARES projects. It would not be equitable for the Department to move a project up this list simply based on the fact that it is designed. Our capital investment planning process and methodology involve a Department-wide approach for the use of capital funds and ensure all major investments are based upon sound economic principles and are fully linked to strategic planning, budget, and performance measures and targets. All CARES projects have been reviewed using a consistent set of evaluation criteria that address service delivery enhancements, safeguarding assets, support of special emphasis programs and services, capital portfolio goals, alignment with the President's Management Agenda, and financial priorities.

Question. What level of funding for the VA's major construction program will be required annually and for what period of time to complete all of the projects listed in the VA's Five-Year Capital Plan, 2005–2010?

Answer. VA will need to reexamine its needs each year and determine the appropriate breakout between major and minor construction. The Department is unable to determine for what period of time it would take to complete all the projects listed in our Five-Year Capital Plan because the plan is a dynamic document which is updated each year based on competing new projects and priorities. In addition, VA is still developing cost estimates for the 70 outyear projects that are listed in the plan. Most of these conceptual projects require further refinement and development. To date, VA has committed \$2.15 billion to implementing CARES plans, and additional funding will be requested in the outyears as specific capital plans are designed.

Question. How many design awards has the Department made to date and for which projects? How many land purchases and for which projects? How many construction awards have been made and for which projects?

Answer. There have been 16 design awards and 2 construction awards. There were no land purchases.

Design Awards:

- Atlanta, GA—Modernize Patient Wards—6/04
- Chicago Westside, IL—Modernize Inpatient Space—11/02
- Columbus, OH—Outpatient Clinic—8/04
- Des Moines, IA—Extended Care Building—7/04
- Durham, NC—Renovate Patient Wards—9/04
- Las Vegas, NV—New Medical Facility—2/05
- North Chicago, IL—Surgical Suite/Emergency—11/03
- Pensacola, FL—Outpatient Clinic—1/04
- Pittsburgh, PA—Medical Center Consolidation—12/04

- San Antonio, TX—Ward Upgrades and Expansion—1/05
- San Diego, CA—Seismic Corrections—1/05
- San Francisco, CA—Seismic Corrections—12/03
- Tampa, FL—SCI—10/04
- Tampa, FL—Upgrade Electrical—10/04
- Tucson, AZ—Mental Health Clinic—8/04
- Wes Los Angeles, CA—Seismic Corrections—3/03
- Construction Awards:
- Chicago Westside, IL—Modernize Inpatient Space—9/04
- North Chicago, IL—Surgical Suite Emergency—9/04
- Pensacola, FL—Outpatient Clinic—3/05

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

REAL HEALTH CARE INCREASE

Question. This budget cites an increase of \$522 million over last year; however, the number is much lower in reality—about \$100 million. As is typical of this Administration, smoke and mirrors are used to deflect attention from the real number. Mr. Secretary, let's be perfectly clear about what the President is offering as an increase for VA health care. Your testimony cites a 2.5 percent increase for medical spending. The Majority staff on the Veterans' Affairs Committee provided a terrific chart which tries to make sense of the number and found that the requested increase is under \$80 million. That's only \$80 million more for the nearly 7 million veterans who are enrolled in VA healthcare, for the 170 hospitals and hundreds of outpatient clinics, for medical inflation, and payroll increases for thousands of VA health care workers. Mr. Secretary, Washington state has nearly 700,000 veterans and the population is growing. The CARES commission and my VISN director have told these veterans that two outreach clinics—in North Central Washington and Whatcom County—are on the way. But now they are on hold because of funding shortages.

Simply put: help me to understand how an \$80 million increase keeps our promise to veterans? Set aside the possible increased revenue from insurance companies and the spending associated with new veterans' fees.

Answer. The President's 2006 request includes budgetary resources of \$30.7 billion which will enable VA to provide the high-quality health care services that VA has become renowned for to more than 5.2 million patients in fiscal year 2006.

Question. The Budget proposes \$30.7 billion (including collections) for medical care—a \$0.8 billion (2.5 percent) increase over the 2005 enacted level—to treat over 5.2 million patients. The Budget assumes that Congress will authorize new authority whereby veterans with higher incomes and no military disabilities will pay a \$250 annual enrollment fee and higher drug co-pays (from \$7 to \$15). These will still be low and more aligned with other public and private health plans.

What is the amount the President is requesting Congress appropriate for VA's hospitals and clinics?

Answer. VA is requesting the following appropriations in fiscal year 2006:

[In thousand of dollars]

Description	Amount
Medical Services	19,789,141
Medical Care Collections Fund	2,588,000
Medical Administration	4,439,124
Medical Facilities	3,888,469
Total 2006 Budget Request	30,704,734

Question. And again to be clear: what is the amount associated with payroll increases and inflation? The amount associated with payroll and inflation for VA health care is more than \$1 billion, so the President's request doesn't even cover inflation.

Answer. The 2006 budget request reflects an increase of \$858.9 million for payroll increases and an increase of \$539.7 million for inflation. These increases are offset by a decrease in requested appropriations of \$1.1 billion from a comprehensive set of legislative and regulatory policy proposals and a decrease of \$590,000 for management efficiencies.

INCREASED COSTS FOR MIDDLE-INCOME VETS/BAN ON PRIORITY 8S

Question. This budget includes an increase in the drug co-payment and an annual enrollment fee of \$250 for Priority 7 and 8 veterans. The threshold for Priority 7 is only \$25,163 a year, so veterans with incomes above this level would be required to pay these new fees. The budget also continues the ban on Priority 8 veterans, who in some regions of the country can be making as little as \$28,000 a year and still not be eligible for VA care. The President's co-pay increase and new enrollment fee are designed to literally drive veterans out of the system. Two years ago, the President had no qualms about prohibiting enrollment for new "middle-income" veterans. That policy continues today. In fact, the testimony touts that the President's enrollment decision was the "most effective" vehicle to manage health care resources. This budget takes a different route, however. The goal is to make the cost of coming to VA for health care prohibitively expensive. Either way, I have to question the priorities of this Administration. As you know, my father returned home from World War II as a disabled veteran and during the Viet Nam War, I interned in the Seattle VA hospital. I know first-hand the scars and wounds that burden our veterans when they come back home.

Mr. Secretary, our veterans—new and old—are some of our most important national security assets. Why not provide sufficient resources to care for all veterans?

Is this care not part of the cost of past wars and the current conflicts in which we are engaged?

Do you agree that VA healthcare for our soldiers returning home is a cost of war?

Answer. In the Eligibility Reform legislation, Congress established a priority-based enrollment system and required the VA Secretary, every year, to assess veteran demand for VA health care and determine whether or not resources are available to provide timely, quality care to all enrollees. Using this legislatively mandated system for prioritizing care to veterans, VA suspended enrollment in Priority 8 and has proposed cost-sharing policies for Priority 7 and 8 enrollees as a means of balancing veteran demand for VA health care and available resources. These policies also refocus the VA health care system on those veterans who need us most. With the implementation of the enrollment fee for Priority 7 and 8 enrollees, VA expects that 71 percent of all those using VA's health care system in 2006 will be veterans with service-connected medical conditions, special needs, and low incomes, up from 66 percent in 2004. The fees are more closely aligned with other public and private health plans.

REAL EFFECTS OF INCREASING OUT-OF-POCKET COSTS

Question. The Administration's budget calls for increasing the drug co-payment from \$7 to \$15 per 30-day prescription for Priority 7 and 8 veterans, as mentioned in an earlier question. It also would require these veterans to pay a \$250 annual enrollment fee. At the bottom end of this spectrum, older veterans on fixed incomes could be making as little as \$26,000 a year and still be subject to these increases in costs.

I'd like to briefly discuss the potential impact of some of your proposals on veterans in the "middle-income" bracket. Some of these veterans could be making as little as \$26,000 a year and still be subject to the increases in out-of-pocket costs that are built into your budget. And, for a veteran living on a fixed income in a city with a high cost of living, like Seattle, this is quite harsh. For example, an older veteran on an average of eight medications would see a cost increase per year of more than \$1,000, just to continue getting his or her needed medications and continue enrollment in VA health care.

How do you reconcile this with VA's mission of providing care to all who have served?

Answer. In the Eligibility Reform legislation, Congress established a priority-based enrollment system and required the VA Secretary, every year, to assess veteran demand for VA health care and determine whether or not resources are available to provide timely, quality care to all enrollees. Using this legislatively mandated system for prioritizing care to veterans, VA has proposed cost-sharing policies for Priority 7 and 8 enrollees as a means of balancing veteran demand for VA health care and available resources. These policies also refocus the VA health care system on those veterans who need us most. With the implementation of the enrollment fee for Priority 7 and 8 enrollees, VA expects that 71 percent of all those using VA's health care system in 2006 will be veterans with service-connected medical conditions, special needs, and low incomes, up from 66 percent in 2004. The fees are more closely aligned with other public and private health plans.

STATE VETERANS HOMES: ON THE CHOPPING BLOCK

Question. This budget contains proposals that will severely affect the State Veterans Home program. On the one side, the President will be seeking authority to restrict who can receive VA funding for care in these homes. While 50 percent of the veterans currently being cared for in Washington state's three facilities, the State Home Association has told me that in many States, 80 percent or more of State Home residents will be excluded by this change. According to the VA's average daily census for long-term care, there are estimated to be more than 19,000 individuals in State nursing homes. This budget would slash that figure to about 7,000—a 62 percent decline in 1 year.

Explain to me how you believe these homes will remain viable if these proposed policies are accepted?

Answer. State Veterans Homes are owned, operated, and financed by the States. VA provides limited financial assistance to the States in the form of per diem grants for nursing home, hospital, domiciliary, and adult day healthcare. Only the nursing home per diem is affected by the fiscal year 2006 budget proposal. The cost of care in State Veterans Homes varies from State to State, as does the amount of assistance provided to the Homes by the State. Currently, costs not covered by the VA per diem payments are covered from various sources, including the veterans themselves and State and Federal programs such as Medicare and Medicaid. VA's proposal could increase the share of costs borne by the State, depending upon the State's own policies for coverage of the costs of State Home care. In addition, VA long-term care has shifted from inpatient to outpatient, similar to the private sector. This is more convenient to patients and their families, and is more cost-effective

VA NURSING HOMES: ALSO ON THE CHOPPING BLOCK

Question. The Administration would also like to reduce VA's in-house capacity by almost 14,000 beds.

What can you tell me about where VA is in meeting the non-institutional capacity called for by GAO, and relied upon so heavily in your budget, to make up for this loss?

Answer. Non-institutional home and community-based care (HCBC) is part of the medical and extended care benefits package available to all enrolled veterans. We recognize that access to these services varies across VA's health care system. Last year, VA adopted a policy of increasing HCBC capacity by 18 percent annually to meet the full need of enrolled veterans by 2011, and established a performance measure for Network Directors to meet that goal. Capacity growth is targeted to those regions with the greatest current and projected need for services in order to reduce variability in access to care. Progress so far has been excellent. Capacity growth exceeded 20 percent in fiscal year 2004 and is at 113 percent of target so far in fiscal year 2005. The number of individual programs is also expanding. For example, VA recently approved its 100th Home-Based Primary Care Program (up from 77 less than 5 years ago), and Care Coordination services have now been approved in all 21 VISNs.

Care Coordination services involve the ongoing monitoring and assessment of selected patients using telehealth technologies to proactively enable prevention, investigation, and treatment that enhances the health of patients and prevents unnecessary and inappropriate utilization of resources. Care coordination provides patients a continuous connection to clinical services from the convenience of their place of residence.

SUBCOMMITTEE RECESS

Senator HUTCHISON. So with that, we are in our second vote and I am going to close this meeting. I thank you very much for your patience and look forward to working with all of you. And thank you, Dr. Perlin, for your comments as well.

[Whereupon, at 3:37 p.m., Tuesday, March 15, the subcommittee was recessed, to reconvene subject to the call of the Chair.]