

STATEMENT OF  
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BEFORE THE

COMMITTEE ON APPROPRIATIONS  
SUBCOMMITTEE ON MILITARY CONSTRUCTION AND VETERANS AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

**VA'S BUDGET REQUEST FOR FISCAL YEAR 2011**

WASHINGTON, D.C.

March 23, 2010

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.1 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today. The VFW works alongside the other members of the Independent Budget (IB) – AMVETS, Disabled American Veterans and Paralyzed Veterans of America – to produce a set of policy and budget recommendations that reflect what we believe would meet the needs of America's veterans. The VFW is responsible for the construction portion of the IB, so I will limit my remarks to that portion of the budget.

VA's infrastructure—particularly within its health-care system—is at a crossroads. The system is facing many challenges, including the average age of buildings (60 years) and significant funding needs for routine maintenance, upgrades, modernization and construction. VA is beginning a patient-centered reformation and transformation of the way it delivers care and new ways of managing its infrastructure plan based on needs of sick and disabled veterans in the 21<sup>st</sup> Century. Regardless of what the VA health care system of the future looks like, our focus must remain on a lasting and accessible VA health-care system that is dedicated to their unique needs and one that can provide high quality, timely care when and where they need it.

VA manages a wide portfolio of capital assets throughout the nation. According to its latest Capital Asset Plan, VA is responsible for 5,500 buildings and almost 34,000 acres of land. It is a vast network of facilities that requires significant time and attention from VA's capital asset managers.

CARES – VA’s data-drive assessment of their current and future construction needs – gave VA a long-term roadmap and has helped guide its capital planning process over the past few fiscal years. CARES showed a large number of significant construction priorities that would be necessary for VA to fulfill its obligation to this nation’s veterans and over the last several fiscal years, the administration and Congress have made significant inroads in funding these priorities. Since FY 2004, \$4.9 billion has been allocated for these projects. Of these CARES-identified projects, VA has completely five and another 27 are currently under construction. It has been a huge, but necessary undertaking and VA has made slow, but steady progress on these critical projects.

The challenge for VA in the post-CARES era is that there are still numerous projects that need to be carried out, and the current backlog of partially funded projects that CARES has identified is large, too. This means that VA is going to continue to require significant appropriations for the major and minor construction accounts to live up to the promise of CARES. VA’s most recent Asset Management Plan provides an update of the state of CARES projects – including those only in the planning of acquisition process. Table 4-5: (page 7.4-49) shows a need of future appropriations to complete these projects of \$3.25 billion.

<b>Project</b>	<b>Future Funding Needed (\$ In Thousands)</b>
Denver	492,700
San Juan	122,920
New Orleans	370,000
St. Louis	364,700
Palo Alto	478,023
Bay Pines	80,170
Seattle	38,700
Seattle	193,830
Dallas	80,100
*Louisville	1,100,000
<b>TOTAL</b>	<b>3,246,143</b>

This amount represents just the backlog of current construction projects. It does reflect the administration’s FY 2011 proposed appropriation toward Denver, New Orleans, and Palo Alto. (\*Louisville’s cost estimate is found on table 5-6, on Page 7.5-93).

Meanwhile, VA continues to identify and reprioritize potential major construction projects. These priorities, which are assessed using the rigorous methodology that guided the CARES decisions, are released in the Department’s annual Five Year Capital Asset Plan, which is included in the Department’s budget submission. The most recent one was included in Volume IV and is available on VA’s website:

[http://www4.va.gov/budget/docs/summary/Fy2011\\_Volume\\_4-Construction\\_and\\_5\\_Year\\_Cap\\_Plan.pdf](http://www4.va.gov/budget/docs/summary/Fy2011_Volume_4-Construction_and_5_Year_Cap_Plan.pdf).

Table 4-5 shows a long list of partially funded major construction projects. These 82 ongoing projects demonstrate the continued need for VA to upgrade and repair its aging infrastructure,

and that continuous funding is necessary for not just the backlog of projects, but to keep VA viable for today's and future veterans.

In a November 17, 2008 letter to the Senate Veterans Affairs Committee, Secretary Peake said that "the Department estimates that the total funding requirement for major medical facility projects over the next 5 years would be in excess of \$6.5 billion."

It is clear that VA needs a significant infusion of cash for its construction priorities. VA's own words and studies show this.

<b>Major Construction Account Recommendations</b>	
<b>Category</b>	<b>Recommendation (\$ in Thousands)</b>
VHA Facility Construction	\$1,000,000
NCA Construction	\$60,000
Advance Planning	\$40,000
Master Planning	\$15,000
Historic Preservation	\$20,000
Medical Research	
Infrastructure	\$100,000
Miscellaneous	
Accounts	\$58,000
<b>TOTAL</b>	<b>\$1,295,000</b>

- VHA Facility Construction – this amount would allow VA to continue digging into the \$3.25 billion backlog of partially funded construction projects. Depending on the stages and ability to complete portions of the projects, any additional money could be used to fund new projects identified by VA as part of its prioritization methodology in the Five-Year Capital Plan.
- NCA Construction's Five-Year Capital Plan details numerous potential major construction projects for the National Cemetery Association throughout the country. This level of funding would allow VA to begin construction on at least three of its scored priority projects.
- Advance Planning – helps develop the scope of the major construction projects as well as identifying proper requirements for their construction. It allows VA to conduct necessary studies and research similar to planning processes in the private sector.
- Master Planning – a description of our request follows later in the text.
- Historic Preservation – a description of our request follows later in the text.
- Miscellaneous Accounts – these include the individual line items for accounts such as asbestos abatement, the judgment fund, and hazardous waste disposal. Our recommendation is based upon the historic level for each of these accounts.

### **Minor Construction Account Recommendations**

<b>Category</b>	<b>Funding (\$ in Thousands)</b>
Veterans Health Administration	\$450,000
Medical Research Infrastructure	\$200,000
National Cemetery Administration	\$100,000
Veterans Benefits Administration	\$20,000
Staff Offices	\$15,000
<b>TOTAL</b>	<b>\$785,000</b>

- Veterans Health Administration – Page 7.8-138 of VA’s Capital Plan reveals hundreds of already identified minor construction projects. These projects update and modernize VA’s aging physical plant, ensuring the health and safety of veterans and VA employees. Additionally, a great number of minor construction projects address FCA-identified maintenance deficiencies; the backlog of 216 projects in FY 2010 with over \$1 billion that has yet to be funded.
- Medical Research Infrastructure – a description of our request follows later in the text.
- National Cemetery Administration of the Capital Plan identifies numerous minor construction projects throughout the country including the construction of several columbaria, installation of crypts and landscaping and maintenance improvements. Some of these projects could be combined with VA’s new NCA nonrecurring maintenance efforts.
- Veterans Benefits Administration – Page 7.6-106 of the Capital Plan lists several minor construction projects in addition to the leasing requirements VBA needs.
- Staff Offices – Page 7.8-134 lists numerous potential minor construction projects related to staff offices.

### **Increase Spending on Nonrecurring Maintenance**

#### **The deterioration of many VA properties requires increased spending on nonrecurring maintenance**

For years, the Independent Budget Veteran Service Organizations (IBVSOs) have highlighted the need for increased funding for the nonrecurring maintenance (NRM) account. NRM consists of small projects that are essential to the proper maintenance and preservation of the lifespan of VA’s facilities. NRM projects are one-time repairs such as maintenance to roofs, repair and replacement of windows, and flooring or minor upgrades to the mechanical or electrical systems. They are a necessary component of the care and stewardship of a facility.

These projects are so essential because if left unrepaired, they can really take their toll on a facility, leading to more costly repairs in the future, and the potential of a need for a minor construction project. Beyond the fiscal aspects, facilities that fall into disrepair can create access difficulties and impair patient and staff health and safety. If things do develop into a larger

construction projection because early repairs were not done, it creates an even larger inconvenience for veterans and staff.

The industry standard for medical facilities is for managers to spend from 2%-4% of plant replacement value (PRV) on upkeep and maintenance. The 1998 PriceWaterhouseCoopers study of VA's facilities management practices argued for this level of funding and previous versions of VA's own Asset Management Plan have agreed that this level of funding would be adequate.

The most recent estimate of VA's PRV is from the FY 08 Asset Management Plan. Using the standards of the Federal government's Federal Real Property Council (FRPC), VA's PRV is just over \$85 billion (page 26).

Accordingly, to fully maintain its facilities, VA needs a NRM budget of at least \$1.7 billion. This number would represent a doubling of VA's budget request from FY 2009, but is in line with the total NRM budget when factoring in the increases Congress gave in the appropriations bill and the targeted funding included in the supplemental appropriations bills.

Increased funding is required not to just to fill current maintenance needs and levels, but also to dip into the extensive backlog of maintenance requirements VA has. VA monitors the condition of its structures and systems through the Facility Condition Assessment (FCA) reports. VA surveys each medical center periodically, giving each building a thorough assessment of all essential systems. Systems are assigned a letter grade based upon the age and condition of various systems, and VA gives each component a cost for repair or replacement.

The bulk of these repairs and replacements are conducted through the NRM program, although the large increases in minor construction over the last few years have helped VA to address some of these deficiencies.

VA's 5-Year Capital Plan discusses FCAs and acknowledges the significant backlog the number of high priority deficiencies – those with ratings of D or F – had replacement and repair costs of over \$9.4 billion, found on page 7.1-18. VA estimates that 52 percent of NRM dollars are obligated to toward this cost.

VA uses the FCA reports as part of its Federal Real Property Council (FRPC) metrics. The department calculates a Facility Condition Index, which is the ratio of the cost of FCA repairs to the cost of replacement. According to the FY 08 Asset Management Plan, this metric has gone backwards from 82% in 2006 to just 68% in 2008. VA's strategic goal is 87%, and for it to meet that, it would require a sizeable investment in NRM and minor construction.

Given the low level of funding the NRM account has historically received, the IBVSOs are not surprised at the metrics or the dollar cost of the FCA deficiencies. The 2007 "National Roll Up of Environment of Care Report," which was conducted in light of the shameful maintenance deficiencies at Walter Reed, further prove the need for increased spending on this account. Maintenance has been neglected for far too long, and for VA to provide safe, high-quality health care in its aging facilities, it is essential that more money be allocated for this account.

We also have concerns with how NRM funding is actually apportioned. Since it falls under the Medical Care account, NRM funding has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This model works when divvying up health-care dollars, targeting money to those areas with the greatest demand for health care. When dealing with maintenance needs, though, this same formula may actually intensify the problem.

By moving money away from older hospitals, such as in the northeast, to newer facilities where patient demand is greater, even if the maintenance needs are not as high. We were happy to see that the conference reports to the VA appropriations bills required NRM funding to be apportioned outside the VERA formula, and we would hope that this continues into the future.

Another issue related to apportionment of funding came to light in a May 2007 Government Accountability Office (GAO) report. They found that the bulk of NRM funding is not actually apportioned until September, the final month of the fiscal year. In September 2006, GAO found that VA allocated 60% of that year's NRM funding. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and since NRM funding is year-to-year, it means that it could lead to wasteful or unnecessary spending as hospital managers rushed in a flurry to spend their apportionment before forfeiting it back. We cannot expect VA to perform a year's worth of maintenance in a month. It is clearly poor policy and not in the best interest of veterans. The IBVSOs believe that Congress should consider allowing some NRM money to be carried over from one fiscal year to another. While we would hope that this would not resort to hospital managers hoarding money, it could result in more efficient spending and better planning, rather than the current situation where hospital managers sometimes have to spend through a large portion of maintenance funding before losing it at the end of the fiscal year.

#### **Recommendations:**

VA must dramatically increase funding for nonrecurring maintenance in line with the 2%-4% total that is the industry standard so as to maintain clean, safe and efficient facilities. VA also requires additional maintenance funding to allow the department to begin addressing the substantial maintenance backlog of FCA-identified projects.

Portions of the NRM account should be continued to be funded outside of the VERA formula so that funding is allocated to the facilities that actually have the greatest maintenance needs.

Congress should consider the strengths of allowing VA to carry over some maintenance funding from one fiscal year to another so as to reduce the temptation some VA hospital managers have of inefficiently spending their NRM money at the end of a fiscal year for fear of losing it.

### **Inadequate Funding and Declining Capital Asset Value**

#### **VA must protect against deterioration of its infrastructure and a declining capital asset value**

The last decade of underfunded construction budgets has meant that VA has not adequately recapitalized its facilities. Recapitalization is necessary to protect the value of VA's capital assets through the renewal of the physical infrastructure. This ensures safe and fully functional facilities long into the future. VA's facilities have an average age approaching 60 years, and it is essential that funding be increased to renovate, repair, and replace these aging structures and physical systems.

As in past years, the IBVSOs cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). It found that from 1996-2001, VA's recapitalization rate was just 0.64%. At this rate, VA's structures would have an assumed life of 155 years.

The PTF cited a PriceWaterhouseCoopers study of VA's facilities management programs that found that to keep up with industry standards in the private sector and to maintain patient and employee safety and optimal health care delivery, VA should spend a minimum of 5 to 8 percent of plant replacement value (PRV) on its total capital budget.

The FY08 VA Asset Management Plan provides the most recent estimate of VA's PRV. Using the guidance of the Federal government's Federal Real Property Council (FRPC), VA's PRV is just over \$85 billion (page 26).

Accordingly, using that 5 to 8 percent standard, VA's capital budget should be between \$4.25 and \$6.8 billion per year in order to maintain its infrastructure.

VA's capital budget request for FY 2009 – which includes major and minor construction, maintenance, leases and equipment – was just \$3.6 billion. We greatly appreciate that Congress increased funding above that level with an increase over the administration request of \$750 million in major and minor construction alone. That increased amount brought the total capital budget in line with industry standards, and we strongly urge that these targets continue to be met and we would hope that future VA requests use these guidelines as a starting point without requiring Congress to push them past the target.

#### **Recommendation:**

Congress and the Administration must ensure that there are adequate funds for VA's capital budget so that VA can properly invest in its physical assets to protect their value and to ensure that the Department can continue to provide health care in safe and functional facilities long into the future.

#### **Maintain VA's Critical Infrastructure**

The IBVSOs are concerned with VA's recent attempts to back away from the capital infrastructure blueprint laid out by CARES and we are worried that its plan to begin widespread leasing and contracting for inpatient services might not meet the needs of veterans.

VA acknowledges three main challenges with its capital infrastructure projects. First, they are costly. According to a March 2008 briefing given to the VSO community, over the next five years, VA would need \$2 billion per year for its capital budget. Second, there is a large backlog of partially funded construction projects. That same briefing claimed that the difference in major construction requests given to OMB was \$8.6 billion from FY 03 through FY 09, and that they have received slightly less than half that total. Additionally, there is a \$2 billion funding backlog for projects that are partially but not completely funded. Third, VA is concerned about the timeliness of construction projects, noting that it can take the better part of a decade from the time VA initially proposes a project until the doors actually open for veterans.

Given these challenges, VA has floated the idea of a new model for health care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF, VA would begin leasing large outpatient clinics in lieu of major construction. These large clinics would provide a broad range of outpatient services including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

On the face of it, this sounds like a good initiative. Leasing has the advantage of being able to be completed quickly, as well as being adaptable, especially when compared to the major construction process. Leasing has been particularly valuable for VA as evidenced by the success of the Community Based Outpatient Clinics (CBOCs) and Vet Centers.

Our concern rests, however, with VA's plan for inpatient services. VA aims to contract for these essential services with affiliates or community hospitals. This program would privatize many services that the IBVSOs believe VA should continue to provide. We lay out our objections to privatization and widespread contracting for care elsewhere in the *Independent Budget*.

Beyond those objections, though, is the example of Grand Island, Nebraska. In 1997, the Grand Island VA Medical Center closed its inpatient facilities, contracting out with a local hospital for those services. Recently, the contract between the local facility and VA was canceled, meaning veterans in that area can no longer receive inpatient services locally. They must travel great distances to other VA facilities such as the Omaha VA Medical Center. In some cases, when Omaha is unable to provide specialized care, VA is flying patients at its expense to faraway VA medical centers, including those in St. Louis and Minneapolis.

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

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

But most importantly, CARES required years to complete and consumed thousands of hours of effort and millions of dollars of study. We believe it to be a comprehensive and fully justified roadmap for VA's infrastructure as well as a model that VA can apply periodically to assess and adjust those priorities. Given the strengths of the CARES process and the lessons VA learned and has applied from it, why is the HCCF model, which to our knowledge has not been based on any sort of model or study of the long-term needs of veterans, the superior one? We have yet to see evidence that it is and until we see more convincing evidence that it will truly serve the best needs of veterans, the IBVSOs will have a difficult time supporting it.

**Recommendation:**

VA must resist implementing the HCCF model without fully addressing the many questions the IBVSOs have and VA must explain how the program would meet the needs of veterans, particularly as compared to the roadmap CARES has laid out.

**Research Infrastructure Funding**

**The Department of Veterans Affairs must have increased funding for its research infrastructure to provide a state-of-the-art research and laboratory environment for its excellent programs, but also to ensure that VA hires and retains the top scientists and researchers.**

### **VA Research Is a National Asset**

Research conducted in the Department of Veterans Affairs has led to such innovations and advances as the cardiac pacemaker, nuclear scanning technologies, radioisotope diagnostic techniques, liver and other organ transplantation, the nicotine patch, and vast improvements in a variety of prosthetic and sensory aids. A state-of-the-art physical environment for conducting VA research promotes excellence in health professions education and VA patient care as well as the advancement of biomedical science. Adequate and up-to-date research facilities also help VA recruit and retain the best and brightest clinician scientists to care for enrolled veterans.

### **VA Research Infrastructure Funding Shortfalls**

In recent years, funding for the VA Medical and Prosthetics Research Program has failed to provide the resources needed to maintain, upgrade, and replace VA's aging research facilities. Many VA facilities have exhausted their available research space. Along with space reconfiguration, ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades in VA's academic health centers. In the 2003 Draft National Capital Asset Realignment for Enhanced Services (CARES) plan, VA included \$142 million designated for renovation of existing research space and build-out costs for leased researched facilities. However, these capital improvement costs were omitted from the Secretary's final report. Over the past decade, only \$50 million has been spent on VA research construction or renovation nationwide, and only 24 of the 97 major VA research sites across the nation have benefited.

In House Report 109-95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee directed VA to conduct "a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies." In FY 2008, the VA Office of Research and Development initiated a multiyear examination of all VA research infrastructures for physical condition and capacity for current research, as well as program growth and sustainability of the space needed to conduct research.

### **Lack of a Mechanism to Ensure VA's Research Facilities Remain Competitive**

In House Report 109-95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee expressed concern that "equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." A significant cause of research infrastructure's neglect is that there is no direct funding line for research facilities.

The VA Medical and Prosthetic Research appropriation does not include funding for construction, renovation, or maintenance of research facilities. VA researchers must rely on their local facility managements to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with other medical facilities' direct patient care needs—such as medical services infrastructure,

capital equipment upgrades and replacements, and other maintenance needs—for funds provided under either the VA Medical Facilities appropriation account or the VA Major or Minor Medical Construction appropriations accounts.

### **Recommendations:**

*The Independent Budget* veteran's service organizations anticipate VA's analysis will find a need for funding significantly greater than VA had identified in the 2004 Capital Asset Realignment for Enhanced Services report. As VA moves forward with its research facilities assessment, the IBVSOs urge Congress to require the VA to submit the resulting report to the House and Senate Committees on Veterans' Affairs no later than October 1, 2010. This report will ensure that the Administration and Congress are well informed of VA's funding needs for research infrastructure so they may be fully considered at each stage of the FY 2011 budget process.

To address the current shortfalls, the IBVSOs recommend an appropriation in FY 2010 of \$142 million, dedicated to renovating existing VA research facilities in line with the 2004 CARES findings.

To address the VA research infrastructure's defective funding mechanism, the IBVSOs encourage the Administration and Congress to support a new appropriations account in FY 2010 and thereafter to independently define and separate VA research infrastructure funding needs from those related to direct VA medical care. This division of appropriations accounts will empower VA to address research facility needs without interfering with the renovation and construction of VA direct health-care infrastructure.

### **Program for Architectural Master Plans:**

Each VA medical facility must develop a detailed master plan.

The delivery models for quality healthcare are in a constant state of change. This is due to many factors including advances in research, changing patient demographics, and new technology.

The VA must design their facilities with a high level of flexibility in order to accommodate these new methods of patient care. The department must be able to plan for change to accommodate new patient care strategies in a logical manner with as little effect as possible on other existing patient care programs. VA must also provide for growth in already existing programs.

A facility master plan is a comprehensive tool to look at potential new patient care programs and how they might affect the existing healthcare facility. It also provides insight with respect to possible growth, current space deficiencies, and other facility needs for existing programs and how VA might accommodate these in the future.

In some cases in the past, VA has planned construction in a reactive manner. After funding, VA would place projects in the facility in the most expedient manner – often not considering other projects and facility needs. This would result in shortsighted construction that restricts, rather than expands options for the future.

The IBVSOs believe that each VA medical Center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility. Short and long-term CARES objectives should be the basis of the master plan.

Four critical programs were not included in the CARES initiative. They are long-term care, severe mental illness, domiciliary care, and Polytrauma. VA must develop a comprehensive plan addressing these needs and its facility master plans must account for these services. VA has undertaken master planning for several VA facilities; most recently Tampa, Florida. This is a good start, but VA must ensure that all facilities develop a master plan strategy to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care.

### **Recommendation:**

Congress must appropriate \$20 million to provide funding for each medical facility to develop a master plan.

Each facility master plan should include the areas left out of CARES; long-term care, severe mental illness, domiciliary care, and Polytrauma programs as it relates to the particular facility. VACO must develop a standard format for these master plans to ensure consistency throughout the VA healthcare system.

### **Empty or Underutilized Space**

VA must not use empty space inappropriately and must continue disposing of unnecessary property where appropriate. Studies have suggested that the VA medical system has extensive amounts of empty space that the Department can reuse for medical services. Others have suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function, but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. For example, VA cannot use unoccupied rooms on the eighth floor to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intra-departmental adjacencies that must be maintained for efficient and hygienic patient care. When a department expands or moves, these demands create a domino effect of everything around it. These secondary impacts greatly increase construction expense, and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs of different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85% of what a similar, new space would. When

you factor in the aforementioned domino or secondary costs, the renovation can end up costing more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA Medical Centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for modern needs. Most of these Bradley-style buildings were designed before the widespread use of air conditioning and the floor-to-floor heights are very low. Accordingly, it is impossible to retrofit them for modern mechanical systems. They also have long, narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise, VA would have previously renovated or demolished this space for new construction. This space is typically located in outlying buildings or on upper floor levels, and is unsuitable for modern use.

### **VA Space Planning Criteria / Design Guides:**

VA must continue to maintain and update the Space Planning Criteria and Design Guides to reflect state-of-the-art methods of healthcare delivery.

VA has developed space-planning criteria it uses to allocate space for all VA healthcare projects. These criteria are organized into sixty chapters; one for each healthcare service provided by VA as well as their associated support services. VA updates these criteria to reflect current methods of healthcare delivery.

In addition to updating these criteria, VA has utilized a computer program called VA SEPS (Space and Equipment Planning System) it uses as a tool to develop space and equipment allocation for all VA healthcare projects. This tool is operational and VA currently uses it on all VA healthcare projects.

The third component used in the design of VA healthcare projects is the design guides. Each of the sixty space planning criteria chapters has an associated design guide. These design guides go beyond the allocation of physical space and outline how this space is organized within each individual department, as well as how the department relates to the entire medical facility.

VA has updated several of the design guides to reflect current patient delivery models. These include those guides that cover Spinal Cord Injury / Disorders Center, Imaging, Polytrauma Centers, as well as several other services.

### **Recommendation:**

The VA must continue to maintain and update the Space Planning Criteria and the VA SEPS space-planning tool. It also must continue the process of updating the Design Guides to reflect current delivery models for patient care. VA must regularly review and update all of these space-planning tools as needed, to reflect the highest level of patient care delivery.

## **Design-build Construction Delivery System**

The VA must evaluate use of the Design-build construction delivery system.

For the past ten years, VA has embraced the design-build construction delivery system as a method of project delivery for many healthcare projects. Design-build attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to the owner and reduce the project delivery schedule. Design-build, as used by VA, places the contractor as the design builder.

Under the contractor-led design build process, VA gives the contractor a great deal of control over how he or she designs and completes the project. In this method, the contractor hires the architect and design professionals. With the architect as a subordinate, a contractor may sacrifice the quality of material and systems in order to add to his own profits at the expense of the owner.

Use of design-build has several inherent problems. A short-cut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents may not provide adequate scope for the project, leaving out important details regarding the workmanship and / or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, which often compromises VA's design standards.

Design-build forces the owner to rely on the contractor to properly design a facility that meets the owner's needs. In the event that the finished project is not satisfactory to the owner, the owner may have no means to insist on correction of work done improperly unless the contractor agrees with the owner's assessment. This may force the owner to go to some form of formal dispute resolution such as litigation or arbitration.

### **Recommendation:**

VA must evaluate the use of Design-build as a method of construction delivery to determine if design-build is an appropriate method of project delivery for VA healthcare projects.

The VA must institute a program of "lessons learned". This would involve revisiting past projects and determining what worked, what could be improved, and what did not work. VA should compile and use this information as a guide to future projects. VA must regularly update this document to include projects as they are completed.

### **Preservation of VA's Historic Structures:**

The VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

The VA has an extensive inventory of historic structures that highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great nation. Of the approximately 2,000 historic structures, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected and preserved

because they are an integral part our nation's history.

Most of these historic facilities are not suitable for modern patient care. As a result, a preservation strategy was not included in the CARES process. For the past six years, the IBVSOs have recommended that VA conduct an inventory of these properties; classifying their physical condition and their potential for adaptive reuse. VA has been moving in that direction and historic properties are identified on their website. VA has placed many of these buildings in an "Oldest and Most Historic" list and these buildings require immediate attention.

At least one project has received funding. The VA has invested over \$100,000 in the last year to address structural issues at a unique round structure in Hampton, VA. Built in 1860, it was originally a latrine and the funding is allowing VA to convert it into office space.

The cost for saving some of these buildings is not very high considering that they represent a part of history that enriches the texture of our landscape that once gone cannot be recaptured. For example, VA can restore the Greek Revival Mansion in Perry Point, MD, which was built in the 1750's, to use as a training space for about \$1.2 million. VA could restore the 1881 Milwaukee Ward Memorial Theater for use as a multi-purpose facility at a cost of \$6 million. This is much less than the cost of a new facility.

As part of its adaptive reuse program, VA must ensure that the facilities that it leases or sells are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds.

We encourage the use of P.L. 108-422, the Veterans Health Programs Improvement Act, which authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property.

**Recommendation:**

VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or the members of the Committee may have.

**STATEMENT OF  
PHILIP D. RILEY, DIRECTOR  
NATIONAL SECURITY-FOREIGN RELATIONS COMMISSIONS  
AND  
BARRY A. SEARLE, DIRECTOR  
VETERANS AFFAIRS AND REHABILITATION COMMISSION  
THE AMERICAN LEGION  
BEFORE THE  
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS AND  
RELATED AGENCIES  
COMMITTEE ON APPROPRIATIONS  
UNITED STATES HOUSE OF REPRESENTATIVES  
ON  
FY 2011 APPROPRIATIONS FOR MILITARY CONSTRUCTION, DEPARTMENT OF  
VETERANS AFFAIRS, AND RELATED FEDERAL AGENCIES**

**MARCH 23, 2010**

Mr. Chairman and Members of the Subcommittee, The American Legion thanks you for this opportunity to present its views on Fiscal Year (FY) 2011 funding issues under your jurisdiction.

**MILITARY CONSTRUCTION**

The American Legion supports the construction and maintenance of physical plants throughout the Department of Defense that meets mission needs of the Armed Forces, especially the quality-of-life needs of service members and their families.

No service member should ever have to worry about the quality and safety of facilities used by their family members on a military installation anywhere in the world. This is especially true for service members deployed away from their families. This includes, but not limited to their military quarters, military health facilities, their children's schools, daycare facilities, youth centers, and other facilities frequented by military families. In keeping with the tradition of taking care of its own, The American Legion strongly recommends close attention to the funding recommendations to address many of these concerns identified by each service branch.

The American Legion fully supports the expansion of affordable, high-quality child care services at child development centers on installations both in the United States and overseas. Clearly, the increased number of rotations by service members in support of Operations Enduring Freedom and Iraqi Freedom is taking its toll on the military family unit.

Over 58,000 students of military families attend classes in one of the 127 Department of Defense Education Activity (DODEA) schools currently in 12 countries and nearly 30,000 additional students in 67 schools in 7 states, Puerto Rico, and Guam. The American Legion supports the President's budget request to begin a five-year plan to replace and recapitalize more than half of the 194 DODEA schools, specifically calling for the replacement or modernization of schools at some of the major military installations both stateside and overseas.

**The American Legion recommends \$14.5 billion in military construction to modernize Department of Defense facilities.**

**The American Legion recommends \$2 billion for the construction, operation and maintenance of government-owned housing and the privatization of selected family housing units.**

**The American Legion recommends \$3 billion for the implementation of the Base Realignment and Closure (BRAC) process to fund construction, operations, and maintenance to relocate personnel and equipment; to conduct environmental studies and remediation; and to install communications, automation, and information management system equipment in support of construction projects.**

#### **DEPARTMENT OF VETERANS AFFAIRS**

The American Legion appreciates the President's budget request for \$125 billion for the Department of Veterans Affairs (VA). This budget request would meet several of the funding recommendations offered by The American Legion National Commander Clarence Hill last September during the joint hearing of the Committees on Veterans' Affairs. The budget request directs funding to assure veterans and their families timely access to the highest quality benefits and services provided by VA (The Best Care Anywhere). The American Legion sees these benefits and services as earned through honorable military service.

Due to the foresight and leadership of the President and Congress through the enactment of the 2008 Veterans' Budget Reform and Transparency Act, Secretary of Veterans Affairs (VA) Eric K. Shinseki is much more fortunate than many of his colleagues in the Cabinet because he has a timely, predictable and sufficient budget with which to administer the health care portion of his FY 2011 budget. The American Legion once again thanks you and your colleagues for the leadership on this critical issue.

As a nation at war, America has a moral, ethical and legal commitment to the men and women of the Armed Forces of the United States and their survivors. These current defenders of democracy will eventually join the ranks of their 23.5 million comrades that we refer to as veterans. Therefore, it is absolutely critical that the entire veterans' community (active-duty, Reserve component, and veterans) continue to remain supportive of honorable military service.

No service member should ever be in doubt about:

- the quality of health care he or she will receive if injured;
- the availability of earned benefits for honorable military service upon discharge; or
- the quality of survivors' benefits should he or she pay the ultimate sacrifice.

After reviewing the budget request for VA funding in FY 2011, The American Legion shares the vision to continue VA's transformation into a 21<sup>st</sup> Century organization. VA's approach to veterans' care, as a lifetime initiative, from the day the oath is taken and continuing with perpetual care after veterans are laid to rest, is a paradigm shift that is long overdue.

The FY2011 budget request focuses on three specific concerns that are of critical importance to the veterans' community and have long been priorities for The American Legion:

- **Easier access to benefits and services;**
- **Reducing the disability claims backlog and expediting the delivery of veterans earned benefits;**
- **Ending veterans' homelessness.**

In the budget request, VA has identified six "high priority" performance goals which again are consistent with The American Legion's priorities:

- **Reduce the Claims Backlog,**
- **Eliminate Veteran Homelessness,**
- **Automate the GI Bill Benefits System,**
- **Establish a Virtual Lifetime Electronic Record,**
- **Improve Mental Health Care,**
- **Deploy a Veterans Relationship Management System.**

### **Claims Backlog**

The American Legion applauds the technical efforts being attempted by VA to restructure the physical configuration of Regional Offices in order to streamline the claims process. In December, representatives of The American Legion and other VSO's were invited to Little Rock, Arkansas to be briefed on the VA's Pilot "POD" claims processing system. We were favorably impressed with the concept of triaging incoming mail and confining a claim to one working area for action by a cross-functional team. These actions are expected to and have demonstrated less lost official correspondence and reduced time in processing a claim. The American Legion feels that if implemented across VA, this concept will in fact have a positive impact on the claims backlog.

The American Legion believes that the way to reduce the back log is to make claims adjudicators more accountable. Additionally, the entry level position of a claims adjudicator inherently causes a turnover rate which is not conducive to an efficient process. It is recognized that the training period of new adjudicators is approximately 2 years. Within that time period and once in the "system," adjudicators often move to more financially rewarding positions. VA, with the help of 2009 "stimulus money," hired approximately 1800 temporary adjudicators and now these new adjudicators at this point are becoming efficient at their positions. Those individuals should be made permanent employees and encouraged and rewarded for remaining in their current positions.

### **The Changing Demographics of the Veterans' Population**

The American Legion is fully aware of the dramatic changes in demographics within the veterans' population. Women, in increasing numbers, continue to enter military service. When they join the veterans' population, the demand for gender specific health services also increases. The previously "male dominated" culture of the VA must be changed to include more extensive health care for women veterans and single parent veterans with children. This will require a change in how VA does business on a daily basis. VA medical facilities must be modified to reflect this new shift in the patient population. VA must have the resources to make timely adjustments and, if necessary, renovations to provide the gender specific medical services, as

well as Military Sexual Trauma (MST) support and childcare for single parents. The American Legion feels that a continued priority must be given to addressing this growing population of American veterans

Veterans, as with the US population at large, are mobile. Many are moving to rural or highly rural -- some would even say remote -- areas where the presence of VA medical facilities is at a premium. These veterans nonetheless are entitled to timely access to the VA health care system. VA is taking bold steps to help address this problem with such rural initiatives as establishing rural clinics, telehealth, and deploying more mobile clinics. The American Legion supports continued outreach initiatives to rural veterans and believes that more should be done in the future. In fact, The American Legion has a physical presence in many of these rural areas. The local American Legion family is more than willing to assist VA in the timely delivery of quality health care. If VA needs a place to park a mobile clinic, an American Legion Post would make an excellent “waiting room” for patients. Some local Post homes may even have enough space to set up a temporary or semi-permanent remote clinic, if appropriate.

### **Priority Group 8**

The American Legion continues to support additional funding to expand health care access to more Priority Group 8 veterans. The American Legion believes all veterans, through their honorable military service, earned and should be provided health care, especially if VA medical care is their best health care option.

### **Information Technology**

In his recent testimony before the House Veterans’ Affairs Committee, the VA Secretary outlined his four principles guiding VA into the future: increased agility in order to take advantage of and leverage resources; show demonstrable return on investment; improved service to veterans and their families; and control costs.

Many of VA’s “fixes” will depend on information technology. This decision moves technology forward through a transformation by creating new approaches and producing outcomes of greater convenience, quality, and client satisfaction for veterans. The American Legion believes Secretary Shinseki’s vision calls for information technology to be results-oriented; investing in emerging technologies; creating and implementing a coordinated, synchronized IT structure in order to continue VA transformation into the 21st Century. Secretary Shinseki plans to restructure IT funding to more accurately demonstrate IT support to its primary customers (Veterans Health Administration, Veterans Benefits Administration, National Cemetery Administration, and Corporate offices). At the same time, he has acknowledged VA’s responsibilities for inter-agency IT development to create a single electronic record for service members and veterans, known as Virtual Lifetime Electronic Record (VLER)

The American Legion understands that the investment for VLER is approximately \$157.6 million to fund the on-going collaborative work with DoD. This initiative will enable VA to begin collecting data about future veterans by instituting a uniform VA/DoD registration event at the point of accession to military service. By enabling information interoperability between VA and DoD, VA service delivery will be improved. Access to electronic records is essential to modern health care delivery and the paperless administration of benefits. It provides a framework

to ensure that all health care providers have all the information they need to deliver quality health care at the right time and place while reducing the occurrence of medical errors and duplicative testing. The creation of VLER would allow VA and DoD to take the next step in delivering seamless, high quality care, and will serve as a model for the nation. The American Legion supports a close collaborative effort between DoD and VA in order to insure a smooth transition of information.

The American Legion supports the continued commitment to develop the next generation health care technology known as HealthVet which will enhance and supplement the current Legacy system (VisTA) with more flexibility, improved security, and the infrastructure designed for data sharing among providers within and outside of VA. In addition, technological innovations in the field of telemedicine and telehealth will make it possible to reach out and provide access to veterans and families through non-institutional care. These innovations have significant implications for how care is organized and delivered in the future.

### **The American Legion Recommends \$3.8 billion for Information Technology in FY 2011**

#### **Medical and Prosthetics Research**

The American Legion believes VA's focus in research must remain on understanding and improving treatment for medical conditions unique to veterans. Service members are surviving catastrophically disabling blast injuries due to the superior armor they are wearing in the combat theaters and the timely access to quality combat medical care. The unique injuries sustained by the new generation of veterans clearly demand particular attention. It has been reported that VA does not have state-of-the-art prostheses like DoD and that the fitting of prostheses for women has presented problems due to their smaller stature.

The American Legion also supports other VA research activities, including basic biomedical research and bench-to-bedside projects in FY 2011. Congress and the Administration should continue to encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans, such as prostate cancer, addictive disorders, and trauma and wound healing, post-traumatic stress disorder, rehabilitation, and other research that is conducted jointly with DoD, the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

### **The American Legion recommends \$700 million for Medical and Prosthetic Research in FY 2011.**

#### **Major VHA Construction**

The Capital Asset Realignment for Enhanced Services (CARES) process identified approximately 100 major construction projects throughout the VA Medical Center System. Now that VA has disclosed the plan to deliver health care through 2022, Congress has the responsibility to provide funding. The CARES plan called for the construction of new hospitals in Orlando and Las Vegas and replacement facilities in Louisville and Denver for a total cost estimated over \$1 billion for these four facilities.

VA has not had this type of progressive construction agenda in decades. Major construction costs can be significant and proper utilization of funds must be well planned. However, if timely completion is truly a national priority, The American Legion continues to have concerns due to

inadequate funding.

In addition to the cost of the proposed new facilities, there are many construction projects that have been “placed on hold” for the past several years due to inadequate funding and the moratorium placed on construction spending by the CARES process. Two of the most glaring shortfalls are the neglect of the buildings sorely in need of seismic correction and the modification of VA facilities to support the growing women veterans’ population. The delivery of health care in unsafe buildings cannot be tolerated and funds must be allocated to not only construct the new facilities, but also to pay for much needed upgrades at existing facilities. Gambling with the lives of veterans, their families and VA employees is absolutely unacceptable. Delivery of services in less than “user friendly” facilities, will negate the entitlement, and alienate a growing portion of the veterans’ population.

### **The American Legion recommends \$2 billion for FY2011 Major Construction**

#### **Minor VA Construction**

VA’s minor construction program has also suffered significant neglect over the past several years. Maintaining the infrastructure of VA’s buildings is no small task, due to the age of these buildings, continuous renovations, relocations and expansions. When combined with the added cost of the CARES program recommendations, it is easy to see that a major increase over the previous funding level is crucial and overdue.

### **The American Legion recommends \$1.5 billion for Minor Construction in 2011.**

#### **State Cemetery Construction Grants Program**

VA's State Cemetery Grant Program is designed to complement VA's 125 national cemeteries across the country. This state cemetery grant program helps states establish new state veterans’ cemeteries, and expand or improve existing state cemeteries. To date, the VA program has helped establish, expand, or improve 72 state veterans’ cemeteries in 38 states, Northern Mariana Islands and Guam, which provided more than 25,000 burials in FY 2008. VA has awarded 174 grants totaling more than \$344 million.

The American Legion believes States will increasingly use the State Cemetery Grants Program to supplement the needs of veteran populations that are still not well served by the “75-mile service area/170,000 veteran population” threshold that currently serves as the benchmark for establishing a new national cemetery. New state cemeteries, and expansions and improvements of existing cemeteries, are therefore likely to increase. With increasing costs, especially the high costs of land in urban areas, and increased demand, The American Legion suggests that the amount of money for the State Cemetery Grants Program be substantially increased.

### **The American Legion recommends \$50 million for the State Cemetery Grants Program in FY 2011.**

#### **National Cemetery Administration**

The mission of the National Cemetery Administration (NCA) is to honor veterans with final resting places in national shrines and with lasting tributes that commemorate their service to this nation. The NCA’s mission is to serve all veterans and their families with the utmost dignity, respect, and compassion. Every national cemetery should be a place that inspires visitors to understand and appreciate the service and sacrifice of our nation’s veterans.

The American Legion recognizes NCA's excellent record in providing timely and dignified burials to all veterans who opt to be buried in a National Cemetery. Equally noteworthy is NCA's fine record in providing memorial headstones, markers and Presidential Memorial Certificates (PMC) to all who request such benefits. We also recognize the hard work that is required to restore and maintain National Cemeteries as national shrines and applaud NCA for its commitment and success toward that endeavor.

The American Legion looks forward to evaluation results and recommendations that VA is currently conducting, and which is expected to be available soon. The evaluation will cover program outcomes and policies including the "75-mile service area/170,000 veteran population" threshold that currently serves as the benchmark for establishing a new national cemetery. The American Legion is pleased that driving (commuting) times will also be considered in this evaluation. Inner-city traffic can significantly increase travel times to distant cemeteries. Driving time needs to be a factor when trying to determine if the veteran population is being served effectively.

**The American Legion recommends \$260 million in FY2011.**

#### **State Extended Care Facility Construction Grants Program**

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans' Homes (SVHs) and contracts with public and private nursing homes. Under title 38, USC, VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 133 SVHs in 47 states with over 27,000 beds providing nursing home, hospital, and domiciliary care. Grants for Construction of State Extended Care Facilities provide funding for 65 percent of the total cost of building new veterans' homes. Recognizing the growing Long Term Care (LTC) needs of older veterans, it is essential the State Veterans' Homes Program be maintained as an important alternative health care provider to the VA system.

The American Legion opposes attempts to place a moratorium on new SVH construction grants. State authorizing legislation has been enacted and state funds have been committed. Delaying projects will result in cost overruns and may result in states deciding to cancel these much needed facilities.

The American Legion supports increasing the amount of authorized per diem payments to 50 percent for nursing home and domiciliary care provided to veterans in State Veterans' Homes; providing prescription drugs and over-the-counter medications to State Homes Aid and Attendance patients along with the payment of authorized per diem to State Veterans' Homes; and allowing full reimbursement of nursing home care to 70 percent or higher service-connected disabled veterans, if those veterans reside in a State Veterans' Home.

**The American Legion recommends \$275 million for the State Extended Care Facility Construction Grants Program in FY 2011.**

#### **Homelessness**

VA's Community Homeless Assessment Local Education and Networking Groups (CHALENG), which conduct an annual census of homeless veterans, estimated 107,000 veterans were homeless each night in 2009. That figure was 131,000 in 2008 and 154,000 in 2007.

Further, more and more homeless veterans are male and have children, are female, and are female with children. These new paradigms are changing the way that VA does business in order to attain the Secretary's directive to "end homelessness for veterans."

The Homeless Veterans Reintegration Program (HVRP) is a competitive grant program. HVRP provides services to assist in reintegrating homeless veterans into meaningful employment in the labor force and stimulates the development of effective service delivery systems that address the complex problems facing homeless veterans. HVRP is the only nationwide program focused on assisting homeless veterans to reintegrate into the workforce.

**The American Legion recommends \$50 million for HVRP in FY 2011.**

#### **Homeless Providers Grant and Per Diem Program Reauthorization**

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem Program under the Homeless Veterans Comprehensive Service Programs Act of 1992, P.L. 102-590. The Grant and Per Diem Program is offered annually (as funding permits) by VA to fund community agencies providing services to homeless veterans.

VA can provide grants and per diem payments to help public and nonprofit organizations establish and operate supportive housing and/or service centers for homeless veterans. Funds are available for assistance in the form of grants to provide transitional housing (up to 24 months) with supportive services, supportive services in a service center facility for homeless veterans not in conjunction with supportive housing; or to purchase vans.

**The American Legion recommends \$200 million for the Grant and Per Diem Program in FY 2011.**

#### **CONCLUSION**

Mr. Chairman and Members of the Subcommittee, The American Legion sincerely appreciates the efforts of you and your colleagues to address the funding needs of military construction and the Department of Veterans Affairs.

Without question, The American Legion continues to advocate for many of the quality-of-life military construction needs. Military housing, military schools for dependents, and child care facilities remain critical factors in the recruitment and retention of military families. You and your colleagues deserve praise for the attention paid to the military construction needs of today's all-volunteer force.

The American Legion is encouraged by President Obama's budget request for FY 2011 for the Department of Veterans Affairs. While several of the key issues raised by the National Commander in September 2009 have been addressed in a positive issue, The American Legion feels that additional attention should be paid to Major and Minor Construction in the VA budget to reflect the changing demographics of the veterans' population, Long Term Care facilities for aging veterans and their dependents, and additional funds for the inclusion of Priority Group 8 veterans who like their less fortunate fellow veterans have served this nation faithfully, and their families have sacrificed equally and should not be penalized because of economic fortunes.

The American Legion thanks the Subcommittee once again for being allowed to testify today and I welcome any questions you or your colleagues may have.



**NATIONAL ASSOCIATION FOR UNIFORMED SERVICES**

**TESTIMONY**

**on**

**Military Construction and Veterans Affairs**

**before the**

**House Committee on Appropriations  
Subcommittee on Military Construction, Veterans Affairs  
and Related Agencies**

**presented by**

**Rick Jones, Legislative Director,  
National Association for Uniformed Services**

**Thursday, March 23, 2010  
H-143 Capitol**

Chairman Edwards, Ranking Member Wamp, and members of the Committee:

I am pleased today to present testimony on behalf of the National Association for Uniformed Services (NAUS) on selected fiscal year 2011 issues before the Military Construction, Veterans Affairs, and Related Agencies Subcommittee. My name is Richard Jones, legislative director for NAUS.

Mr. Chairman, on behalf of our nationwide membership, the National Association for Uniformed Services thanks you and the members of this Subcommittee for working so hard with House leadership to make veterans the #1 priority over the past four years. Your accomplishments have helped address the critical medical-care needs facing our service men and women as they return home.

### **Funding for the Department of Veterans Affairs (VA) Health Care**

The National Association for Uniformed Services is encouraged that the administration's overall recommendation for VA resources continues to move in the right direction, building upon the strides taken over the recent past years. It is important that we not backtrack from what is necessary in the provision of health care for sick and disabled veterans, and for the number of troops returning from Iraq and Afghanistan.

The National Association for Uniformed Services is generally pleased with the President's fiscal year 2011 VA budget request. It recommends a level of \$51.5 billion, \$4.3 billion above last year's level or 9.1 percent more. However, it is important to note that the recommendation includes a projected \$3.3 billion in medical collection of fees and copays, which may falter especially in a difficult economic year with high unemployment.

The National Association for Uniformed Services is also pleased to endorse, with 62 other veterans organizations, *The Independent Budget*, formulated by AMVETS, the Disabled Veterans of America, Paralyzed Veterans of America, and Veterans of Foreign Wars of the

United States. *The Independent Budget* has a superb record on recognizing the needs of the department in fulfilling its mission to care for sick and disabled veterans.

The National Association for Uniformed Services recommends a total of \$52.0 billion for medical care, an increase of \$4.5 billion over fiscal year 2010. We urge the Subcommittee to recognize the unique specialized care provided at VA facilities and to provide the resources needed for VA to treat sick and disabled veterans.

The Department's Veterans Health Administration (VHA) is a world-class leader in advanced care medicine and in the provision of primary care. In addition, VHA has consistently pioneered research initiatives in areas that have directly benefited not only veterans, but also our entire population.

We are pleased to see advancement in lifting the ban on access to VA health care for certain veterans classified as Priority 8 veterans. Denying access only devalues the service of those who seek care with VA. Recent estimates indicate that VA will enroll about 193,000 veterans by the close of fiscal year 2010. We encourage your efforts to resource healthcare eligibility to an additional 500,000 Priority 8 veterans over the next years.

But more should be done. We strongly recommend restoring Priority 8 access with the enrollment of those veterans who can identify private- or public-health insurance. In this way, we would make certain that VA would receive reimbursement and third-party payers would be used to the fullest extent.

The National Association for Uniformed Services firmly believes that the veterans healthcare system is an irreplaceable national investment, critical to the nation and its veterans. The provision of quality, timely care is considered one of the most important benefits afforded veterans. And our citizens have benefited from the advances made in medical care through VA research and through VA innovations as well, such as the electronic medical record.

We urge the Subcommittee to take the actions necessary to honor our obligation to those men and women who have worn the nation's military uniform. Clearly, when VA does not receive adequate funding, it is forced to ration, delay or deny care.

### **Department of Veterans Affairs, Disability Claims Backlog**

The National Association for Uniformed Services strongly supports the provision of timely benefits to disabled veterans and their families. These benefits help offset the economic effects of disability and are one of the essential functions of the Department of Veterans Affairs (VA). The capacity of the disabled veteran to afford the necessities of life is oftentimes dependent on these benefits, so delays in the resolution of a claim is a matter of serious concern.

Despite VA's best efforts to deliver benefits to entitled veterans, the claims workload of the Veterans Benefits Administration (VBA) continues to increase. Simply stated, VBA is falling farther behind.

The severe and growing backlog of veterans' claims is well documented. A recent report from the VA Inspector General, which reviewed a 12-month period of claims, found that 22 percent of all decisions were incorrect or incomplete. Out of the 1 million claims received, more than 220,000 veterans claims, 1 of every 5 submitted, were inaccurate or incomplete. Many of those cases were sent back to the VA for review or added to the caseload of the Board of Veterans Appeals or found their way to the Court of Appeals for Veterans Claims, further clogging the system. Whatever the destination of those claims, the simple fact is that VA can ill-afford an increase of that number of claims for review due to its own inaccurate or incomplete work. With the high percentage of inaccurate decisions, it's not hard to see why the system is so overwhelmed.

The disability claims workload has continuously grown since 2000. Annual claims grew from 674,219 in 2001 to 1,013,712 in 2009. Claims received by VA are more complex and require additional time to decide and rate. NAUS firmly believes VA need to put additional emphasis on the quality of its claims decisions in order to get a handle on this matter. Improvements are

required in the Veterans Benefits Management System and associated areas that deal with benefit claims issues.

Improvement in operations of the VA benefit claims approval system is critical. It is clear to the National Association for Uniformed Services that until this problem is tackled head on, thousands of veterans injured in military service will continue to face unnecessary delays and red tape in receiving the benefits we owe them and their transition to civilian life will be rough.

We need to make headway to overcome the chronic claims backlog and consequent protracted delays in claims disposition. Every effort must be made to gain ground on the problem.

The problem is deeply troubling, but it can be corrected. Training must be resourced and technical support must be provided to ensure progress is found to bring down the number of pending claims and shorten the waiting period for decision.

The National Association for Uniformed Services calls on lawmakers to make the VBA a priority within the national budget. The challenge is to provide timely decisions on claims submitted by veterans who suffer disability as a result of their military service. And the solution is to ensure that VBA has adequate funding to reduce the backlog and achieve the mission of providing timely claims adjudication.

### **Department of Veterans Affairs, Seamless Transition Between the DoD and VA**

Congress must direct the Pentagon to remove remaining roadblocks between DoD and VA to ensure a seamless transition of veterans' medical records. The two departments need to develop better communications to help identify, locate and follow up with injured servicemembers separated from the military.

The provision of a seamless transition for recently discharged military is critically important for medical reasons, particularly for the most severely injured patients. Most important in the calculus of a seamless transition is the capacity to share information at the earliest possible moment prior to separation or discharge. It is essential that surprises be reduced to a minimum

to ensure that all troops receive timely, quality health care and other benefits earned in military service.

The DoD/VA exchange should include a detailed history of care provided and an assessment of what each patient may require in the future, including mental health services. No veteran leaving military service should fall through the bureaucratic cracks.

We urge the Subcommittee to hold the departments to a strict line for pursuit of a joint lifetime electronic health and benefits records for service members and veterans. We have seen progress, and we urge members of the Subcommittee to motivate DoD and VA to end red-tape resistance and to get the job done.

### **Department of Veterans Affairs, Medical and Prosthetic Research**

As Congress moves forward in consideration of funding for fiscal 2011, the National Association for Uniformed Services encourages a strong effort to provide for the Department of Veterans Affairs (VA) medical research mission, especially in the area of prosthetic research. National Association for Uniformed Services recommends \$590 million, \$9 million dollars more than the current year level of \$581 million. The National Association for Uniformed Services supports increasing medical and prosthetic research to continue support for new research initiatives and to maintain a stable, predictable funding stream for advances under this account.

Clearly, care for our troops with limb loss and special needs is a matter of national concern. In order to help meet the challenge, VA research must be adequately funded to continue its intent on treatment of troops surviving this war with grievous injuries. The research program also requires funding for continued development of advanced prosthesis that will focus on the use of prosthetics with microprocessors that will perform more like the natural limb.

The National Association for Uniformed Services encourages the Subcommittee to ensure that funding for VA's medical and prosthetic research supports the full range of programs needed to meet current and future health challenges facing wounded veterans.

## **Department of Veterans Affairs, Post Traumatic Stress Disorder (PTSD)**

The National Association for Uniformed Services commends VA for its enhanced awareness on mental health issues. We support VA continued improvements in care of troops demonstrating symptoms of mental health disorders and treatment for PTSD.

Over the past several years, VA has dedicated a higher level of attention to veterans who exhibit PTSD symptoms. The programs for treatment of veterans exhibiting PTSD symptoms are essential for the recovery and restoration of many of those who must deal with the debilitating effects of mental injuries, which are as inevitable in combat as gunshot and shrapnel wounds.

While many new approaches to treatments have been developed and are available to veterans, the National Association for Uniformed Services is concerned that VA's capacity to serve the mental health needs of returning veterans remains below the level needed.

The need for treatment for veterans is immediate, yet too many servicemembers are discharged from the service undiagnosed, while continuing to suffer debilitating symptoms.

The key to physical brain damage is healing of both injured tissue and the arterial support to blood flow to assure continued normal function. Trauma injuries are complex internal injuries.

The National Association for Uniformed Services is encouraged to see reliable advancement of cases under a treatment known as Hyperbaric Oxygen Therapy (HBOT) at an atmospheric pressure of 1.5 atmospheres (HBOT 1.5). HBOT 1.5 has produced dramatic improvement for more than 30 Iraq/Afghanistan casualties facing TBI issues. We recommend the subcommittee give this therapy its close attention and provide the necessary resources for clinical trials of HBOT 1.5 to complete a more formal treatment for regeneration of brain tissue biologically instead of simply treating the symptoms with drugs.

The National Association for Uniformed Services encourages the members of the Subcommittee to increase funding for mental health to meet the surging need of servicemembers returning from fields of combat. We simply must have substantial numbers of providers who are trained and certified to deliver care for post-combat PTSD and major depression.

While VA and Congressional leaders have taken important steps to move VA toward better care for veterans with mental health problems, many challenges still remain. The National Association for Uniformed Services urges the development of a consistent, seamless, and working approach that allows VA and DOD to screen returning service members and provide more effective early intervention that leads to healing.

VA requires additional funds to expand its specialized mental health programs, to provide additional capacity for inpatient psychiatric and residential care, to ensure effective treatment for post-traumatic stress and to help families deal with their loved ones return to civilian life.

### **Department of Veterans Affairs, Medicare Reimbursement**

The National Association for Uniformed Services supports legislation to authorize Medicare reimbursement for healthcare services provided Medicare-eligible veterans in VA facilities. Medicare subvention will benefit veterans, taxpayers and VA.

The National Association for Uniformed Services sees an all around win-win-win for establishment of Medicare subvention. VA would receive additional, non-appropriated funding. Medicare-eligible veterans would receive world-class medical treatment in the system our government provided for their care. Scarce resources would be saved because medical services can be delivered for less cost at VA than in the private sector.

In addition, direct billing between VA and the Centers for Medicare and Medicaid Services (CMS) would reduce opportunities for waste, fraud and abuse losses in the Medicare system.

The National Association for Uniformed Services encourages the Subcommittee to permit Medicare-eligible veterans to use their Medicare entitlement for care at local VA medical facilities.

### **Armed Forces Retirement Home**

The National Association for Uniformed Services is pleased to note the Subcommittee's continued interest in providing funds for the Armed Forces Retirement Home (AFRH). We urge the Subcommittee to meet the challenge in providing adequate funding for the facility in Washington, DC, and Gulfport, Mississippi.

And we thank the Subcommittee for the provision of funding that has led to the Armed Forces Retirement Home in Gulfport to be nearly ready for completion. And we look forward to the completion of the home scheduled for June 2010. When completed, the facility will provide independent living, assisted living and long-term care to 584 residents.

The National Association for Uniformed Services also applauds the recognition of the Washington AFRH as a historic national treasure. And we look forward to working with the Subcommittee to continue providing a residence for and quality-of-life support to these deserving veterans without turning over large portions of this campus, just four miles from the nation's Capitol, to developers. We ask that continued care and attention be given to the mixed-use development to the property's southern end, which has been stalled due to a bankruptcy of a construction development partner approved by the National Capital Planning Commission.

### **Appreciation for Opportunity to Testify**

As a staunch advocate for military retirees and veterans, the National Association for Uniformed Services represents all ranks, branches and components of uniformed services, their families and survivors. The Association recognizes that these brave men and women did not fail us in their service to country, and we, in turn, must not fail them in providing the benefits and services they *earned* through honorable military service.

Mr. Chairman, the National Association for Uniformed Services appreciates the Subcommittee's hard work. We ask that your work continue in good faith to put the dollars where they are most needed in our nation's highest priority areas, which include veterans health care and benefits services, housing for our military troops and their families, particularly in time of war and when we are increasing our troop level in Afghanistan.

The National Association for Uniformed Services is confident you will take special care of our nation's greatest assets: the men and women who serve and have served in uniform. We are proud of the service they give, and we recognize that the price we pay for their earned benefits will never equal the value their service provides our nation.

Again, the National Association for Uniformed Services deeply appreciates the opportunity to present the Association's views on issues before the Military Construction, Veterans Affairs, and Related Agencies Subcommittee.

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# Subcommittee on Military Construction and Veterans Affairs

## Witness Disclosure Form

**Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.**

Your Name, Business Address, and Telephone Number:

Richard A. Jones, 5535 Hempstead Way, Springfield, VA 22151  
(703) 750-1342 extension 1008

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

Representing the National Association for Uniformed Services

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2006?

No  X

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Signature:



Date: March 23, 2010



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The Servicemember's Voice in Government  
Established in 1968



Richard A. “Rick” Jones  
Legislative Director  
National Association for Uniformed Services (NAUS)

Richard A. “Rick” Jones joined NAUS as Legislative Director on Sept. 1, 2005. As legislative director, he is the primary individual responsible for promoting the NAUS legislative, national security, and foreign affairs goals before the Departments of Defense and Veterans Affairs, and the Congress of the United States.

Rick presently serves as co-chairman of the National Military and Veterans Alliance (NMVA) and co-chairman of the Alliance for Military and Overseas Voting Rights (AMOVR). NMVA is composed of 31 military associations and veterans organizations with a combined membership of more than 3.5 million members. AMOVR is a working alliance of 36 military and overseas advocacy groups, elected officials, students and voting rights advocates formed to ensure that our military men and women are afforded their right to vote and to ensure their votes are counted.

Rick is an Army veteran who served as a medical specialist during the Vietnam War era. His assignments included duty at Brooke General Hospital in San Antonio, Texas; Fitzsimons General Hospital in Denver, Colorado; and Moncrief Community Hospital in Columbia, South Carolina.

Rick completed undergraduate work at Brown University prior to his Army draft and earned a Master Degree in Public Administration from East Carolina University in Greenville, North Carolina, following military service.

Prior to assuming his current position, Rick served five years as National Legislative Director for AMVETS, a major veterans service organization. He also worked nearly twenty years as a legislative staff aide in the offices of Senator Paul Coverdell, Senator Lauch Faircloth, and Senator John P. East. He also worked in the House of Representatives as a committee staff director for Representative Larry J. Hopkins and Representative Bob Stump.

In working for Rep. Stump on the House Committee on Veterans’ Affairs, he served two years as minority staff director for the subcommittee on housing and memorial affairs and two years as majority professional staff on funding issues related to veterans’ affairs budget and appropriations.

Rick and his wife Nancy have three children and reside in Springfield, Virginia.

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**Written Statement**

**of the**

**AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (AANA)**

**and the**

**ASSOCIATION OF VA NURSE ANESTHETISTS (AVANA)**

**to the**

**HOUSE APPROPRIATIONS COMMITTEE**  
**MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED**  
**AGENCIES SUBCOMMITTEE**

**March 23, 2010**  
**WASHINGTON, DC**

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Chairman Edwards, Ranking Member Wamp, and Members of the Subcommittee:

The American Association of Nurse Anesthetists (AANA) is the professional association that represents more than 40,000 Certified Registered Nurse Anesthetists (CRNAs) across the United States. More than 500 CRNAs are employed by the Department of Veterans Affairs (DVA) healthcare system. The Association of Veterans Affairs Nurse Anesthetists (AVANA) is a professional organization that represents VA CRNAs across the United States and Puerto Rico. We appreciate the opportunity to present our testimony to the subcommittee. With our military personnel and veterans' access to safe, high quality healthcare as our first priority, we want you to know that the profession of nurse anesthesia is working creatively and effectively with the DVA, in partnership with the U.S. Army, to improve its retention and recruitment of CRNAs so that high quality anesthesia services remain available and accessible to our nation's veterans. This work is crucial for several reasons, but most importantly because the DVA's anesthesia workforce needs are increasing. We request the committee consider as part of the 2011 Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill providing at least \$400,000 to expand the U.S. Army nurse anesthesia educational program at Ft. Sam Houston, Texas, to ensure the safest, most cost-effective anesthesia services for our Veterans; to examine more closely the VA anesthesia workforce by supporting current retention and recruitment efforts from the U.S. Senate,

including lifting the statutory pay cap for nurse anesthetists; and, provide \$3 million for the DVA to collaborate with the Centers for Disease Control and Prevention (CDC) to develop and assess systems for complete and consistent adherence to injection safety and infection control guidelines across the VA healthcare system throughout the spectrum of care.

## **CRNAs AND THE VA: A TRADITION OF SERVICE**

Let us begin by describing the profession of nurse anesthesia and its history and role with the DVA healthcare system.

In the administration of anesthesia, CRNAs perform the same functions as anesthesiologists and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer more than 32 million anesthetics to patients each year in the United States. Nurse anesthetists are also the sole anesthesia providers in the vast majority of rural hospitals, assuring access to surgical, obstetrical and other healthcare services for millions of rural Americans.

Nurse anesthesia dates back to the late 1800s, when nurses were observed providing pain relief to wounded soldiers on Civil War battlefields. Since World War I, the profession of nurse anesthesia has been proud and honored to provide anesthesia care for our past and present military personnel and their families. CRNAs have been the principal anesthesia providers in combat areas of every war in which the United States has been engaged in the last 100 years, staffing ships, remote US military bases, and forward surgical teams, often without physician anesthesiologist support. The U.S. Army Joint Special Operations Command Medical Team and Army Forward Surgical Teams are staffed by CRNAs. Wherever our military men and women are stationed in harm's way around the world, on land and at sea, CRNAs are there providing anesthesia care and supporting the mission and interests of the United States.

As our military personnel advance from active service to retired and veteran status, their anesthesia care in VA facilities is provided predominantly by nurse anesthetists. In 12 percent of VA healthcare facilities, the necessary anesthesia services are provided solely by CRNAs, ensuring our Veterans the safe anesthesia care they deserve and have earned.

Our tradition of service to the military and our veterans is buttressed by our personal and professional commitment to patient safety, made evident through research on our practice. In our professional associations, we state emphatically that "our members' only business is patient safety." Safety is assured through education, high standards of professional practice, and commitment to continuing education. Having first practiced as registered nurses, CRNAs are educated to the master's degree level, and some to the doctoral level, and meet the most stringent continuing education and recertification standards in the anesthesia field. Thanks to this tradition of advanced education and clinical practice excellence, we are humbled and honored to note that anesthesia is 50 times safer now than in the early 1980s (National Academy of Sciences, 2000). Research further demonstrates that the care delivered by CRNAs, physician anesthesiologists, or by both working together yields similar patient safety outcomes. In addition to studies performed by the National Academy of Sciences in 1977, Forrest in 1980, Bechtoldt in 1981, the Minnesota Department of Health in 1994, and others, noted cardiologist and researcher Dr. Michael Pine, MD, MBA, further concluded once again that among CRNAs and physician anesthesiologists "the type of anesthesia provider does not affect inpatient surgical mortality" (Pine, 2003). Most recently, a study published in *Nursing Research* confirmed that obstetrical anesthesia services are extremely safe, and that there is no difference in safety between hospitals that use only CRNAs compared with those that use only

anesthesiologists (Simonson et al, 2007). Both CRNAs and anesthesiologists administer anesthesia for all types of surgical procedures, from the simplest to the most complex, either as single providers or together. Thus, the practice of anesthesia is a recognized specialty in both nursing and medicine.

### **NURSE ANESTHESIA PROVIDER SUPPLY AND DEMAND: SOLUTIONS FOR RECRUITMENT AND RETENTION IN THE DVA**

While both types of anesthesia professionals provide the same high quality anesthesia care, CRNAs provide the DVA an additional advantage of cost-effectiveness. Consequently, both our veterans and our DVA healthcare system are best served by policies and initiatives that secure adequate numbers of CRNAs in the DVA. We believe this committee can help accomplish this objective by supporting nurse anesthesia education programs, both within the VA itself and in partnership with military and civilian schools of nurse anesthesia.

It is essential to understand that while there is strong demand for CRNA services in the public and private healthcare sectors, the profession of nurse anesthesia is working effectively to meet this workforce challenge. The AANA and AVANA both anticipate growing demand for CRNAs. Our evidence suggests that while vacancies exist, the demand for anesthesia professionals can be met if appropriate actions are taken. As of January 2010, there are 108 accredited nurse anesthesia schools to support the profession, and the number of qualified registered nurses applying to these schools continues to climb. The growth in the number of schools, number of applicants, and production capacity has yielded significant growth in the number of student nurse anesthetists graduating and being certified into the profession. The Council on Certification of Nurse Anesthetists reports that in 2009 our schools produced 2,228 graduates, a 66% increase since 2003, and 2,386 nurse anesthetists became certified. This growth is expected to continue. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) projects that the 108 CRNA schools will produce 2,430 graduates in 2010.

The number of VA anesthesia vacancies is causing us concern. We believe they can be filled through creative partnership between the VA system and the profession of nurse anesthesia, and commitment by the DVA to effectively recruit and retain CRNAs. More than half of the VA nurse anesthesia workforce is over the age of 53, an age some years above the mean for all CRNAs nationally. The annual turnover and retirement rate among CRNAs within the VA has risen to about 19% over the past few years and continues to rise as the workforce ages, more lucrative employment is offered in the private sector, and new graduates from CRNA educational programs find the VA employment and practice package comparatively uncompetitive. Currently, 24 stations show vacancies on public federal job posting sites. However, we have reason to believe the numbers of stations with actual vacancies is closer to 40, with staff vacancies either being left vacant for extended periods of time or filled by contract personnel. Approximately 150 CRNA slots in the DVA are being filled by contract personnel.

As the nurse anesthesia profession is working to meet the demand for CRNAs generally, we believe that the DVA specifically can meet its CRNA recruitment needs by pursuing three strategies. First, the DVA should expand its relationships with existing CRNA schools. Second, the DVA should expand its joint CRNA educational program together with the Department of Defense (DOD) health system. Third, the DVA should upgrade its recruitment, retention, and practice environment factors to make VA service more competitive with the private market for anesthesia services, within the context of the DVA's mission.

To a degree, some of these strategies are already under way and achieving results for the DVA healthcare system. A recent AANA survey shows our nurse education programs use some 70 VA hospitals and

healthcare facilities as clinical practice education sites, helping to educate CRNAs, provide superior patient care, and aid the VA in recruiting nurse anesthetists. In addition, we recommend that the VA pursue nurse anesthesia resource sharing programs with civilian CRNA schools through faculty exchange initiatives.

We have expressed concern that the DVA has introduced anesthesiologist assistants (AAs) into its healthcare system, through qualifications standards that do not require them to be licensed in any state, or subject to any state's oversight or discipline, or to have graduated from an accredited educational program, or to have secured certification, or to be appropriately supervised by anesthesiologists in a manner consistent with AAs' training as assistants. The DVA handbook VHA-1123 would authorize anesthesiologists to delegate anesthesia care to unlicensed, uncredentialed individuals. There are other substantive concerns with the handbook. Our veterans deserve better. In a letter to DVA in January 2006, we requested the proposed policy be withdrawn and have met with the agency to promote our shared interest in ensuring our veterans access to safe, high quality anesthesia care. Our concerns with this agency policy remain in force today.

### **U.S. ARMY – VA JOINT PROGRAM IN NURSE ANESTHESIA FT. SAM HOUSTON, SAN ANTONIO, TX**

The establishment of the joint U.S. Army-VA program in nurse anesthesia education at the U.S. Army Graduate Program in Anesthesia Nursing, Ft. Sam Houston, San Antonio, TX, holds the promise of making significant improvements in the VA CRNA workforce, as well as improving retention of VA registered nurses in a cost-effective manner. The current program uses existing resources from both the DVA's Employee Incentive Scholarship Program (EISP) and VA hospitals to fund tuition, books, and salary reimbursement for student registered nurse anesthetists.

This VA nurse anesthesia program started in June 2004 with three openings for VA registered nurses to earn a Master of Science in Nursing (MSN) in anesthesia granted through the University of Texas Houston Health Science Center. The program is also granting degrees through the Northeastern University Bouve College of Health Sciences nurse anesthesia educational program in Boston, Mass. This program continues to attract registered nurses into VA service by sending RNs the strong message that the VA is committed to their professional and educational advancement. In order to achieve the goal of expanding the program further, it is necessary for full funding of the current and future EISP to cover tuition, books, and salary reimbursement.

The 30-month program is broken down into two phases. Phase I, 12 months, is the didactic portion of the anesthesia education at the U.S. AMEDD Center and School (U.S. Army Graduate Program in Anesthesia Nursing). Phase II, 18 months, is clinical practice education, in which VA facilities and their affiliates serve as clinical practice sites. In addition to the education taking place in Texas, the agency will use VA hospitals in Augusta, GA, and increase Phase II sites as necessary. Similar to military CRNAs who repay their educational investment through a service obligation to the U.S. Armed Forces, graduating VA CRNAs would serve a three-year obligation to the DVA healthcare system. Through this kind of DOD-DVA resource sharing, the VA will have an additional source of qualified CRNAs to meet anesthesia staffing requirements.

At a time of increased deployments of medical military personnel, VA-DOD partnerships are a cost-effective model to fill these gaps in the military healthcare system. At Ft. Sam Houston nurse anesthesia school, the VA faculty director has covered her Army colleagues' didactic classes when they are deployed at a moment's notice. This benefits both the VA and the DOD to ensure the nurse anesthesia students are

trained and certified in a timely manner to meet their workforce obligation to the federal government as anesthesia providers.

We are pleased to note that the DVA's Acting Deputy Under Secretary for Health and the U.S. Army Surgeon General approved funding to start this VA nurse anesthesia school in 2004. With modest levels of additional funding in the EISP, this joint US Army-VA nurse anesthesia education initiative can grow, thrive, and serve as a model for meeting other VA workforce needs, particularly in nursing.

We recommend that the committee allocate \$400,000 in FY 2011 funds to expand this joint educational program.

### **SAFE INJECTION PRACTICES**

Nurse anesthetists are on the front lines of patient care. As an essential piece of the care model, nurse anesthetists are concerned with the inconsistent adherence to standards of safe practice across the DVA healthcare system as referenced in the VA's Office of Inspector General (OIG) June 2009 report ("Healthcare Inspection: Use and Reprocessing of Flexible Fiberoptic Endoscopes at VA Medical Facilities," VAOIG-09-01784-146, 06/16/2009). This report focused on lapses in proper use and reprocessing of flexible fiberoptic endoscopes at VA medical facilities. These lapses resulted in three known cases of the transmission of blood-borne disease and exposed more than 10,000 veterans to hepatitis B, hepatitis C, and HIV.

As a co-founding member of the Safe Injection Practices Coalition (SIPC), we ask that the subcommittee provide \$3 million for the department to collaborate with the Centers for Disease Control and Prevention (CDC) and the SIPC to develop and assess systems for complete and consistent adherence to injection safety and infection control guidelines across the DVA healthcare system throughout the spectrum of care. These funds would also pilot test a provider education and patient awareness campaign for safe injection practices, titled the *One & Only Campaign*, in VA facilities, in the same manner that the campaign is being piloted in several states.

### **LOCALITY PAY**

In order to meet the demand for nurse anesthetists, each VA facility's administrator may make use of existing locality pay structures as authorized and funded by Congress. Competitive salaries assist the VA with retention of CRNAs to provide anesthesia services for our nation's veterans. Though providing competitive salaries for excellent employees is an ongoing challenge, using locality pay to keep personnel is most cost-effective. This is where this subcommittee can help, by providing adequate funding for personnel through locality pay adjustments where base salaries are not sufficiently competitive with the local private market.

For several reasons, ensuring sufficient locality pay flexibility is in the interest of both our VA and our veterans. The VA faced a severe shortage of CRNAs in the early 1990s, which was moderately corrected with the implementation of a locality pay system in 1991. In 1992, Congress expanded the authority to the local medical directors and allowed them to survey an expanded area to determine more competitive average salaries for CRNAs, which boosted pay and morale. Implementation of this expanded authority helped assist the VA in making great leaps in retention and recruitment of CRNAs at that time. However, times and the local labor markets for healthcare professionals have continued to change. In the past few years CRNA salaries have increased in the private sector, while the VA has not adjusted to these new

salary rates. This means that in some markets the VA locality pay system is no longer competitive with the private sector, and new nurse anesthetist graduates are choosing not to work in the DVA healthcare system. We believe the VA would benefit by providing CRNAs competitive salaries in VA facilities and making use of effective locality pay adjustments, which reduces VA hospital administrators' requirements for contracted outside services at higher rates.

Though nurse anesthetists provide the lion's share of anesthesia services to DVA healthcare facilities, the agency is facing a wave of retirements and subsequent challenges recruiting CRNAs because the compensation it offers is below local market levels, a Government Accountability Office (GAO) report highlighted ("Many Medical Facilities Have Challenges in Recruiting and Retaining Nurse Anesthetists," GAO-08-56, 12/13/2007) The GAO recommended that the VA apply its locality pay system more vigorously to recruit and retain nurse anesthetists.

At the time the report was issued, the AANA issued a statement saying, "The profession of nurse anesthesia is committed to caring for our nation's Veterans. Nurse Anesthesia continues to be a safe, flexible and highly cost-effective means for the VA to ensure our Veterans the healthcare that they need and deserve. We look forward to continuing work with the Department of Veterans Affairs, the Congress, and the members of the Association of Veterans Affairs Nurse Anesthetists (AVANA) to help carry out the recommendations of this report."

The GAO found that VA medical facilities have had to temporarily close operating rooms or delay elective surgeries due to a shortage of CRNAs. While demand for CRNA services is increasing, the report says 26 percent of the VA's CRNAs are projected to retire or leave the department in the next five years. The GAO said that the VA's CRNA recruitment and retention challenges are caused primarily by the agency's below-market compensation compared with local market conditions around the country. The GAO based its findings on surveys of VA CRNAs and VA managing personnel in local VA facilities and at VA headquarters, and through other data sources. The report says the nurse anesthesia profession has been working effectively to meet high U.S. demand for anesthesia workforce by increasing the number of qualified professionals graduating from accredited nurse anesthesia programs.

The report recommended that the agency deploy and carry out its existing locality pay system to adjust salaries to be more competitive. Any locality pay system should be structured to set competitive salary levels for nurse anesthetists working in VA healthcare facilities. The VA could implement a system guaranteeing that accurate surveys on pay are being conducted in a timely manner. This salary data would be used to adjust Nurse 1 (Step 1) to be competitive within the local market to assist VA facilities in hiring new nurse anesthesia graduates.

The subcommittee should also express support for the *Caregivers and Veterans Omnibus Health Services Act of 2009* (S 1963) recently passed in the Senate. The legislation contains provisions from the *Veterans Health Care Authorization Act of 2009* (S 252), expanding incentive professional pay for CRNAs by lifting the statutory pay cap for Certified Registered Nurse Anesthetists (CRNAs). This pay cap removal will allow the VA to not only recruit new nurse anesthetists to the VA, but will also help retain current anesthesia professionals, thus ensuring the highest quality care for our nation's veterans.

Finally, with adjustments in the pay structure to include professional pays for recruitment and retention of CRNAs, VA facilities may well realize cost savings in contrast with other arrangements for securing anesthesia services.

## CONCLUSION

In conclusion, we recognize that the VA has nurse anesthesia staffing needs. Through an effective partnership with the nurse anesthesia profession, the VA can meet its future CRNA workforce requirements through three cost-effective models which exist today and can be expanded. Our VA hospitals can serve as clinical practice sites for CRNA schools. Going one step further, the DVA healthcare system can pursue resource sharing and faculty exchange agreements with nurse anesthesia schools. Further still, the VA and DOD can share resources outright to educate nurse anesthetists for veterans and military settings alike, particularly with modest additional funding. This VA commitment to CRNA education helps secure the nurse anesthesia workforce our veterans need, and attracts registered nurses into VA service by sending the strong message that the VA is committed to RNs' professional and educational advancement. Last, the VA should examine and improve the effectiveness of its recruitment, retention and practice environment for CRNAs.

Thank you. If you have further questions, please contact the AANA Federal Government Affairs Office at 202-484-8400.

# # # #

# FOVA

Friends of VA Medical Care and  
Health Research

A coalition of national organizations  
committed to quality care for  
America's veterans

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STATEMENT OF

## THE FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH (FOVA)

ON

## THE FISCAL YEAR 2011 APPROPRIATIONS

FOR

## THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL AND PROSTHETIC RESEARCH PROGRAM

BEFORE

## THE HOUSE SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS AND RELATED AGENCIES APPROPRIATIONS OF THE COMMITTEE ON APPROPRIATIONS

PRESENTED BY

**Dona Upson, MD**

March 23, 2010

Mr. Chairman, my name is Dona Upson MD and I am testifying on behalf of FOVA – the Friends of VA Health Care and Medical Research – a coalition of over 80 veteran’s service, voluntary health and medical professional organizations that support funding for veteran’s health programs. We are especially committed to ensuring a strong VA Medical and Prosthetic Research program. FOVA recommends that the Subcommittee provide \$1 billion for the VA medical and prosthetic research program in fiscal year 2011.

Our request is structured somewhat differently than previous years. In the past we have requested funding for the VA research program and a separate request for upgrading VA lab spaces in the minor construction budget. This year we are combining the recommendations to highlight the need to view the research program and its infrastructure, as one complete entity – not two separate unrelated budget lines.

Unfortunately, for too long, policy makers have viewed the research program and its infrastructure as two unrelated accounts. The good news is that this Subcommittee and its Senate counterpart have been generous in providing additional funds for the VA research program. We are grateful for the resources and they are being well used. The bad news is that funds available to maintain the VA lab infrastructure are woefully insufficient and are threatening the ability of the VA research program to conduct state-of-the-art research.

State-of-the-art research requires state-of-the-art technology, equipment, and facilities in addition to highly qualified and committed scientists. Modern research cannot be conducted in facilities that more closely resemble high school science labs than university-class spaces. In recent years, funding for the VA Minor Construction Program has failed to provide the resources needed to maintain, upgrade, and replace aging research facilities. In addition to impeding medical discovery, poor research infrastructure undermines the ability of the VA to recruit and retain the clinical investigators who would normally be drawn to the VA system for its unique research opportunities. FOVA recommends Congress provide at least \$300 million for VA laboratory renovations in the FY11 VA minor Construction budget.

This issue has been brought to the attention of the subcommittee before. In House Report 109-95 accompanying FY 2006 VA appropriations, the House Appropriations Committee expressed concern that “equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department’s research facilities remain competitive.”

VA is conducting an internal audit to gauge the infrastructure needs of the VA Medical and Prosthetics Research Program. To date, a total of 53 sites within 47 research programs have been surveyed. Approximately 20 sites remain to be assessed in FY 2010. Internally, VA estimates that the combined total estimated

cost for improvements exceeds \$570 million. About 44% of the estimated correction costs constitute “priority 1” deficiencies — those with an immediate need for correction to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and correct life-safety hazards.

Unless funds are provided to address the infrastructure deficiencies in the VA system, VA researchers will be unable to answer the pressing health questions facing veterans. I urge the committee to provide \$300 million in the minor construction budget to address the laboratory infrastructure.

Mr. Chairman, I started out my testimony talking about a problem. I want to spend my remaining time assuring you that the VA research program is in the business of solving programs – the health problems of our nations veterans.

For over 60 years, the VA research program has been improving veterans’ lives through innovation and discovery that has led to advances in health care for veterans and all Americans. The VA research program hosts three Nobel Laureates, 6 Lasker Award recipients, and produces an increasing number of scientific papers annually, many of which are published in the most highly regarded peer-reviewed scientific journals.

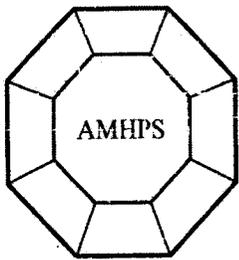
**The VA Research Program is veteran-centric** – Like NIH, all projects funded by the VA research program are peer-reviewed for scientific merit. Unlike the NIH, research proposals are also reviewed to ensure they are relevant to the health needs of veterans. While the research findings help all Americans, the additional programmatic review ensures that the VA research program continues to serve the special needs of men and women who are served in our nation’s armed forces.

In FY 2009 VA awarded more than 2,200 new grants to VA-based investigators designed to enhance the health care the VA provides to veterans. Among other initiatives, VA researchers are currently:

- Developing new assistive devices for the visually impaired, including an artificial retina to restore vision.
- Working on ways to ease the physical and psychological pain of veterans now returning from two current overseas wars.
- Gaining new knowledge of the biological and behavioral roots of post-traumatic stress disorder (PTSD) and developing and evaluating effective PTSD treatments.
- Developing powerful new approaches to assess, manage, and treat chronic pain to help veterans with burns and other injuries.
- Learning how to deliver low-level, computer-controlled electrical currents to weakened or paralyzed muscles to allow people with incomplete spinal cord injury to once again walk and perform other everyday activities.

- Studying new drug therapies and ways to enhance primary care models of mental health care.
- Identifying genes associated with Alzheimer's disease, diabetes, and other conditions.
- Studying ways to prevent, diagnose, and treat hearing loss.
- Pioneering new home dialysis techniques.
- Developing a system that decodes brain waves and translates them into computer commands to allow quadriplegics to perform routine daily tasks such as using e-mail.
- Exploring organization of care, delivery methods, patient outcomes, and treatment effectiveness to further improve access to health care for veterans.

Mr. Chairman, thank you again for your support for the VA research program. FOVA respectfully requests \$1 billion for the VA research program, including \$700 million for the VA research program and an additional \$300 million for VA laboratory infrastructure. I look forward to your questions.



# **ASSOCIATION OF *MINORITY HEALTH PROFESSIONS SCHOOLS, INC.***

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## **Testimony of**

**Eve Higginbotham, SM, M.D.**  
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**Howard University**  
**Washington, D.C.**

## **On behalf of the**

**ASSOCIATION OF MINORITY HEALTH PROFESSIONS  
SCHOOLS**

## **Before the**

**Military Construction, Veterans Affairs, and Related Agencies Subcommittee  
Committee on Appropriations  
United States House of Representatives**

**“Addressing Healthcare Workforce Issues in the VA Healthcare System”**

**Tuesday, March 23rd, 2010**

Chairman Edwards, Ranking Member Wamp, and members of the Subcommittee, thank you for the opportunity to present the views of the Association of Minority Health Professions Schools (AMHPS) regarding our collaborative efforts with health care facilities of the Department of Veterans Affairs (VA). My name is Dr. Eve Higginbotham. January marked the beginning of my term as Senior Vice President and Executive Dean for Health Sciences at Howard University. In my previous post I was Dean of the Morehouse School of Medicine. Those are two of our nation's four historically black medical schools. In addition, I am proud to have served at seven Veterans Administration hospitals during my career as well as served as a member of the Blue Ribbon Panel on Medical School Affiliations set up by the Department of Veterans Affairs.

I am here representing AMHPS, a consortium of our nation's twelve (12) historically black health professions training institutions, spanning the disciplines of medicine, dentistry, pharmacy, and veterinary science. Historically, the AMHPS institutions have collectively trained 50 per cent of the African American physicians and dentists, 60 per cent of its African American pharmacists, and 75 percent of its African American veterinarians. We occupy a unique niche among the nation's array of academic health centers and are a vital component of the American healthcare system, supporting the national goal to create a healthier America by diversifying the health care workforce.

Ensuring that the supply of physicians, dentist and other health professionals' keeps pace with the disease-specific needs of the country, in particular its military personnel, is the one of most critical issues facing our nation. Many national studies project a critical shortage of the health workforce, including estimates of a projected shortage of 90,000 physicians by 2020.<sup>i</sup> This looming shortage of health professionals is exacerbated by a lack of diversity.<sup>ii</sup>

Equally important to the aggregate supply of physicians, dentists, and other health professionals is its composition, including racial and ethnic diversity. Although underrepresented minorities (URM) are the fastest growing segment of the U.S. population, our national demographics are not reflected in the classrooms of health profession schools. At a time when more than 86% of existing medical schools have started enrollment expansion to respond to the nation's physician shortage, many programs specifically designed to attract minority students to the profession are shutting down. While minority groups comprise 30 percent of the total U.S. population, ethnically and culturally they are represented by less than 10 percent of all U.S. physicians. According to the Sullivan Commission Report and other studies, this underrepresentation extends to dentist, nurses, pharmacist, veterinarians, and other health profession disciplines.

There is little left to discover or dispute with respect to the benefits of achieving greater racial and ethnic diversity of the nation's health professionals – the attention has once again shifted to identifying the most effective and sustainable methods to do so. Considering their legacy of

contributions and mission focus AMHPS institutions are naturally best suited to lead the way in helping to ensure diversity in the health workforce and eliminating racial and ethnic-based health disparities. To do so, however, we must overcome a number of challenges directly related to our community-based mission, primary care focus, and orientation toward generalist medical education. Where the prevailing model for an academic medical center is one in which the clinical system cross-subsidizes the academic and research missions AMHPS institutions are less able to leverage surplus-generating sub-specialty clinical services and/or inpatient revenue streams through hospitals. Moreover, our clinical programs are almost exclusively affiliated with safety-net hospitals and targeted toward improving access to uninsured and underinsured populations.

Unfortunately, the mission related challenges of the AMHPS institutions have been exacerbated as the result of our limited access to U.S. Department of Veterans Affairs (VA) medical facilities. Now, I will highlight in this testimony the successes our institutions are seeing by way of increased collaboration with the VA. However, I will underscore that the major hurdle is a proper working relationship with the large VA hospitals geographically closest to many of our institutions. This restriction (implicit or explicit) to the larger VA facilities limits the clinical training experiences of students and residents and places a greater funding burden on AMPHS medical schools for resident and faculty salaries. Furthermore, these less than optimal arrangements have severely limited opportunities for faculty to participate in VA-funded research projects.

Mr. Chairman, the legacy of unequal access to VA facilities for AMHPS institutions spans decades. Our leaders were previously told that the VA had a policy which instructed its satellite hospitals and facilities to have only one academic affiliation per VA facility. In other words, the Morehouse School of Medicine, for instance, could not have a relationship with the Atlanta VA because of its existing relationship with Emory University School of Medicine. As a result, MSM, based in Atlanta, Georgia, was forced to forge a relationship with the Tuskegee, Alabama VA some two and a half hours away. In addition to the two and half hours commute, MSM had to provide housing for the residents while they trained in Tuskegee, Alabama. This was and continues to be an additional cost and burden for the medical school.

The MSM experience is a microcosm of the experiences our minority serving institutions have had with the VA and hopefully provides the committee with the context behind our concerns and the basis for our continuing quest towards an equitable relationship with the VA. Further, my institution, Howard, has seen disparities in the number of ophthalmologists Howard can allow to train as opposed to other academic health centers here in D.C.

The VA is among the very few opportunities that exist to expand funded resident positions for medical schools in urban areas. Combined with the reality that our nation's veterans represent a highly diverse population, we stand ready to play a key role in the process of helping to expose

our residents to health care and training opportunities, and in the process, serve the heroes of our nation. As the VA seeks to train more health professionals of color, we are poised to respond.

Last year, the committee included the following recommendation in the House Mil Con-VA committee report:

*“Blue Ribbon Panel on VA-Medical School Affiliations.—*The Committee recognizes the efforts made by the Department to provide students at minority health professions schools with opportunities to learn and gain experience through its health care system. The Committee understands that the Department has established a Blue Ribbon Panel on VA Medical School Affiliations to “advise the Secretary of Veterans Affairs and Under Secretary for Health on the formation of a comprehensive framework for guiding VA’s affiliations with medical schools and academic medical centers”. The Committee looks forward to learning the recommendations of this panel and directs the Under Secretary for Health to provide a report to the Appropriations Committees of both Houses of Congress by January 29, 2010 on the panel’s recommendations” (Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, p.40, June 28, 2010).

I thank the Subcommittee for the addition of this important recommendation. As a member of the Blue Ribbon Panel, I am happy report that the following recommendation was produced concerning the minority health professions schools:

“1.2. To prepare an appropriately skilled healthcare workforce, VA and its academic partners should increase investments in the development and testing of innovative educational programs to better align health professions education with the healthcare needs of Veterans and the Nation.

1.2.1. VA and its academic partners should strengthen their collaborative efforts to prepare a diverse and culturally-sensitive clinical workforce with the competencies to deliver high quality, safe and effective patient care. These efforts should include joint ventures between VA and selected health professions to design and test new models of inter-professional education, expansion of existing relationships with minority health professions schools, and the implementation of trainee exchange programs with the Military healthcare system” (The Report of the Blue Ribbon Panel on VA-Medical School Affiliations: *Transforming an Historic Partnership for the 21<sup>st</sup> Century*, p. 2).

Additionally, it is important to note the letter which Ranking Member Wamp and Committee Member Sanford Bishop co-authored to the VA Secretary Eric Shinseki. In that letter, they encouraged the VA to pay careful consideration to recommendations of the minority health professions schools which Dr. Maupin, giver of this testimony last year, made to this Subcommittee a year ago. Those recommendations were:

1. The national VA should extend its efforts regarding collaboration with minority health professions schools beyond the VISN to the medical center level. Additionally it should provide technical assistance and other resources to VA facilities to identify best practices in the development of optimal working relations between the respective medical schools sharing VA facilities.

2. Continue to increase the number of residency positions and ensure greater integration of AMHPS medical schools into “core” residency programs such as medicine and surgery and other procedural based specialties.
3. Provide access to and appropriate funding for attending positions (full time and part time) that can serve both the VA and the minority health profession schools to ensure continuity of educational and clinical service objectives across graduate medical educational programs.
4. AMHPS medical schools should be afforded equitable opportunities to play a leadership role in the development of new health initiatives.
5. Encourage and facilitate full participation (patient care and residency training) in the expansion of VA subspecialty services in the metropolitan areas, including the CBOCs and consideration for contracted CBOC arrangement
6. Inclusion of AMHPS faculty in the vast array of research opportunities in the VA, including but not limited to the Career Development and Merit Award programs and shared IRB status for affiliated VA hospitals to facilitate research conducted by AMHPS faculty.
7. AMHPS schools should be provided the opportunity to partner with other medical school affiliates and the VA in strategic planning, both at the level of the Atlanta Affiliated Partnership Council and at the VISN level.

Mr. Chairman, I want to be clear that the AMHPS institutions strongly suggest that the recommendations above are adopted by the Department of Veterans Affairs. However, the AMHPS institutions have had success increasing collaborative activities with the VA, including:

MSM boasting a new graduate medical education (GME) rotation in internal medicine to start July 2010, the GME rotation in psychiatry continuing as a valuable educational experience for MSM psychiatry residents, MSM continuing to use CBOCs for GME clinical rotations, plans to work with the VA on a strategic partnership for homeless veterans, the addition of the first MSM research faculty member at the Atlanta VA, the Atlanta VA planning to open a new women’s health clinic in the next two years, and Atlanta VA moving to acquire Army Medical Clinic at Fort McPherson.

Since 2007, collaborative efforts with Meharry Medical College and the VA include 3 clinics: the VA Primary Care Clinic at Meharry, which serves the primary health care needs of more than 6,000 veterans in the Nashville metropolitan area; the VA Women's Comprehensive Health Center, which serves the health care needs of more than 2,500 women veterans; and the VA Primary Care Clinic at Meharry, which serves the primary health care needs of more than 6,000 veterans.

Recent budget constraints are currently holding up several additional collaborative projects, which include: the VA Mental Health Clinic at the Elam Center (2011); the Compensation and Pension Clinic (2010); and the VA Dental Clinic at Meharry (2011).

The relationship with the VA can be enhanced with a stronger approach to allow MMC access to VA research dollars, programs and infrastructure. Additionally, expanded inpatient opportunities at the Nashville VA campus and other clinical service opportunities would strengthen the relationship.

Local VA leadership is increasingly inclusive and cooperative, which fosters an effective partnership. However, this recent pleasant reality is tempered by the fact that MMC and other minority academic health centers are working with the VA to ameliorate 60 plus years of “arrested development”. Thus, more should and can be done to enhance our contributions to caring for these cherished Americans – our nation’s veterans.

Charles Drew University of Medicine and Science in Los Angeles has started discussions with the VA to provide residency training positions and serve as a site for clinical rotations—which are much needed there.

Howard University has a unique position, with more affiliations with the large DC VA geographically closest to our institution.

AMHPS institutions want to serve our nation’s men and women whom have worn our country’s uniform. The military professionals have risked their lives for us, and our institutions are prepared to deliver their expertise and cultural sensitivity to assist the VA system. AMHPS institutions seek equal opportunity in resident and research positions at VA facilities. We are pleased with the language included in the Blue Ribbon Panel report and the expansion opportunities recently we see on the horizon. However these opportunities have been primarily at smaller satellite facilities. We are hopeful that our expanding relationships, quite frankly due in large part from this Subcommittee’s active oversight, will continue to improve, eventually including equal access to residency training in medicine and surgery, increased resident and faculty funding, and full integration into the landmark VA hospital facilities located in the same cities where our institutions are located.

Mr. Chairman, thank you for the opportunity to engage you and the Subcommittee on this important topic.

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<sup>i</sup> American Association of Medical Colleges: AAMC Statement on the Physician Workforce, 2006

<sup>ii</sup> 2001 American Association of Medical Colleges: *Recent Studies and Reports on Physician Shortages in the U.S.*; Washington DC 2007

Written Testimony of Steven J. Breckler, Ph.D.  
**On behalf of the American Psychological Association**

Submitted March 16<sup>th</sup>, 2010 to the  
United States House of Representatives Committee on  
Appropriations  
Subcommittee on Military Construction, Veterans Affairs, and Related  
Agencies  
The Honorable Chet Edwards, Chair

**Fiscal Year 2011 Appropriations for the Department of  
Veterans Affairs**

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Mr. Chairman and Members of the Subcommittee, I am Dr. Steve Breckler, Executive Director for Science at the American Psychological Association (APA), a scientific and professional organization of more than 142,000 psychologists and affiliates. Many of these psychologists work within the Department of Veterans Affairs (VA) as research scientists and clinicians committed to improving the lives of our nation's veterans.

On behalf of APA, thank you for your continued support of the VA Medical and Prosthetic Research program. APA joins the Friends of VA Medical Care and Health Research (FOVA) coalition in urging Congress to appropriate \$700 million in FY11 for VA Medical and Prosthetic Research, which represents an increase of \$120 million over current funding, and an additional \$300 million dedicated for research facilities upgrades.

**Psychological Research in the VA**

A strong VA psychological research program provides the scientific foundation for high-quality care within the VA system. Through its Medical and Prosthetic Research Account, the VA funds intramural research that supports its clinical mission to care for veterans. VA psychologists play a dual role in providing care for veterans and conducting research in all areas of health, including high-priority areas particularly relevant to veterans, such as: mental health, traumatic brain injury (TBI), substance abuse, aging-related disorders and physical and psychosocial rehabilitation. VA psychologists are leaders in providing effective diagnosis and treatment for all mental health, substance use and behavioral

health issues. In addition, VA psychologists often receive specialty training in rehabilitation psychology and/or neuropsychology, which helps to improve assessment, treatment, and research on the many conditions affecting veterans of the current conflicts, including: post-traumatic stress disorder (PTSD), burns, amputation, blindness, spinal cord injuries and polytrauma. Equally important are the profoundly positive impacts of psychological interventions on the care of veterans suffering from chronic illnesses such as cancer, cardiovascular disease, HIV and chronic pain.

VA psychologists continue to be at the forefront of cutting-edge research on, assessment of and treatment for PTSD, a particular concern within the VA and Congress. The care of veterans suffering psychological wounds as a result of military service is at the heart of the VA's mandate "to care for him who shall have borne the battle," and preventing and treating PTSD has become an even more important priority within the VA given the current conflicts overseas. VA psychologists are responsible for the development of the most widely respected and used diagnostic instruments and therapeutic techniques for assessing and treating PTSD. The current conflicts present new challenges for VA psychologists, as many veterans with PTSD have post-concussive symptoms stemming from blast injuries. Additional research is needed to develop novel treatments for PTSD in cases when cognitive problems also may stem from a history of documented TBI.

VA psychologists also have used their expertise in program development and evaluation to successfully improve the VA's coordinated service approach. This includes models and practices of care that encompass inpatient, partial hospitalization and outpatient services including psychosocial rehabilitation programs, geriatric services in the community, and homelessness programs within the VA Secretary's new emphasis. VA psychologists have initiated and evaluated innovative programs, such as tele-mental health services, that will dramatically expand the VA's continuum of care for veterans.

### **VA Research Facilities Upgrades**

Cutting-edge research also requires cutting-edge technologies, equipment and facilities in order to both recruit stellar scientists into the VA and provide them the basic space and tools needed to conduct 21<sup>st</sup> century science. FOVA anticipates that VA's ongoing research facilities assessment will identify a need for research infrastructure funding between \$1.5 and \$2 billion. VA has simply failed to provide the resources needed to adequately maintain, upgrade and replace aging research facilities. As a member of FOVA, APA urges Congress to make a down payment in FY11 of \$300 million dedicated exclusively to renovating existing research facilities.

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Statement of  
The Fleet Reserve Association

Before the

Committee on Appropriations  
Subcommittee on Military Construction and Veterans Affairs  
U.S. House of Representatives

Presented by

John R. Davis  
Director, Legislative Programs  
Fleet Reserve Association

March 23, 2010

## **THE FRA**

The Fleet Reserve Association (FRA) is the oldest and largest enlisted organization serving active duty, Reserves, retired and veterans of the Navy, Marine Corps, and Coast Guard. It is Congressionally Chartered, recognized by the Department of Veterans Affairs (VA) as an accrediting Veteran Service Organization (VSO) for claim representation and entrusted to serve all veterans who seek its help. In 2007, FRA was selected for full membership on the National Veterans' Day Committee.

FRA was established in 1924 and its name is derived from the Navy's program for personnel transferring to the Fleet Reserve or Fleet Marine Corps Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Secretary of the Navy.

FRA's mission is to act as the premier "watch dog" organization in maintaining and improving the quality of life for Sea Service personnel and their families. FRA is a leading advocate on Capitol Hill for enlisted active duty, Reserve, retired and veterans of the Sea Services. The Association also sponsors a National Americanism Essay Program and other recognition and relief programs. In addition, the newly established FRA Education Foundation oversees the Association's scholarship program that presents awards totaling nearly \$100,000 to deserving students each year.

The Association is also a founding member of The Military Coalition (TMC), a 34-member consortium of military and veteran's organizations. FRA hosts most TMC meetings and members of its staff serve in a number of TMC leadership roles.

FRA celebrated 85 years of service in November 2009. For over eight decades, dedication to its members has resulted in legislation enhancing quality of life programs for Sea Services personnel, other members of the uniformed services plus their families and survivors, while protecting their rights and privileges. CHAMPUS, now TRICARE, was an initiative of FRA, as was the Uniformed Services Survivor Benefit Plan (USSBP). More recently, FRA led the way in reforming the REDUX Retirement Plan, obtaining targeted pay increases for mid-level enlisted personnel, and sea pay for junior enlisted sailors. FRA also played a leading role in advocating recently enacted predatory lending protections and absentee voting reform for service members and their dependents.

FRA's motto is: "Loyalty, Protection, and Service."

### **CERTIFICATION OF NON-RECEIPT OF FEDERAL FUNDS**

Pursuant to the requirements of House Rule XI, the Fleet Reserve Association has not received any federal grant or contract during the current fiscal year or either of the two previous fiscal years.

## **INTRODUCTION**

Mr. Chairman and other distinguished Members of the Subcommittee: The Fleet Reserve Association (FRA) appreciates the opportunity to present its recommendations regarding the FY 2011 Budget.

FRA thanks you and Members of the Subcommittee for the progress to date on enhancing funding for various military construction projects and to ensure that wounded troops, their families and the survivors of those killed in action are cared for by a grateful Nation.

FRA is deeply concerned about the backlog of claims at the Department of Veterans Affairs. The Association appreciates funding in the FY 2010 MilCon/VA appropriations bill for an additional 1,200 claim adjusters. The VA has hired nearly 4,200 more employees since January 2007, but despite the additional resources and manpower, the backlog of disability claims increased by more than 80,000 since the beginning 2009. The Association appreciates the \$145 million for a paperless claims process, and \$347 million to develop and implement an electronic health record at VA. FRA welcomes the enrollments in the VA health care system for some Priority 8 veterans, that will eventually (FY 2013) provide access to more than 500,000 veterans that are currently ineligible.

As an Association made up primarily of career Navy enlisted personnel, the Agent Orange claims controversy is a high priority for the Association and FRA welcomes the \$13.4 billion FY 2010 supplemental appropriations for new presumptions related to Agent Orange exposure. FRA notes that the FY 2011 VA budget for claims processing is increased by 27 percent (\$460 million) over the FY 2010 budget that includes improved benefits processing through a combination of additional staff, enhanced business practices, and improved use of technology.

## **POST 9/11 GI BILL**

The Association understands that funding for the Post 9/11/2001 G.I. Bill is mandatory, thus eliminating the year-to-year uncertainty about adequate resources to support the authorized and dramatically increased education benefits for qualifying service members. This is a very significant program and FRA is grateful for its enactment. The VA budget also provides funding to meet the increased education claims workload resulting from the enactment of the Post 9/11 GI Bill program. This benefit program has had an immeasurable improvement on the morale of those currently serving. The Association appreciates the logistical difficulty of implementing a new system while still administering the current system. FRA welcomed additional VA processors until a new automated system is developed and implemented and appreciates that the VA issued more than 30,000 checks up to \$3,000 each in October to students who had not yet received benefits. As the fall semester came to an end more than 26,000 students had not received any benefits at all. It appears that processing payments for the spring semester has been improved but more work needs to be done to improve delivery of benefits for this program.

## WOUNDED WARRIORS

FRA is cautiously optimistic about the progress toward establishing the joint DoD-VA office that will oversee development of a bi-directional electronic medical record per provisions in the FY 2008 National Defense Authorization Act (NDAA). The creation of the electronic health record is a critical element in developing a seamless transition process between DoD and VA care. Despite jurisdictional challenges, this Subcommittee should ensure that this office has adequate funding to effectively implement a bi-directional electronic medical record as a critical first step in improved treatment of physical injuries as well as PTSD and TBI for veterans of Operations Iraqi and Enduring Freedom (OIF/OEF).

The FRA is encouraged by the improved cooperation between of the Departments of Defense (DoD) and Veterans' Affairs (VA) in working to help our wounded warriors. For example, DoD is working with the VA to expand the Disability Evaluation System (DES) pilot program that simplifies the current disability evaluation process for wounded, injured and ill service members and is aimed at assisting wounded service members obtain faster access to TRICARE and other health care and VA benefits. A single medical examination used by both DoD and VA, with a single source disability evaluation done by VA and accepted by DoD is key to this initiative. The pilot, implemented in the National Capitol Region in November 2007, expanded to 19 additional installations last year. FRA has strongly supported a streamlined and seamless disability evaluation process and supported the legislative effort to create the pilot program. More than 700 service members have participated in the pilot program.

The pilot was initiated at the Washington D.C. VA Medical Center and at three Military Treatment Facilities in the National Capitol Region – Malcolm Grow Medical Center at Andrews Air Force Base, Md., Walter Reed Army Medical Center in Washington, D.C., and National Naval Medical Center in Bethesda, Md. More installations were added to the study, including Fort Carson, Colo., Naval Medical Center San Diego, Calif., and Elmendorf Air Force Base, Alaska.

The FY 2008 National Defense Authorization Act established a comprehensive policy on the care and management of wounded service members in order to facilitate and enhance their care, rehabilitation, physical evaluation, transition from DoD care to the VA, and transition from military service to civilian life.

Although DoD and VA have made great progress in sharing information and resources, much more is needed, particularly with regard to access standards, to truly provide a “seamless transition” from military service to veteran status. The Special Oversight Committee (SOC) is important to this process. FRA advocates that a truly seamless transition can not be implemented and maintained without the adequate funding of a permanent joint VA/DoD office is staffed by both DoD and VA personnel.

FRA supports the Administration's efforts to modernize the administration of veterans' health care by creating a Joint Virtual Lifetime Electronic Record (VLER). The creation of a VLER for every service member would be a major step toward FRA's long-standing goal of a seamless transition from military to veteran status. The VLER ultimately would permit a health care pro-

vider (DOD, VA or a private provider) a timely, seamless access to an individual's (service member/veteran) health data.

Although these and other reforms are improvements, the fact remains that the VA disability process and the VA health care system is still overwhelmed. A two-front war, a lengthy occupation and repeated deployments for many service members has put a strain on the DoD/VA medical system that treats our wounded warriors. The system is being strained not only by volume but by the complexity of injuries, and the military has shown that it is inadequate in recognizing and treating cases of TBI and PTSD, even though more than 3,900 new mental health employees have been hired since 2005 – bringing our total number to more than 17,000. Soaring medical costs, decades of inadequate appropriations and increasing demand for medical services have severely hampered timely access to quality health care for our Nation's sick and disabled veterans.

### **VA 2011 BUDGET OUTLINE**

Under the Advanced Funding law, the Administration is now able to request two budgets for the VA: one to provide fiscal 2011 total funding and another to provide fiscal 2012 funding for certain VA medical accounts.

For fiscal year 2011, the Administration has proposed a VA budget of \$125 billion, an \$11 billion increase (7.6 percent) from the 2010 enacted budget. The Administration is requesting \$51.5 billion in resources for VA medical care, an increase of \$4.1 billion over fiscal year 2010 levels. For fiscal year 2012, the Administration has requested a 5 percent increase in funding above the amounts requested for fiscal year 2011. The VA has requested a \$460 million increase for processing disability claims, a 27 percent increase over the current fiscal year. The proposed budget adds \$44 million for a new automated claims system for processing Post 911 GI Bill education benefits. Since the VA expects education benefit claims to increase by nearly 30 percent in FY 2011.

FRA supports the FY 2011 Independent Budget (IB) and welcomes the Department of Veterans Affairs (VA) budget being excluded from the Administration's freeze on discretionary spending and the implementation of advanced funding for VA health care for FY 2012 (\$54.3 billion).

The proposed FY 2011 VA budget includes a \$5 billion increase (\$51.5 billion) over FY 2010 levels for medical care programs, and the IB recommends an additional \$500 million more (\$52.0 billion) for medical care programs. The budget also contains a significant increase in funding for the Veterans Benefits Administration (VBA), the VA agency charged with providing compensation and benefits to veterans. The President's budget recommends \$2.1 billion for VBA, an increase of \$460 million over the FY 2010 appropriated level. This funding increase reflects a real commitment toward bringing down the massive claims backlog and providing timely, accurate education benefits to service members and veterans eligible for the Post-9/11 GI Bill.

FRA is troubled by the level of funding recommended for construction projects and information technology. With VA facing a massive backlog of important construction requirements and

states becoming ever more reliant on VA to contribute to the funding for construction of long-term care facilities, now is not the time to reduce this critical funding. Likewise, there are a number of critical information technology initiatives that need to be addressed. Finally FRA wants to express doubts about the projection that VA will be able to get \$3.3 billion from third-party insurers.

### **HEALTH CARE FEES**

FRA continues its strong opposition to establishing a tiered enrollment fee structure for veterans in Priority Groups 7 and 8 within the VA Health Care System. Past proposals include fees based on annual family income adjusted by region averaging approximately \$30,000 and above, along with an increase on pharmacy co-pays from \$8 to \$15 for Priority Group 7 and 8 beneficiaries. There are approximately 1.3 million veterans in these groups and FRA supports adequate appropriations to prevent shifting costs to them for care they've earned in service to our Nation. Although not under the oversight of this Subcommittee, FRA continues its strong opposition to TRICARE fee increases for military retirees and believes there are other cost-saving options which must be implemented prior to adjusting fees for younger retirees. The Association salutes Chairman Edwards for his leadership on this issue and strongly supports the "Military Retirees Health Care Protection Act" (H.R. 816) which he sponsored along with Rep. Walter Jones (N.C.)

Rather than focus efforts on cost-shifting to beneficiaries, the VA should look at other cost-saving measures. The VHA should focus on improving wellness systems, such as "My Health-Vet," expanding outreach to work on prevention, early, effective interventions, and innovative methods of motivating beneficiaries toward healthy life styles. These measures could result in substantial savings for the VHA in the coming years.

### **MEDICAL AND PROSTHETIC RESEARCH**

The VA's research should focus on improving treatments for conditions that are unique to veterans. Medical and prosthetic research is one of the most successful aspects of all VA medical programs. That is why FRA is concerned that there is no increase (\$3.345 billion) in medical research budget which could result in possible cuts in research. The Association, however, appreciates and supports the eight percent increase (\$148 million) in prosthetic research for 2011.

### **MILITARY CONSTRUCTION**

FRA is concerned that the Administration's FY 2011 military construction budget is reduced by 19.5 percent and the family housing budget is reduced by 19.3 percent from the current fiscal year. Child care facilities, work spaces and associated structures, and barracks construction are top concerns for enlisted personnel. FRA appreciates that the FY 2011 Navy budget includes improving bachelor quarters, including sustained funding for Homeport Ashore initiatives. FRA welcomes the Marine Corps hiring an additional 400 full-time family-readiness officers on the battalion level per provisions in the FY 2011 budget. Currently the Marines are meeting 64 percent of potential day-care needs (same as last year) and need 3,000 additional spaces to reach the DoD standard of 80 percent. The Marines plan to increase 2,615 child-care spaces over the next 18-24 months. The Navy added more than 7,000 child care spaces in the current fiscal year and

plans to reach the 80 percent child care goal by the end of FY 2011. It is often said that the individual enlists but it's the family that re-enlists. The Navy and Marine Corps child care programs are highly valued benefits for military families and are a critical element in maintaining adequate retention numbers.

FRA wants to express its gratitude to this distinguished Subcommittee for extending an invitation to the senior enlisted leaders of the Navy, Marine Corps, Army and Air Force to discuss Quality of Life issues with the Subcommittee. These issues include child care facilities, work spaces and associated structures, and barracks construction and other top concerns of the enlisted community.

### **BRAC**

FRA notes that the recently enacted "American Recovery and Reinvestment Act" includes funding for new military construction, renovation projects and funding for VA hospitals.

The Association remains concerned, however, about the inadequacy of funding for implementation plans for other DoD transformation initiatives, global repositioning, and BRAC actions. During the current wartime environment, it's important to establish and maintain support services and quality of life programs for active and reserve service members, their families, and retirees at affected sites.

### **AFRH**

FRA appreciates support from appropriators for funding to rebuild the Armed Forces Retirement Home in Gulfport, Miss. Construction is progressing on the new facility and FRA members who were residents at the Home and forced to relocate due to damage caused by Hurricane Katrina in 2005, are eager to go home. The new facility is scheduled to re-open sometime in October 2010 and is scheduled to have opening ceremonies on November 9, 2010. FRA thanks this distinguished Subcommittee for its supporting this important project.

### **CONCLUSION**

Mister Chairman, FRA sincerely appreciates all that you and members of your distinguished Subcommittee – and your outstanding staff do to support our magnificent service members and veterans. Thanks again for the opportunity to present the Association's recommendations for your consideration.

###

**JOHN R. DAVIS**  
**DIRECTOR OF LEGISLATIVE PROGRAMS**  
**FLEET RESERVE ASSOCIATION**

John Davis served in the United States Marine Corps Reserve in an artillery unit (155 self-propelled howitzers) and as a Second Lieutenant in the Illinois Army National Guard in the 1980s. He joined the FRA team as Director, Legislative Programs in February 2006, and is President of FRA Branch 181 (Arlington, Virginia). He is co-chairman of The Military Coalition's (TMC) Retired Affairs Policy Committee.

John worked for almost 13 years with the National Federation of Independent Business, including 9 years as Director of the Illinois chapter and 3 ½ years in the federal lobbying office in Washington DC. John has lobbied on a variety of issues including healthcare, tort reform, education, insurance, taxation, and labor law.

In 2005 John received a Masters of Public Policy (MPP) degree from Regent University, Alexandria VA. John has a BS degree from Illinois State University in Political Science and History. John has two children: Anne age 26 and Michael age 23 who is currently serving in a Marine Corps Reserve unit deployed in Afghanistan.



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**STATEMENT OF**

**RAYMOND C. KELLEY**  
**AMVETS NATIONAL LEGISLATIVE DIRECTOR**

**BEFORE THE**

**HOUSE MILITARY CONSTRUCTION AND VETERANS AFFAIRS**  
**APPROPRIATIONS SUBCOMMITTEE**

**CONCERNING**

***THE INDEPENDENT BUDGET AND***

**THE DEPARTMENT OF VETERANS AFFAIRS**  
**BUDGET REQUEST FOR FISCAL YEAR 2011**

**MARCH 23, 2010**

**H-143 THE CAPITOL**

**1:30 PM**



Chairman Edwards, Ranking Member Wamp, and members of the Committee:

AMVETS is honored to join our fellow veterans' service organizations and partners at this important hearing on the Department of Veterans Affairs budget request for fiscal year 2011. My name is Raymond C. Kelley, National Legislative Director of AMVETS, and I am pleased to provide you with our best estimates on the resources necessary to carry out a responsible budget for VA.

AMVETS testifies before you as a co-author of *The Independent Budget*. This is the 24th year AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars have pooled our resources to produce a unique document, one that has stood the test of time.

In developing the *Independent Budget*, we believe in certain guiding principles. Veterans should not have to wait for benefits to which they are entitled. Veterans must be ensured access to high-quality medical care. Specialized care must remain the focus of VA. Veterans must be guaranteed timely access to the full continuum of health care services, including long-term care. And, veterans must be assured accessible burial in a state or national cemetery in every state.

The VA healthcare system is the best in the country and responsible for great advances in medical science. VHA is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected ailments. The delivery care system provides a wide array of specialized services to veterans like those with spinal cord injuries, blindness, traumatic brain injury, and post traumatic stress disorder.

As a partner of the *Independent Budget*, AMVETS devotes a majority of its time with the concerns of the National Cemetery Administration (NCA) and I would like to speak directly to the issues and concerns surrounding NCA.

## **The National Cemetery Administration**

The Department of Veterans Affairs National Cemetery Administration (NCA) currently maintains more than 2.9 million gravesites at 130 national cemeteries in 39 states and Puerto Rico. Of these cemeteries, 70 will be open to all interments; 20 will accept only cremated remains and family members of those already interred; and 40 will only perform interments of family members in the same gravesite as a previously deceased family member. NCA also maintains 33 soldiers' lots and monument sites. All told, NCA manages 19,000 acres, half of which are developed.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the Global War on Terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from approximately 111,000 in 2009 to 114,000 in 2010. Historically, 12 percent of veterans opt for burial in a state or national cemetery.

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the armed forces. Therefore, the purpose of these cemeteries as national shrines is one of the NCA's top priorities. Many of the individual cemeteries within the system are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of the United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and cherished.

*The Independent Budget* veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families. We call on the Administration and Congress to provide the resources needed to meet the changing and critical nature of NCA's mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

In FY 2009, \$230 million was appropriated for the operations and maintenance of NCA, \$49 million over the administration's request, with \$2.7 million in carryover. NCA awarded 49 of the 56 minor construction projects that were in the operating plan. The State Cemetery Grants Service awarded \$40 million in grants for 10 projects.

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

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

Several geographical areas will remain unserved if the population threshold is not reduced. Lowering the population threshold to 100,000 veterans would immediately make several areas eligible for a National Cemetery regardless of any change to the mile radius threshold. A new threshold model must be implemented so more of our veterans will have access to this earned benefit.

### **National Cemetery Administration (NCA) Accounts**

*The Independent Budget* recommends an operations budget of \$274.5 million for the NCA for

fiscal year 2011 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

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

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

The IBVSOs is encouraged that \$25 million was set aside for the National Shrine Commitment for FY 07 and 08. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. In 2006 only 67 percent of headstones and markers in national cemeteries were at the proper height and alignment. By 2009 proper height and alignment increased to 76 percent. The NCA has also identified 153 historic monuments and memorials that need repair and/or restoration. With funding from The American Recovery and Reinvestment Act (ARRA), the NCA will make repairs on 32 percent of these monuments and memorials.

The IBVSOs support the NCA's operational standards and measures outlined in the National Shrine Commitment, and in the past *The Independent Budget* advocated for a five-year, \$250 million National Shrine Initiative to assist the NCA in achieving its performance goals.

However, over the past few years, the NCA has made marked improvements in the National Shrine Commitment by earmarking a portion of its operations and maintenance budget for the commitment and pending receipt of funding from the ARRA. Therefore, the IBVSOs no longer believe it is necessary to implement the National Shrine Initiative program at \$50 million per year for five years but, rather, propose an increase in the NCA's operations and maintenance budget by \$25 million per year until the operational standards and measures goals are reached.

In addition to the management of national cemeteries, the NCA is responsible for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries. Public Law 110-157 gives VA authority to provide a medallion to be attached to the headstone or marker of veterans who are buried in a private cemetery. This benefit is available to veterans in lieu of a government-furnished headstone or marker. The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully.

### **The State Cemetery Grants Program**

The State Cemeteries Grant Program faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial service to veterans,

especially those living in less densely populated areas not currently served by a national cemetery. Currently there are 60 state and tribal government cemetery construction grant pre-applications, 36 of which have the required state matching funds necessary totaling \$121million.

The Independent Budget recommends that Congress appropriate \$51 million for SCGP for FY 2011. This funding level would allow SCGP to establish 13 new state cemeteries that will provide burial options for veterans who live in a region that currently has no reasonably accessible state or national cemetery.

### **Burial Benefits**

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

Burial allowance was first introduced in 1917 to prevent veterans from being buried in potters' fields. In 1923 the allowance was modified. The benefit was determined by a means test, and then in 1936 the allowance was changed again, removing the means test. In its early history, the burial allowance was paid to all veterans, regardless of the service-connectivity of their death. In 1973 the allowance was modified to reflect the relationship of their death as service connected or not.

The plot allowance was introduced in 1973 as an attempt to provide a plot benefit for veterans who did not have reasonable access to a national cemetery. Although neither the plot allowance nor the burial allowances were intended to cover the full cost of a civilian burial in a private cemetery, the increase in the benefit's value indicates the intent to provide a meaningful benefit

by adjusting for inflation.

The national average cost for a funeral and burial in a private cemetery has reached \$8,555, and the cost for a burial plot is \$2,133. At the inception of the benefit the average costs were \$1,116 and \$278 respectively. While the cost of a funeral has increased by nearly seven times the burial benefit has only increased by 2.5 times. To bring both burial allowances and the plot allowance back to its 1973 value, the SC benefit payment will be \$6,160, the NSC benefit value payment will be \$1,918, and the plot allowance will increase to \$1,150. Readjusting the value of these benefits, under the current system, will increase the obligations from \$70.1 million to \$335.1 million per year.

Based on accessibility and the need to provide quality burial benefits, *The Independent Budget* recommends that VA separate burial benefits into two categories: veterans who live inside the VA accessibility threshold model and those who live outside the threshold. For those veterans who live outside the threshold, the SC burial benefit should be increased to \$6,160, NSC veteran's burial benefit should be increased to \$1,918, and plot allowance should increase to \$1,150 to match the original value of the benefit. For veterans who live within reasonable accessibility to a state or national cemetery that is able to accommodate burial needs, but the veteran would rather be buried in a private cemetery the burial benefit should be adjusted. These veterans' burial benefits will be based on the average cost for VA to conduct a funeral. The benefit for a SC burial will be \$2,793, the amount provided for a NSC burial will be \$854, and the plot allowance will be \$1,150. This will provide a burial benefit at equal percentages, but based on the average cost for a VA funeral and not on the private funeral cost that will be provided for those veterans who do not have access to a state or national cemetery.

The recommendations of past legislation provided an increased benefit for all eligible veterans but it currently fails to reach the intent of the original benefit. The new model will provide a meaningful benefit to those veterans whose access to a state or national cemetery is restricted as well as provides an improved benefit for eligible veterans who opt for private burial. Congress should increase the plot allowance from \$300 to \$1,150 for all eligible veterans and expand the

eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime. Congress should divide the burial benefits into two categories: veterans within the accessibility model and veterans outside the accessibility model. Congress should increase the service-connected burial benefit from \$2,000 to \$6,160 for veterans outside the radius threshold and \$2,793 for veterans inside the radius threshold. Congress should increase the non-service-connected burial benefit from \$300 to \$1,918 for veterans outside the radius threshold and \$854 for veterans inside the radius threshold. Congress should enact legislation to adjust these burial benefits for inflation annually.

The NCA honors veterans with a final resting place that commemorates their service to this nation. More than 2.8 million soldiers who died in every war and conflict are honored by burial in a VA national cemetery. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans; they are hallowed ground to those who died in our defense, and a memorial to those who survived.

Mr. Chairman, this concludes my testimony. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

**Raymond C. Kelley**  
**AMVETS National Legislative Director**

Ray Kelley is the National Legislative Director for AMVETS (American Veterans) at AMVETS National Headquarters in Lanham, Md. He is responsible for the planning, coordination, and implementation of AMVETS' relations with the United States Congress and federal departments and agencies, and other organizations. He develops and executes AMVETS' Washington agenda in areas of budget, appropriations, health care, veterans' benefits issues, national security, and foreign policy. Ray also represents AMVETS to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, and the Office of Personnel Management. Ray's work also includes building relationships with other non-profit organizations and developing plans to promote veteran transition to civilian life after their honorable service.

Ray served six years in the United States Marine Corps. He left the service and earned a Bachelor of Science in Political Science from Indiana University. Upon completion of his degree, Ray entered service in the Army Reserve and in April of 2006, Ray was deployed to Iraq as a Psychological Operations Team Leader. Ray served for 12 months in the base of the Sunni/Shi'ia tri-angle.

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March 23, 2010

The Honorable Chet Edwards, Chairman  
House Military Construction, Veterans Administration Appropriations  
Subcommittee  
H-143 The Capital  
Washington, D.C. 20510

Dear Chairman Edwards:

Neither AMVETS nor I have received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the March 23, 2010, Appropriations Subcommittee hearing on the VA's budget request for fiscal year 2011.

Sincerely,



Raymond C. Kelley

National Legislative Director



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**STATEMENT OF**  
**CARL BLAKE**  
**NATIONAL LEGISLATIVE DIRECTOR**  
**PARALYZED VETERANS OF AMERICA**  
**BEFORE THE**  
**HOUSE COMMITTEE ON APPROPRIATIONS**  
**SUBCOMMITTEE ON MILITARY CONSTRUCTION AND**  
**VETERANS' AFFAIRS**  
**CONCERNING**  
***THE INDEPENDENT BUDGET***  
**AND THE DEPARTMENT OF VETERANS AFFAIRS BUDGET**  
**FOR FISCAL YEAR 2011**

**MARCH 23, 2010**

Chairman Edwards, Ranking Member Wamp, and members of the Subcommittee, as one of the four co-authors of *The Independent Budget* (IB), Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for FY 2011.

When looking back on 2009, it is fair to say that the 111<sup>th</sup> Congress took an historic step toward providing sufficient, timely, and predictable funding, and yet it still failed to complete its appropriations work prior to the start of the new fiscal year on October 1. The actions of Congress last year generally reflected a commitment to maintain a viable VA health care system. More important, Congress showed real interest in reforming the budget process to ensure that the VA knows exactly how much funding it will receive in advance of the start of the new fiscal year.

As you know, for more than a decade, the Partnership for Veterans Health Care Budget Reform (hereinafter “Partnership”), made up of nine veterans service organizations, including the four co-authors of *The Independent Budget*, advocated for reform in the VA health care budget formulation process. By working with the leadership of the House and Senate Committees on Veterans’ Affairs, the Military Construction and Veterans Affairs Appropriations Subcommittees, and key members of both parties, we were able to move advance appropriations legislation forward. Congress ultimately approved and the President signed into law P.L. 111-81, the “Veterans Health Care Budget Reform and Transparency Act.” Mr. Chairman, we particularly appreciate your leadership on this issue. Without the support of you and the members of the Subcommittee on Military Construction and Veterans’ Affairs, it is unlikely that we would have achieved such a monumental accomplishment.

A review of recent budget cycles made it evident that even when there was strong support for providing sufficient funding for veterans medical care programs, the systemic flaws in the budget and appropriations process continued to hamper access to and threaten the quality of the VA health care system. Now, with enactment of advance appropriations the VA can properly plan to meet the health care needs of the men and women who have served this nation in uniform.

In February 2009, the President released a preliminary budget submission for the Department of Veterans Affairs for FY 2010. This submission only projected funding levels for the overall VA budget. The Administration recommended an overall funding authority of \$55.9 billion for the VA, approximately \$5.8 billion above the FY 2009 appropriated level and nearly \$1.3 billion more than *The Independent Budget* had recommended.

In May, the Administration released its detailed budget blueprint that included approximately \$47.4 billion for medical care programs, an increase of \$4.4 billion over the FY 2009 appropriated level and approximately \$800 million more than the recommendations of *The Independent Budget*. The budget also included \$580 million in funding for Medical and Prosthetic Research, an increase of \$70 million over the FY 2009 appropriated level. By the end of the year, Congress enacted P.L. 111-117, the “Consolidated Appropriations Act for FY 2010,” that provided funding for the VA to virtually match the recommendations of the Administration. While the importance of these historic funding levels coupled with the enactment of advance appropriations legislation cannot be overstated, it is important for Congress and the Administration to continue this commitment to the men and women who have served and sacrificed for this country.

### **Funding for FY 2011**

Despite the fact that Congress has already provided advance appropriations for FY 2011, *The Independent Budget* has chosen to still present budget recommendations for the medical care accounts specifically for FY 2011. Included in P.L. 111-117 was advance appropriations for FY 2011. Congress provided approximately \$48.2 billion in discretionary funding for VA medical care. When combined with the \$3.3 billion Administration projection for medical care collections in 2010, the total available operating budget provided by the appropriations bill is approximately \$51.5 billion. Accordingly for FY 2011, *The Independent Budget* recommends approximately \$52.0 billion for total medical care, an increase of \$4.5 billion over the FY 2010 operating budget level established by P.L. 111-117, the “Consolidated Appropriations Act for FY 2010.” We believe that this estimation validates the advance projections that the Administration developed last year and has carried forward into this year. Furthermore, we remain confident that the Administration is headed in a positive direction that will ultimately benefit the veterans who rely on the VA health care system to receive their care.

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health care funding level. For FY 2011, *The Independent Budget* recommends approximately \$40.9 billion for

Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate.....	\$38,988,080,000
Increase in Patient Workload.....	\$1,302,874,000
Policy Initiatives.....	\$650,000,000
Total FY 2011 Medical Services.....	\$40,940,954,000

In order to develop our current services estimate, we first added the estimated collections for FY 2010 to the Medical Services appropriation for FY 2010. This best reflects the total budget authority that the VA will use to provide health care services. This amount was then increased by relevant rates of inflation. We also use the Obligations by Object in the President’s Budget submission in order to set the framework for our recommendation. We believe this method allows us to apply more accurate inflation rates to specific sub-accounts within the overall account. Our inflation rates are based on five-year averages of different inflation categories from the Consumer Price Index-All Urban Consumers (CPI-U) published by the Bureau of Labor Statistics every month. Once again this year, we are faced with the difficult challenge of determining inflation rates to apply while having to make assumptions about an uncertain long-term economic course for the country. However, by using an average of past inflation rates, we are better able to reasonably reflect the impact on the medical care accounts of the VA, even if a dramatic up-turn or down-turn occurs.

Our growth in patient workload is based on a projected increase of approximately 117,000 new unique patients—Priority Group 1-8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately \$926 million. The increase in patient workload also includes a projected increase of 75,000 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans at a cost of approximately \$252 million.

Finally, our increase in workload includes the projected enrollment of new Priority Group 8 veterans who will use the VA health care system as a result of the Administration’s plan to incrementally increase the enrollment of Priority Group 8 veterans by 500,000 enrollments by FY 2013. We estimate that as a result of this policy decision, the number of new Priority Group 8 veterans who will enroll in the VA will increase by 125,000 in each of the next four years.

Based on the Priority Group 8 empirical utilization rate of 25 percent, we estimate that approximately 31,250 of these new enrollees will become users of the system. This translates to a cost of approximately \$125 million.

As we have emphasized in the past, the VA must have a clear plan for incrementally increasing this enrollment. Otherwise, the VA risks being overwhelmed by significant new workload. *The Independent Budget* is committed to working with the VA and Congress to implement a workable solution to allow all eligible Priority Group 8 veterans who desire to do so to begin enrolling in the system.

Our policy initiatives have been streamlined to include immediately actionable items with direct funding needs. Specifically, we have limited our policy initiatives recommendations to restoring long-term care capacity (for which a reasonable cost estimate can be determined based on the actual capacity shortfall of the VA). Moreover, we have provided a projection for centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service). In order to restore the VA's long-term care average daily census (ADC) to the level mandated by P.L. 106-117, the "Veterans Millennium Health Care Act," we recommend \$375 million. Finally, to meet the increase in demand for prosthetics, the *IB* recommends an additional \$275 million. This increase in prosthetics funding reflects the significant increase in expenditures projected from FY 2010 to FY 2011 (explained in the section on Centralized Prosthetics Funding) and the expected continued growth in expenditures in the coming years. The funding for prosthetics is particularly important because it reflects current services and represents a demonstrated need now; whereas, our funding recommendations for long-term care reflect our desire to see this capacity expanded beyond the current services level.

For Medical Support and Compliance, *The Independent Budget* recommends approximately \$5.3 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately \$5.7 billion. Our recommendation once again includes an additional \$250 million for non-recurring maintenance (NRM) provided under the Medical Facilities account. This would bring our overall NRM recommendation to approximately \$1.26 billion for FY 2011. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding

still lags behind the recommended two to four percent of plant replacement value. Based on that logic, the VA should actually be receiving at least \$1.7 billion annually for NRM (Refer to Construction section article “Increase Spending on Nonrecurring Maintenance).

For Medical and Prosthetic Research, *The Independent Budget* recommends \$700 million. This represents a \$119 million increase over the FY 2010 appropriated level, and approximately \$110 million above the Administration’s request. We are particularly pleased that Congress has recognized the critical need for funding in the Medical and Prosthetic Research account in the last couple of years. Research is a vital part of veterans’ health care, and an essential mission for our national health care system. We are extremely disappointed in the Administration’s decision to virtually flat line the research budget. VA research has been grossly underfunded in contrast to the growth rate of other federal research initiatives. At a time of war, the government should be investing more, not less, in veterans’ biomedical research programs.

*The Independent Budget* recommendation also includes a significant increase in funding for Information Technology (IT). For FY 2011, we recommend that the VA IT account be funded at approximately \$3.553 billion. This amount includes approximately \$130 million for an Information Systems Initiative to be carried out by the Veterans Benefits Administration. This initiative is explained in greater detail in the policy portion of *The Independent Budget*. This represents an increase of \$246 million over the FY 2010 appropriated level as well as the Administrations request. We are greatly concerned that the Administration is shortchanging this account in a budget in which the VA and the Department of Defense are called on to jointly implement the Virtual Lifetime Electronic Record, and in which the Administration proposes to automate claims processing to improve the accuracy and timeliness of veterans’ benefits, particularly disability compensation and the new Post-9/11 GI Bill.

As explained in *The Independent Budget*, there is a significant backlog of major and minor construction projects awaiting action by the VA and funding from Congress. We have been disappointed that there has been inadequate follow-through on issues identified by the Capital Asset Realignment for Enhanced Services (CARES) process. In fact, we believe it may be time to revisit the CARES process all together. For FY 2011, *The Independent Budget* recommends

approximately \$1.295 billion for Major Construction and \$785 million for Minor Construction. The Major Construction recommendation includes approximately \$100 million for research infrastructure and the Minor Construction recommendation includes approximately \$200 million for research facility construction needs.

We note that the Budget Request reduces funding for Major Construction and slashes funding for Minor Construction. Despite additional funding that has been provided in recent years to address the construction backlog and maintenance needs facing VA, a great deal remains to be done. We cannot comprehend what policy decisions could justify such a steep decrease in funding for Minor Construction and we look forward to reviewing the detailed explanation in the President's Budget Request.

### **Advance Appropriations for FY 2012**

Public Law 111-81 required the President's budget submission to include estimates of appropriations for the medical care accounts for FY 2012 and the VA Secretary to provide detailed estimates of the funds necessary for these medical care accounts in his budget documents submitted to Congress. Consistent with advocacy by *The Independent Budget*, the law also requires a thorough analysis and public report of the Administration's advance appropriations projections by the Government Accountability Office (GAO) to determine if that information is sound and accurately reflects expected demand and costs to be incurred in FY 2012 and subsequent years.

We are pleased to see that the Administration has followed through on its responsibility to provide an estimate for the Medical Care accounts of the VA for FY 2012. It is important to note that this is the first year the budget documents have included advance appropriations estimates. This will also be the first time that the GAO examines the budget submission to analyze its consistency with VA's Enrollee Health Care Projection Model, and what recommendations or other information the GAO report will include. *The Independent Budget* looks forward to examining all of this new information and incorporating it into future budget estimates.

In the end, it is easy to forget, that the people who are ultimately affected by wrangling over the budget are the men and women who have served and sacrificed so much for this nation. We hope that you will consider these men and women when you develop your budget views and estimates, and we ask that you join us in adopting the recommendations of *The Independent Budget*.

This concludes my testimony. I will be happy to answer any questions you may have.

**Information Required by Rule XI 2(g)(4) of the House of Representatives**

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

***Fiscal Year 2010***

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—  
National Veterans Legal Services Program— \$300,000 (estimated).

***Fiscal Year 2009***

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation —  
National Veterans Legal Services Program— \$296,687.

***Fiscal Year 2008***

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation —  
National Veterans Legal Services Program— \$302,556.

**William Carl Blake  
National Legislative Director  
Paralyzed Veterans of America  
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Carl Blake is the National Legislative Director for Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's relations with the United States Congress and federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans' benefits issues. He also represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, and the Office of Personnel Management.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 504<sup>th</sup> Parachute Infantry Regiment (1<sup>st</sup> Brigade) of the 82<sup>nd</sup> Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute operation.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.



**STATEMENT  
BY  
CMSGT (RET.) USAF JOHN R. "DOC" MCCAUSLIN  
CHIEF EXECUTIVE OFFICER  
AIR FORCE SERGEANTS ASSOCIATION**

**FOR**

**THE HOUSE COMMITTEE ON APPROPRIATIONS  
SUBCOMMITTEE FOR MILITARY CONSTRUCTION AND  
VETERANS AFFAIRS**

**FY 2011 BUDGET PRIORITIES**

**March 23, 2010**

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**\*\* A participating organization in The Military Coalition \*\***



## CURRICULUM VITAE

CMSgt (Ret.) USAF John McCauslin was elected as the Air Force Sergeants Association (AFSA) International President during the Association's International Convention in Dallas, Texas, in August 2005. He was reelected International President during the 2006, 2007, and 2008 Professional Airmen's Conferences. He resigned his elected office in early January 2009. On 1 June 2009, he became the Chief Executive Officer replacing the retiring incumbent.

Chief McCauslin joined AFSA in 1977 as a lifetime member and has been active within the organization. He was elected to his first term as the AFSA International Trustee, Retired/Veterans Affairs in 2003. He enlisted in the US Air Force in June 1955. After basic training, he was first assigned to Gunter AFB, Alabama, where he underwent medical training. Later in his career he became the Command Senior Enlisted Advisor, Fifth Air Force, Yokota AB, Japan, followed by Command Senior Enlisted Advisor to Commander In Chief to the United States Air Force Europe, Ramstein AB, Germany, where he retired after 32 years of service.

Chief McCauslin's educational background includes both military and civilian achievements. The Chief obtained Bachelor of Arts degrees in History and Sociology from Chaminade University, Hawaii, in 1976. He also achieved Masters of Arts degrees in Management/Supervision and Education from Central Michigan University in 1978.

Following Chief McCauslin's retirement from the Air Force in 1987, he was the AFSA Special Assistant to the Executive Director and subsequently, Chief Field Operations for the Air Force Association. After his retirement, he followed his passion for volunteerism to enhance the quality of life for our Air Force members and their families.

His awards and decorations consist of a Legion of Merit, a Bronze Star Medal with one oak leaf cluster, a Meritorious Service Medal with two oak leaf clusters, an Air Force Commendation Medal with one oak leaf cluster, an Air Force Outstanding Unit Award, a Vietnam Campaign Medal, a Republic of Korea Service Medal, an Air Force Marksmanship Ribbon, and the State of Virginia Meritorious Service Award. In addition, he is the recipient of the Outstanding AFSA Division Award for Division 16, Outstanding Young Men of America, Outstanding Jaycee President and Outstanding Parent/Teachers President.

## DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Air Force Sergeants Association (AFSA) does not currently receive, nor has the association ever received, any federal money for grants or contracts. All of the association's activities and services are accomplished completely free of any federal funding.

Mr. Chairman and committee members, on behalf of the 120,000 members of the Air Force Sergeants Association, I thank you for the opportunity to present our views on what we believe should be the priorities for Fiscal Year 2011 for the Military Construction and Veterans Affairs Subcommittee of the House Appropriations Committee.

Air Force Sergeants Association represents Active Duty, Guard, Reserve, retired, and veteran enlisted Airmen and their families. We are grateful for this committee's efforts and I can't overstate the importance your work has to those serving this nation. The Air Force's most important resource – our Airmen – are a diverse group of highly-skilled and dedicated men and women who ensure our Air Force remains the most powerful in the world. Our Airmen have been continuously deployed and globally engaged in combat missions for over nineteen years.

We are grateful Congress understands this solemn duty and has increased the Administration's programmed budget in each of the past few years to fulfill that commitment. We believe more still needs to be done.

In this statement I will cover three broad categories - military construction, veterans affairs, and readiness and families – and identify specific areas we hope this committee will pursue during FY 2011. The content of this statement reflects the views of our members. As always, we are prepared to present more details and discuss these issues with your staffs.

## **Military Construction**

**Adequate infrastructure funding impacts readiness.** While many focus attention on “front line” conditions during periods of war-it is natural and vitally important. However, we shouldn't overlook the value of providing adequate temporary and/or permanent construction, repair, and maintenance funds at home station installations. The quality of the facilities where military members and their families live, work and play directly impacts their desire to continue serving through multiple deployments and extended separations. We devote significant resources to training/equipping America's sons and daughters—a long-term investment—and that same level of commitment should be reflected in the facilities where they work. We caution deferring these costs, especially at installations impacted by base realignment and closure decisions, organizational transformation or mission-related shifts. Congress did approve in the FY 2010 Appropriation bill, \$23.3 billion for military construction and family housing which will fund many projects for the Active Duty, Guard and Reserve, and military families. These funds will be used to upgrade barracks and child care centers, provide readiness centers, and more family base housing. Each of these projects and others are very important and we thank you for funding them. Oversight of these important projects is paramount in making sure that they are completed and the Force benefits.

**Housing privatization.** We urge congress to keep a keen over-sight on the privatization of military housing. Areas of concern include maintenance and upkeep of

the housing, renting military housing to those who have no affiliation with DoD (so that they simply have the housing occupied), and employing contractors with a true interest in providing quality military housing and who are not focused on the highest financial gains any way possible. In 1996 the Military Housing Privatization Initiative was enacted into law with the "...goal of revitalizing, replacing, or demolishing all inadequate housing by 2007..." At that time "approximately 10 percent of all families lived on-base, in government-owned military housing that is often dilapidated, too small, and lacked modern facilities. Forty three percent (or 58,000 units) were substandard" (DOD). As of January 2010 there are 186,870 military housing construction projects awarded to contractors at military installations across the U.S. with the intent of revitalizing, replacing, or demolishing facilities to create a better living environment for our service members. AFSA urges Congress to fully fund appropriate accounts to ensure all remaining installations eliminate substandard housing as quickly as possible. Those devoted to serving this country deserve nothing less.

**Child Development and Fitness Centers.** Tremendous strides have been made to improve access to quality child care and fitness centers on military installations and we are grateful to the Department of Defense and Congress for your collective efforts addressing these areas of concern. There is still more work to be done. The demand for child care continues to grow as a larger percentage of military members have young children. As such, the Air Force named July 2009 - July 2010 as the Year of the Air Force Family and has focused over this period of time on implementing changes and introducing new family support programs that will keep pace with the needs of Airmen and their families. The Air Force plans to add capacity to their child care facilities so that every Air Force child will have a spot in an Air Force child care facility by FY2012 and also provide more support for exceptional family member programs. Funding these programs is essential to meeting force needs and developing an environment that will ensure service member quality-of-life. There also needs to be a provision allowing additional household goods weight for shipment of special needs equipment for their exceptional needs family member whether they're moving to their next duty station or making their final move after retiring or separating. For example, an E-6 had to pay \$7,000.00 out of his own pocket to transport Exceptional Family Member goods for a Permanent Change of Station (PCS), because it exceeded his allotted weight allowance for his house hold goods.

**Homeowners Assistance Program (HAP).** This program is designed to help service member homeowners who suffer financial loss on the sale of their primary residences when a base closure or realignment announcement causes a decline in the residential real estate market and they are not able to sell their homes under reasonable terms or conditions. We applaud the actions of this committee to improve this program along with legislators like Representative Dina Titus for introducing H.R. 4324 which will allow the Secretary of Defense leeway in deciding the dates of eligibility for HAP. We would like the committee to support this improvement to the HAP because there are many instances where BRAC has affected military base communities differently. Many service members are outside the eligibility range but are affected by BRAC closures just as

badly and need help. This program may not be a big budget item but it has a tremendous affect on retention of service members.

**Energy.** Good energy efficiency practices are an important Air Force goal. The Air Force has requested \$250 million for energy and water conservation projects in FY11. This funding will help us to complete projects, which the Air Force finalized in their FY10 energy plan that will meet our 2015 efficiency goals. The Air Force is focused on using alternative energy resources that will reduce energy costs and improve the work environment for all Airmen. Additionally, the plan recognizes that aviation operations account for over 80 percent of the energy used by the Air Force each year, and directs Airmen and mission planners to continue managing aviation fuel as an increasingly scarce resource.

## **Veterans Affairs**

Taking care of our veterans is a solemn duty and is reflected in the trust between the government and its uniformed members that have entered into a contract where each pledges with their life to support and defend the constitution. Today, the men and women of the armed forces continue a tradition of honor and valor exemplified by past generations. It is important our country lives up to its commitments made to all veterans-the role models for today and tomorrow's forces.

**Support VA Subvention.** With more than 40 percent of veterans eligible for Medicare, VA-Medicare subvention is a very promising venture, and AFSA offers support for this effort. Under this plan, Medicare would reimburse the VA for care the VA provides to non-disabled Medicare-eligible veterans at VA medical facilities. This funding method would, no doubt, enhance some older veterans' access to VA health care. The VA has an infra-structural network to handle this, and we anticipate the effort would be successful. This is an opportunity to ensure that those who served are not lumped in with all those who have not, and would, no doubt, save taxpayer dollars by potentially reducing an overlap in spending by Medicare and the VA for the same services. While we recognize the current Administration's intent to open the VA health care system to hundreds of thousands of additional veterans, we suggest that VA subvention can be used as a methodology that will economically promote this effort.

**“Seamless” Transferable Medical Records.** The record numbers of veterans being generated by the wars in Afghanistan and Iraq underscore the importance of accelerating DoD and VA plans to seamlessly transfer medical information and records between the two federal departments. A lifetime DoD-VA service medical record will help veterans obtain early, accurate, and fair VA disability ratings, save the Department of Veterans Affairs funding, and facilitate pre- and post-deployment research that will advance standards of care. Additional savings will be realized by preventing the “doubling” of diagnostic testing which currently occurs when VA runs similar testing (MRIs/X-rays, etc.) to validate DoD findings. We are pleased the two Departments are working together to resolve this issue, and the work of the committee on this matter has not gone unnoticed. The technology exists to accomplish the goal of a seamless record,

and we urge the committee to assume an even greater, more aggressive oversight role and facilitate implementation of this important program as quickly as possible. The implementation of the Virtual Lifetime Electronic Record by 2012 is long overdue and a welcomed step in the 21st century.

**Care for Women Veterans.** The unique health care challenges faced by women veterans must be met with a sense of higher urgency from Congress. By next year, the VA estimates that women veterans will comprise well over 10 percent of the veteran population (includes women from all military services, Reserve, Guard components). During Desert Storm 41,000 women served in theater during the operational period (according to the *Women In Military Service For America Memorial Foundation*). Currently, women make up more than 19 percent of the active duty Air Force and approximately 21 percent of the reserve Air Force (Air Force Personnel Center). As of September 30, 2009 we have 471,079 women in uniform (from all military services), many of which have already returned from service in Iraq and Afghanistan. They too, suffer from the same effects of battle as many of their fellow male service members; such as PTSD, TBI, and Wounded Warrior issues that come with wearing the uniform. As the number of women veterans increases, the VA must be funded to increasingly provide the resources and legal authority to care for female-specific health care needs. We have been transitioning over the years away from the large male population of previous wars and conflicts and we must absolutely make sure that we do not neglect the needs of the women who have volunteered to serve our country.

**Support State Veterans Homes.** One hundred and forty state-run veterans' homes serve about 33,000 former service-members. These homes are a good federal investment since the states provide funding for two-thirds of total operating costs. We urge the committee to take a close look at the required level of support to protect these important national assets and further, to consider them as opportunities to provide high quality care for our nation's veterans while simultaneously minimizing the cost of providing that care and having a positive impact on homelessness.

With current military activities, our nation will bear the burden of a generation of service-members who have been inflicted with severe disabilities who will need a health care environment in which to live. In recognizing this, we must be prepared to fund, build, and maintain significantly more facilities than we have today. Unfortunately, many families will have to make the difficult decision to place their loved one in a veterans' home. It is absolutely necessary that our nation's leaders ensure there is room for them and quality care available. We must plan now--not later. We must determine funding now, start building now, and become proactive in our approach to provide long-term care for the next 50 to 75 years for this generation of service members. We also need to begin the steps to provide care for women veterans. With more than 1.8 million female veterans who have served in the military, according to the Secretary of Veterans Affairs. It is projected that by 2020 women Veterans will comprise 10 percent of the Veteran population. The State Veterans homes will host more females in the future and we need to be able to provide the necessary services for them.

Unfortunately, the recently released State Home Construction Grant Program Priority List indicates a backlog of \$405 million in Priority One and \$946 million for all projects. Consequently, the \$250 million we received in FY 2010 through appropriated and stimulus funds is seriously inadequate, given the number of applications waiting funding. We desperately need to address this funding shortage in the FY 2011 budget and work to provide the maximum amount of funding needed to complete the required construction projects to provide quality care for our veterans (Armed Forces Veterans Homes Foundation). AFSA also recommends enactment of HR 4241 to properly take care of over 33,000 veterans that are in State Veterans homes across the country.

**EDUCATION PROGRAMS.** There's no escaping the fact that college costs are rising. As the gap between the cost of an education and value of the Montgomery G.I. Bill widened, the significance of the benefit became less apparent. For that reason, the Post-9/11 GI Bill is a giant step forward. However, we must make sure that the new Post-9/11 GI Bill stays current at all times, so that this benefit will not lose its effectiveness when it comes to recruiting this nation's finest young men and women into service. As a member of The Military Coalition and the Partnership for Veterans' Education, we strongly recommend you make the remaining technical corrections to the Post-9/11 GI Bill. Examples that stand out are active duty not receiving the \$1,000.00 annual book stipend, Title 32 credit for Guard and Reserve service, and BAH for those veterans or retirees taking on-line college courses full time.

## **Readiness and Families**

**Personnel Support.** Nearly 40,000 Airmen are deployed and 130,000 Airmen support combatant commanders from their home stations. These Airmen operate mission essential support operations and are working around that clock at home and overseas to support their comrades in arms through flying sorties, delivering passengers and cargo, providing combat support, and transporting patients and casualties. In support of these efforts and to continue this legacy we need to recruit and retain the highest quality service members. With our country fighting two wars and maintaining active component end strengths, it is imperative that we fund military personnel initiatives to include a 1.9 percent pay increase, and retention and recruiting bonuses for targeted wartime critical skills.

**Personnel Recovery.** The increased reliance on military and civilian personnel supporting overseas contingency operations (OCO) creates the backdrop for an increased need of Air Force recovery missions that include crucial medical and casualty rescue missions. These types of missions show how important it is that we replace our aging fleet of aircraft to support operations overseas. We ask that you fund these requirements for more support and operational aircraft and that you fund the Guardian Angel personnel recovery program so that the pararescuemen can operate with modern mission essential equipment.

**Airmen and Families.** Retention rates have exceeded expectations, as they continue to progress toward the desired end strength goal of 332,200 active duty Airmen. In

addition to stabilizing their end strength, training programs and aircraft need to be modernized. With the need to save money and the desire to better partner with Joint and Coalition teams, the Air Force is providing Airmen with cultural and regional expertise and appropriate levels of foreign language training. The efforts to expand foreign language instruction for officer commissioning programs at the Air Force Academy and in ROTC include efforts such as encouraging cadets to take foreign language coursework and to participate in language immersion and study programs abroad. We also need to consider enlisted members when expanding programs of this kind and including programs that enhance expeditionary skills training to prepare Airmen for deployment.

The Air Force continues to expand its efforts to improve the resiliency of Airmen and their families before and after deployments. This year they expanded deployment-related family education, coupling it with psychological screening and post-deployment health assessments. Additionally, they are offering access to chaplains who provide pastoral care, counselors, and mental health providers trained in post-traumatic stress treatment at every base. The Air Force is also developing a continued support plan that includes promoting and encouraging mental health assistance and providing at-risk deployers with tailored and targeted resiliency programs. This very important initiative is urgently needed as a part of the suicide prevention program. To support this increased effort, they will need assistance to enhance mental health career field recruiting and retention through special pays and targeted retention bonuses.

Mr. Chairman, in conclusion, I would like to thank you again for this opportunity to express the views of our members on these important issues as you consider the FY 2011 budget.

We realize you possess incredible responsibility as caretakers of the taxpayers' money and must budget wisely, basing difficult decisions on many factors. Choosing what can and cannot be addressed grows significantly difficult. However, AFSA contends that it is of paramount importance to provide quality health care and top-notch benefits in exchange for the devotion, sacrifice, and service of military members, particularly while this nation remains at war. Putting hundreds of thousands of Americans in Iraq and Afghanistan to protect us is **not** a "pay as you go" situation.

AFSA also firmly believes while much attention is given to the combat capability of technologically advanced systems, the most valuable weapon America has is those that serve, especially those wearing the chevrons of the enlisted grades. If we expect to retain this precious resource we must provide them, and their families, with quality facilities that reflect their level of commitment and sacrifice.

Again, Mr. Chairman, we are pleased by the hard work of this committee and its commitment to America's veterans past and present. On behalf of all Air Force Sergeants Association members, we appreciate your efforts and, as always, are ready to support you in matters of mutual concern.





**NATIONAL ASSOCIATION FOR UNIFORMED SERVICES**

**TESTIMONY**

**on**

**Military Construction and Veterans Affairs**

**before the**

**House Committee on Appropriations  
Subcommittee on Military Construction, Veterans Affairs  
and Related Agencies**

**presented by**

**Rick Jones, Legislative Director,  
National Association for Uniformed Services**

**Thursday, March 23, 2010  
H-143 Capitol**

Chairman Edwards, Ranking Member Wamp, and members of the Committee:

I am pleased today to present testimony on behalf of the National Association for Uniformed Services (NAUS) on selected fiscal year 2011 issues before the Military Construction, Veterans Affairs, and Related Agencies Subcommittee. My name is Richard Jones, legislative director for NAUS.

Mr. Chairman, on behalf of our nationwide membership, the National Association for Uniformed Services thanks you and the members of this Subcommittee for working so hard with House leadership to make veterans the #1 priority over the past four years. Your accomplishments have helped address the critical medical-care needs facing our service men and women as they return home.

### **Funding for the Department of Veterans Affairs (VA) Health Care**

The National Association for Uniformed Services is encouraged that the administration's overall recommendation for VA resources continues to move in the right direction, building upon the strides taken over the recent past years. It is important that we not backtrack from what is necessary in the provision of health care for sick and disabled veterans, and for the number of troops returning from Iraq and Afghanistan.

The National Association for Uniformed Services is generally pleased with the President's fiscal year 2011 VA budget request. It recommends a level of \$51.5 billion, \$4.3 billion above last year's level or 9.1 percent more. However, it is important to note that the recommendation includes a projected \$3.3 billion in medical collection of fees and copays, which may falter especially in a difficult economic year with high unemployment.

The National Association for Uniformed Services is also pleased to endorse, with 62 other veterans organizations, *The Independent Budget*, formulated by AMVETS, the Disabled Veterans of America, Paralyzed Veterans of America, and Veterans of Foreign Wars of the

United States. *The Independent Budget* has a superb record on recognizing the needs of the department in fulfilling its mission to care for sick and disabled veterans.

The National Association for Uniformed Services recommends a total of \$52.0 billion for medical care, an increase of \$4.5 billion over fiscal year 2010. We urge the Subcommittee to recognize the unique specialized care provided at VA facilities and to provide the resources needed for VA to treat sick and disabled veterans.

The Department's Veterans Health Administration (VHA) is a world-class leader in advanced care medicine and in the provision of primary care. In addition, VHA has consistently pioneered research initiatives in areas that have directly benefited not only veterans, but also our entire population.

We are pleased to see advancement in lifting the ban on access to VA health care for certain veterans classified as Priority 8 veterans. Denying access only devalues the service of those who seek care with VA. Recent estimates indicate that VA will enroll about 193,000 veterans by the close of fiscal year 2010. We encourage your efforts to resource healthcare eligibility to an additional 500,000 Priority 8 veterans over the next years.

But more should be done. We strongly recommend restoring Priority 8 access with the enrollment of those veterans who can identify private- or public-health insurance. In this way, we would make certain that VA would receive reimbursement and third-party payers would be used to the fullest extent.

The National Association for Uniformed Services firmly believes that the veterans healthcare system is an irreplaceable national investment, critical to the nation and its veterans. The provision of quality, timely care is considered one of the most important benefits afforded veterans. And our citizens have benefited from the advances made in medical care through VA research and through VA innovations as well, such as the electronic medical record.

We urge the Subcommittee to take the actions necessary to honor our obligation to those men and women who have worn the nation's military uniform. Clearly, when VA does not receive adequate funding, it is forced to ration, delay or deny care.

### **Department of Veterans Affairs, Disability Claims Backlog**

The National Association for Uniformed Services strongly supports the provision of timely benefits to disabled veterans and their families. These benefits help offset the economic effects of disability and are one of the essential functions of the Department of Veterans Affairs (VA). The capacity of the disabled veteran to afford the necessities of life is oftentimes dependent on these benefits, so delays in the resolution of a claim is a matter of serious concern.

Despite VA's best efforts to deliver benefits to entitled veterans, the claims workload of the Veterans Benefits Administration (VBA) continues to increase. Simply stated, VBA is falling farther behind.

The severe and growing backlog of veterans' claims is well documented. A recent report from the VA Inspector General, which reviewed a 12-month period of claims, found that 22 percent of all decisions were incorrect or incomplete. Out of the 1 million claims received, more than 220,000 veterans claims, 1 of every 5 submitted, were inaccurate or incomplete. Many of those cases were sent back to the VA for review or added to the caseload of the Board of Veterans Appeals or found their way to the Court of Appeals for Veterans Claims, further clogging the system. Whatever the destination of those claims, the simple fact is that VA can ill-afford an increase of that number of claims for review due to its own inaccurate or incomplete work. With the high percentage of inaccurate decisions, it's not hard to see why the system is so overwhelmed.

The disability claims workload has continuously grown since 2000. Annual claims grew from 674,219 in 2001 to 1,013,712 in 2009. Claims received by VA are more complex and require additional time to decide and rate. NAUS firmly believes VA need to put additional emphasis on the quality of its claims decisions in order to get a handle on this matter. Improvements are

required in the Veterans Benefits Management System and associated areas that deal with benefit claims issues.

Improvement in operations of the VA benefit claims approval system is critical. It is clear to the National Association for Uniformed Services that until this problem is tackled head on, thousands of veterans injured in military service will continue to face unnecessary delays and red tape in receiving the benefits we owe them and their transition to civilian life will be rough.

We need to make headway to overcome the chronic claims backlog and consequent protracted delays in claims disposition. Every effort must be made to gain ground on the problem.

The problem is deeply troubling, but it can be corrected. Training must be resourced and technical support must be provided to ensure progress is found to bring down the number of pending claims and shorten the waiting period for decision.

The National Association for Uniformed Services calls on lawmakers to make the VBA a priority within the national budget. The challenge is to provide timely decisions on claims submitted by veterans who suffer disability as a result of their military service. And the solution is to ensure that VBA has adequate funding to reduce the backlog and achieve the mission of providing timely claims adjudication.

### **Department of Veterans Affairs, Seamless Transition Between the DoD and VA**

Congress must direct the Pentagon to remove remaining roadblocks between DoD and VA to ensure a seamless transition of veterans' medical records. The two departments need to develop better communications to help identify, locate and follow up with injured servicemembers separated from the military.

The provision of a seamless transition for recently discharged military is critically important for medical reasons, particularly for the most severely injured patients. Most important in the calculus of a seamless transition is the capacity to share information at the earliest possible moment prior to separation or discharge. It is essential that surprises be reduced to a minimum

to ensure that all troops receive timely, quality health care and other benefits earned in military service.

The DoD/VA exchange should include a detailed history of care provided and an assessment of what each patient may require in the future, including mental health services. No veteran leaving military service should fall through the bureaucratic cracks.

We urge the Subcommittee to hold the departments to a strict line for pursuit of a joint lifetime electronic health and benefits records for service members and veterans. We have seen progress, and we urge members of the Subcommittee to motivate DoD and VA to end red-tape resistance and to get the job done.

### **Department of Veterans Affairs, Medical and Prosthetic Research**

As Congress moves forward in consideration of funding for fiscal 2011, the National Association for Uniformed Services encourages a strong effort to provide for the Department of Veterans Affairs (VA) medical research mission, especially in the area of prosthetic research. National Association for Uniformed Services recommends \$590 million, \$9 million dollars more than the current year level of \$581 million. The National Association for Uniformed Services supports increasing medical and prosthetic research to continue support for new research initiatives and to maintain a stable, predictable funding stream for advances under this account.

Clearly, care for our troops with limb loss and special needs is a matter of national concern. In order to help meet the challenge, VA research must be adequately funded to continue its intent on treatment of troops surviving this war with grievous injuries. The research program also requires funding for continued development of advanced prosthesis that will focus on the use of prosthetics with microprocessors that will perform more like the natural limb.

The National Association for Uniformed Services encourages the Subcommittee to ensure that funding for VA's medical and prosthetic research supports the full range of programs needed to meet current and future health challenges facing wounded veterans.

## **Department of Veterans Affairs, Post Traumatic Stress Disorder (PTSD)**

The National Association for Uniformed Services commends VA for its enhanced awareness on mental health issues. We support VA continued improvements in care of troops demonstrating symptoms of mental health disorders and treatment for PTSD.

Over the past several years, VA has dedicated a higher level of attention to veterans who exhibit PTSD symptoms. The programs for treatment of veterans exhibiting PTSD symptoms are essential for the recovery and restoration of many of those who must deal with the debilitating effects of mental injuries, which are as inevitable in combat as gunshot and shrapnel wounds.

While many new approaches to treatments have been developed and are available to veterans, the National Association for Uniformed Services is concerned that VA's capacity to serve the mental health needs of returning veterans remains below the level needed.

The need for treatment for veterans is immediate, yet too many servicemembers are discharged from the service undiagnosed, while continuing to suffer debilitating symptoms.

The key to physical brain damage is healing of both injured tissue and the arterial support to blood flow to assure continued normal function. Trauma injuries are complex internal injuries.

The National Association for Uniformed Services is encouraged to see reliable advancement of cases under a treatment known as Hyperbaric Oxygen Therapy (HBOT) at an atmospheric pressure of 1.5 atmospheres (HBOT 1.5). HBOT 1.5 has produced dramatic improvement for more than 30 Iraq/Afghanistan casualties facing TBI issues. We recommend the subcommittee give this therapy its close attention and provide the necessary resources for clinical trials of HBOT 1.5 to complete a more formal treatment for regeneration of brain tissue biologically instead of simply treating the symptoms with drugs.

The National Association for Uniformed Services encourages the members of the Subcommittee to increase funding for mental health to meet the surging need of servicemembers returning from fields of combat. We simply must have substantial numbers of providers who are trained and certified to deliver care for post-combat PTSD and major depression.

While VA and Congressional leaders have taken important steps to move VA toward better care for veterans with mental health problems, many challenges still remain. The National Association for Uniformed Services urges the development of a consistent, seamless, and working approach that allows VA and DOD to screen returning service members and provide more effective early intervention that leads to healing.

VA requires additional funds to expand its specialized mental health programs, to provide additional capacity for inpatient psychiatric and residential care, to ensure effective treatment for post-traumatic stress and to help families deal with their loved ones return to civilian life.

### **Department of Veterans Affairs, Medicare Reimbursement**

The National Association for Uniformed Services supports legislation to authorize Medicare reimbursement for healthcare services provided Medicare-eligible veterans in VA facilities. Medicare subvention will benefit veterans, taxpayers and VA.

The National Association for Uniformed Services sees an all around win-win-win for establishment of Medicare subvention. VA would receive additional, non-appropriated funding. Medicare-eligible veterans would receive world-class medical treatment in the system our government provided for their care. Scarce resources would be saved because medical services can be delivered for less cost at VA than in the private sector.

In addition, direct billing between VA and the Centers for Medicare and Medicaid Services (CMS) would reduce opportunities for waste, fraud and abuse losses in the Medicare system.

The National Association for Uniformed Services encourages the Subcommittee to permit Medicare-eligible veterans to use their Medicare entitlement for care at local VA medical facilities.

### **Armed Forces Retirement Home**

The National Association for Uniformed Services is pleased to note the Subcommittee's continued interest in providing funds for the Armed Forces Retirement Home (AFRH). We urge the Subcommittee to meet the challenge in providing adequate funding for the facility in Washington, DC, and Gulfport, Mississippi.

And we thank the Subcommittee for the provision of funding that has led to the Armed Forces Retirement Home in Gulfport to be nearly ready for completion. And we look forward to the completion of the home scheduled for June 2010. When completed, the facility will provide independent living, assisted living and long-term care to 584 residents.

The National Association for Uniformed Services also applauds the recognition of the Washington AFRH as a historic national treasure. And we look forward to working with the Subcommittee to continue providing a residence for and quality-of-life support to these deserving veterans without turning over large portions of this campus, just four miles from the nation's Capitol, to developers. We ask that continued care and attention be given to the mixed-use development to the property's southern end, which has been stalled due to a bankruptcy of a construction development partner approved by the National Capital Planning Commission.

### **Appreciation for Opportunity to Testify**

As a staunch advocate for military retirees and veterans, the National Association for Uniformed Services represents all ranks, branches and components of uniformed services, their families and survivors. The Association recognizes that these brave men and women did not fail us in their service to country, and we, in turn, must not fail them in providing the benefits and services they *earned* through honorable military service.

Mr. Chairman, the National Association for Uniformed Services appreciates the Subcommittee's hard work. We ask that your work continue in good faith to put the dollars where they are most needed in our nation's highest priority areas, which include veterans health care and benefits services, housing for our military troops and their families, particularly in time of war and when we are increasing our troop level in Afghanistan.

The National Association for Uniformed Services is confident you will take special care of our nation's greatest assets: the men and women who serve and have served in uniform. We are proud of the service they give, and we recognize that the price we pay for their earned benefits will never equal the value their service provides our nation.

Again, the National Association for Uniformed Services deeply appreciates the opportunity to present the Association's views on issues before the Military Construction, Veterans Affairs, and Related Agencies Subcommittee.

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# Subcommittee on Military Construction and Veterans Affairs

## Witness Disclosure Form

**Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.**

Your Name, Business Address, and Telephone Number:

Richard A. Jones, 5535 Hempstead Way, Springfield, VA 22151  
(703) 750-1342 extension 1008

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

Representing the National Association for Uniformed Services

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2006?

No  X

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Signature:



Date: March 23, 2010



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The Servicemember's Voice in Government  
Established in 1968



Richard A. “Rick” Jones  
Legislative Director  
National Association for Uniformed Services (NAUS)

Richard A. “Rick” Jones joined NAUS as Legislative Director on Sept. 1, 2005. As legislative director, he is the primary individual responsible for promoting the NAUS legislative, national security, and foreign affairs goals before the Departments of Defense and Veterans Affairs, and the Congress of the United States.

Rick presently serves as co-chairman of the National Military and Veterans Alliance (NMVA) and co-chairman of the Alliance for Military and Overseas Voting Rights (AMOVR). NMVA is composed of 31 military associations and veterans organizations with a combined membership of more than 3.5 million members. AMOVR is a working alliance of 36 military and overseas advocacy groups, elected officials, students and voting rights advocates formed to ensure that our military men and women are afforded their right to vote and to ensure their votes are counted.

Rick is an Army veteran who served as a medical specialist during the Vietnam War era. His assignments included duty at Brooke General Hospital in San Antonio, Texas; Fitzsimons General Hospital in Denver, Colorado; and Moncrief Community Hospital in Columbia, South Carolina.

Rick completed undergraduate work at Brown University prior to his Army draft and earned a Master Degree in Public Administration from East Carolina University in Greenville, North Carolina, following military service.

Prior to assuming his current position, Rick served five years as National Legislative Director for AMVETS, a major veterans service organization. He also worked nearly twenty years as a legislative staff aide in the offices of Senator Paul Coverdell, Senator Lauch Faircloth, and Senator John P. East. He also worked in the House of Representatives as a committee staff director for Representative Larry J. Hopkins and Representative Bob Stump.

In working for Rep. Stump on the House Committee on Veterans’ Affairs, he served two years as minority staff director for the subcommittee on housing and memorial affairs and two years as majority professional staff on funding issues related to veterans’ affairs budget and appropriations.

Rick and his wife Nancy have three children and reside in Springfield, Virginia.

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Statement of  
The Fleet Reserve Association

Before the

Committee on Appropriations  
Subcommittee on Military Construction and Veterans Affairs  
U.S. House of Representatives

Presented by

John R. Davis  
Director, Legislative Programs  
Fleet Reserve Association

March 23, 2010

## **THE FRA**

The Fleet Reserve Association (FRA) is the oldest and largest enlisted organization serving active duty, Reserves, retired and veterans of the Navy, Marine Corps, and Coast Guard. It is Congressionally Chartered, recognized by the Department of Veterans Affairs (VA) as an accrediting Veteran Service Organization (VSO) for claim representation and entrusted to serve all veterans who seek its help. In 2007, FRA was selected for full membership on the National Veterans' Day Committee.

FRA was established in 1924 and its name is derived from the Navy's program for personnel transferring to the Fleet Reserve or Fleet Marine Corps Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Secretary of the Navy.

FRA's mission is to act as the premier "watch dog" organization in maintaining and improving the quality of life for Sea Service personnel and their families. FRA is a leading advocate on Capitol Hill for enlisted active duty, Reserve, retired and veterans of the Sea Services. The Association also sponsors a National Americanism Essay Program and other recognition and relief programs. In addition, the newly established FRA Education Foundation oversees the Association's scholarship program that presents awards totaling nearly \$100,000 to deserving students each year.

The Association is also a founding member of The Military Coalition (TMC), a 34-member consortium of military and veteran's organizations. FRA hosts most TMC meetings and members of its staff serve in a number of TMC leadership roles.

FRA celebrated 85 years of service in November 2009. For over eight decades, dedication to its members has resulted in legislation enhancing quality of life programs for Sea Services personnel, other members of the uniformed services plus their families and survivors, while protecting their rights and privileges. CHAMPUS, now TRICARE, was an initiative of FRA, as was the Uniformed Services Survivor Benefit Plan (USSBP). More recently, FRA led the way in reforming the REDUX Retirement Plan, obtaining targeted pay increases for mid-level enlisted personnel, and sea pay for junior enlisted sailors. FRA also played a leading role in advocating recently enacted predatory lending protections and absentee voting reform for service members and their dependents.

FRA's motto is: "Loyalty, Protection, and Service."

### **CERTIFICATION OF NON-RECEIPT OF FEDERAL FUNDS**

Pursuant to the requirements of House Rule XI, the Fleet Reserve Association has not received any federal grant or contract during the current fiscal year or either of the two previous fiscal years.

## **INTRODUCTION**

Mr. Chairman and other distinguished Members of the Subcommittee: The Fleet Reserve Association (FRA) appreciates the opportunity to present its recommendations regarding the FY 2011 Budget.

FRA thanks you and Members of the Subcommittee for the progress to date on enhancing funding for various military construction projects and to ensure that wounded troops, their families and the survivors of those killed in action are cared for by a grateful Nation.

FRA is deeply concerned about the backlog of claims at the Department of Veterans Affairs. The Association appreciates funding in the FY 2010 MilCon/VA appropriations bill for an additional 1,200 claim adjusters. The VA has hired nearly 4,200 more employees since January 2007, but despite the additional resources and manpower, the backlog of disability claims increased by more than 80,000 since the beginning 2009. The Association appreciates the \$145 million for a paperless claims process, and \$347 million to develop and implement an electronic health record at VA. FRA welcomes the enrollments in the VA health care system for some Priority 8 veterans, that will eventually (FY 2013) provide access to more than 500,000 veterans that are currently ineligible.

As an Association made up primarily of career Navy enlisted personnel, the Agent Orange claims controversy is a high priority for the Association and FRA welcomes the \$13.4 billion FY 2010 supplemental appropriations for new presumptions related to Agent Orange exposure. FRA notes that the FY 2011 VA budget for claims processing is increased by 27 percent (\$460 million) over the FY 2010 budget that includes improved benefits processing through a combination of additional staff, enhanced business practices, and improved use of technology.

## **POST 9/11 GI BILL**

The Association understands that funding for the Post 9/11/2001 G.I. Bill is mandatory, thus eliminating the year-to-year uncertainty about adequate resources to support the authorized and dramatically increased education benefits for qualifying service members. This is a very significant program and FRA is grateful for its enactment. The VA budget also provides funding to meet the increased education claims workload resulting from the enactment of the Post 9/11 GI Bill program. This benefit program has had an immeasurable improvement on the morale of those currently serving. The Association appreciates the logistical difficulty of implementing a new system while still administering the current system. FRA welcomed additional VA processors until a new automated system is developed and implemented and appreciates that the VA issued more than 30,000 checks up to \$3,000 each in October to students who had not yet received benefits. As the fall semester came to an end more than 26,000 students had not received any benefits at all. It appears that processing payments for the spring semester has been improved but more work needs to be done to improve delivery of benefits for this program.

## WOUNDED WARRIORS

FRA is cautiously optimistic about the progress toward establishing the joint DoD-VA office that will oversee development of a bi-directional electronic medical record per provisions in the FY 2008 National Defense Authorization Act (NDAA). The creation of the electronic health record is a critical element in developing a seamless transition process between DoD and VA care. Despite jurisdictional challenges, this Subcommittee should ensure that this office has adequate funding to effectively implement a bi-directional electronic medical record as a critical first step in improved treatment of physical injuries as well as PTSD and TBI for veterans of Operations Iraqi and Enduring Freedom (OIF/OEF).

The FRA is encouraged by the improved cooperation between of the Departments of Defense (DoD) and Veterans' Affairs (VA) in working to help our wounded warriors. For example, DoD is working with the VA to expand the Disability Evaluation System (DES) pilot program that simplifies the current disability evaluation process for wounded, injured and ill service members and is aimed at assisting wounded service members obtain faster access to TRICARE and other health care and VA benefits. A single medical examination used by both DoD and VA, with a single source disability evaluation done by VA and accepted by DoD is key to this initiative. The pilot, implemented in the National Capitol Region in November 2007, expanded to 19 additional installations last year. FRA has strongly supported a streamlined and seamless disability evaluation process and supported the legislative effort to create the pilot program. More than 700 service members have participated in the pilot program.

The pilot was initiated at the Washington D.C. VA Medical Center and at three Military Treatment Facilities in the National Capitol Region – Malcolm Grow Medical Center at Andrews Air Force Base, Md., Walter Reed Army Medical Center in Washington, D.C., and National Naval Medical Center in Bethesda, Md. More installations were added to the study, including Fort Carson, Colo., Naval Medical Center San Diego, Calif., and Elmendorf Air Force Base, Alaska.

The FY 2008 National Defense Authorization Act established a comprehensive policy on the care and management of wounded service members in order to facilitate and enhance their care, rehabilitation, physical evaluation, transition from DoD care to the VA, and transition from military service to civilian life.

Although DoD and VA have made great progress in sharing information and resources, much more is needed, particularly with regard to access standards, to truly provide a “seamless transition” from military service to veteran status. The Special Oversight Committee (SOC) is important to this process. FRA advocates that a truly seamless transition can not be implemented and maintained without the adequate funding of a permanent joint VA/DoD office is staffed by both DoD and VA personnel.

FRA supports the Administration's efforts to modernize the administration of veterans' health care by creating a Joint Virtual Lifetime Electronic Record (VLER). The creation of a VLER for every service member would be a major step toward FRA's long-standing goal of a seamless transition from military to veteran status. The VLER ultimately would permit a health care pro-

vider (DOD, VA or a private provider) a timely, seamless access to an individual's (service member/veteran) health data.

Although these and other reforms are improvements, the fact remains that the VA disability process and the VA health care system is still overwhelmed. A two-front war, a lengthy occupation and repeated deployments for many service members has put a strain on the DoD/VA medical system that treats our wounded warriors. The system is being strained not only by volume but by the complexity of injuries, and the military has shown that it is inadequate in recognizing and treating cases of TBI and PTSD, even though more than 3,900 new mental health employees have been hired since 2005 – bringing our total number to more than 17,000. Soaring medical costs, decades of inadequate appropriations and increasing demand for medical services have severely hampered timely access to quality health care for our Nation's sick and disabled veterans.

### **VA 2011 BUDGET OUTLINE**

Under the Advanced Funding law, the Administration is now able to request two budgets for the VA: one to provide fiscal 2011 total funding and another to provide fiscal 2012 funding for certain VA medical accounts.

For fiscal year 2011, the Administration has proposed a VA budget of \$125 billion, an \$11 billion increase (7.6 percent) from the 2010 enacted budget. The Administration is requesting \$51.5 billion in resources for VA medical care, an increase of \$4.1 billion over fiscal year 2010 levels. For fiscal year 2012, the Administration has requested a 5 percent increase in funding above the amounts requested for fiscal year 2011. The VA has requested a \$460 million increase for processing disability claims, a 27 percent increase over the current fiscal year. The proposed budget adds \$44 million for a new automated claims system for processing Post 911 GI Bill education benefits. Since the VA expects education benefit claims to increase by nearly 30 percent in FY 2011.

FRA supports the FY 2011 Independent Budget (IB) and welcomes the Department of Veterans Affairs (VA) budget being excluded from the Administration's freeze on discretionary spending and the implementation of advanced funding for VA health care for FY 2012 (\$54.3 billion).

The proposed FY 2011 VA budget includes a \$5 billion increase (\$51.5 billion) over FY 2010 levels for medical care programs, and the IB recommends an additional \$500 million more (\$52.0 billion) for medical care programs. The budget also contains a significant increase in funding for the Veterans Benefits Administration (VBA), the VA agency charged with providing compensation and benefits to veterans. The President's budget recommends \$2.1 billion for VBA, an increase of \$460 million over the FY 2010 appropriated level. This funding increase reflects a real commitment toward bringing down the massive claims backlog and providing timely, accurate education benefits to service members and veterans eligible for the Post-9/11 GI Bill.

FRA is troubled by the level of funding recommended for construction projects and information technology. With VA facing a massive backlog of important construction requirements and

states becoming ever more reliant on VA to contribute to the funding for construction of long-term care facilities, now is not the time to reduce this critical funding. Likewise, there are a number of critical information technology initiatives that need to be addressed. Finally FRA wants to express doubts about the projection that VA will be able to get \$3.3 billion from third-party insurers.

### **HEALTH CARE FEES**

FRA continues its strong opposition to establishing a tiered enrollment fee structure for veterans in Priority Groups 7 and 8 within the VA Health Care System. Past proposals include fees based on annual family income adjusted by region averaging approximately \$30,000 and above, along with an increase on pharmacy co-pays from \$8 to \$15 for Priority Group 7 and 8 beneficiaries. There are approximately 1.3 million veterans in these groups and FRA supports adequate appropriations to prevent shifting costs to them for care they've earned in service to our Nation. Although not under the oversight of this Subcommittee, FRA continues its strong opposition to TRICARE fee increases for military retirees and believes there are other cost-saving options which must be implemented prior to adjusting fees for younger retirees. The Association salutes Chairman Edwards for his leadership on this issue and strongly supports the "Military Retirees Health Care Protection Act" (H.R. 816) which he sponsored along with Rep. Walter Jones (N.C.)

Rather than focus efforts on cost-shifting to beneficiaries, the VA should look at other cost-saving measures. The VHA should focus on improving wellness systems, such as "My Health-Vet," expanding outreach to work on prevention, early, effective interventions, and innovative methods of motivating beneficiaries toward healthy life styles. These measures could result in substantial savings for the VHA in the coming years.

### **MEDICAL AND PROSTHETIC RESEARCH**

The VA's research should focus on improving treatments for conditions that are unique to veterans. Medical and prosthetic research is one of the most successful aspects of all VA medical programs. That is why FRA is concerned that there is no increase (\$3.345 billion) in medical research budget which could result in possible cuts in research. The Association, however, appreciates and supports the eight percent increase (\$148 million) in prosthetic research for 2011.

### **MILITARY CONSTRUCTION**

FRA is concerned that the Administration's FY 2011 military construction budget is reduced by 19.5 percent and the family housing budget is reduced by 19.3 percent from the current fiscal year. Child care facilities, work spaces and associated structures, and barracks construction are top concerns for enlisted personnel. FRA appreciates that the FY 2011 Navy budget includes improving bachelor quarters, including sustained funding for Homeport Ashore initiatives. FRA welcomes the Marine Corps hiring an additional 400 full-time family-readiness officers on the battalion level per provisions in the FY 2011 budget. Currently the Marines are meeting 64 percent of potential day-care needs (same as last year) and need 3,000 additional spaces to reach the DoD standard of 80 percent. The Marines plan to increase 2,615 child-care spaces over the next 18-24 months. The Navy added more than 7,000 child care spaces in the current fiscal year and

plans to reach the 80 percent child care goal by the end of FY 2011. It is often said that the individual enlists but it's the family that re-enlists. The Navy and Marine Corps child care programs are highly valued benefits for military families and are a critical element in maintaining adequate retention numbers.

FRA wants to express its gratitude to this distinguished Subcommittee for extending an invitation to the senior enlisted leaders of the Navy, Marine Corps, Army and Air Force to discuss Quality of Life issues with the Subcommittee. These issues include child care facilities, work spaces and associated structures, and barracks construction and other top concerns of the enlisted community.

### **BRAC**

FRA notes that the recently enacted "American Recovery and Reinvestment Act" includes funding for new military construction, renovation projects and funding for VA hospitals.

The Association remains concerned, however, about the inadequacy of funding for implementation plans for other DoD transformation initiatives, global repositioning, and BRAC actions. During the current wartime environment, it's important to establish and maintain support services and quality of life programs for active and reserve service members, their families, and retirees at affected sites.

### **AFRH**

FRA appreciates support from appropriators for funding to rebuild the Armed Forces Retirement Home in Gulfport, Miss. Construction is progressing on the new facility and FRA members who were residents at the Home and forced to relocate due to damage caused by Hurricane Katrina in 2005, are eager to go home. The new facility is scheduled to re-open sometime in October 2010 and is scheduled to have opening ceremonies on November 9, 2010. FRA thanks this distinguished Subcommittee for its supporting this important project.

### **CONCLUSION**

Mister Chairman, FRA sincerely appreciates all that you and members of your distinguished Subcommittee – and your outstanding staff do to support our magnificent service members and veterans. Thanks again for the opportunity to present the Association's recommendations for your consideration.

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**JOHN R. DAVIS**  
**DIRECTOR OF LEGISLATIVE PROGRAMS**  
**FLEET RESERVE ASSOCIATION**

John Davis served in the United States Marine Corps Reserve in an artillery unit (155 self-propelled howitzers) and as a Second Lieutenant in the Illinois Army National Guard in the 1980s. He joined the FRA team as Director, Legislative Programs in February 2006, and is President of FRA Branch 181 (Arlington, Virginia). He is co-chairman of The Military Coalition's (TMC) Retired Affairs Policy Committee.

John worked for almost 13 years with the National Federation of Independent Business, including 9 years as Director of the Illinois chapter and 3 ½ years in the federal lobbying office in Washington DC. John has lobbied on a variety of issues including healthcare, tort reform, education, insurance, taxation, and labor law.

In 2005 John received a Masters of Public Policy (MPP) degree from Regent University, Alexandria VA. John has a BS degree from Illinois State University in Political Science and History. John has two children: Anne age 26 and Michael age 23 who is currently serving in a Marine Corps Reserve unit deployed in Afghanistan.

## FACT SHEET



### **JOHN L. WILSON**

Assistant National Legislative Director  
Disabled American Veterans

John L. Wilson, a disabled veteran, was appointed Assistant National Legislative Director of the 1.2 million member Disabled American Veterans on August 25, 2009. He is employed at the organization's National Service and Legislative Headquarters in Washington, D.C.

Mr. Wilson joined the Disabled American Veterans in April 2007 as a National Service Officer at the VA Regional Office, Muskogee, Okla. After successfully completing training, he was assigned to the National Service and Legislative Headquarters in November 2008. He served as Associate National Legislative Director until his current appointment.

A Texas native, Mr. Wilson joined the United States Air Force in 1974. He rose to the rank of sergeant prior to acceptance into Office Training School, where he achieved distinguished graduate and was commissioned as a second lieutenant in 1980. Mr. Wilson achieved the rank of Lieutenant Colonel prior to retiring from the Air Force with 32 years of service.

Mr. Wilson's military career assignments included service in Iraq and Bosnia. He also served as Vice-President, USAF Formal Physical Evaluation Board, Randolph Air Force Base, Texas; Deputy, Diversity Management/Equal Opportunity Office and Executive Officer, Air Force Element, Defense Intelligence Agency, Bolling AFB, Md.; Chief, Officer Professional Development and Education Programs, Air Staff, Pentagon; Commander, 85<sup>th</sup> Mission Support Squadron, Keflavik, Iceland; Command Chief of Social Actions, Headquarters, U.S. Military Entrance Processing Command (MEPCOM), North Chicago, Ill.; Section Chief and Chief, Consolidated Base Personnel Office (CBPO), Tinker Air Force Base, Okla.; and assignments at Royal Air Force bases at Mildenhall and Upper Heyford, England, among others.

Mr. Wilson's military awards and honors include the Air Force Commendation Medal with four Oak Leaf Clusters; Joint Service Commendation Medal with Oak Leaf Cluster; Meritorious Service Medal with Oak Leaf Cluster; and Defense Meritorious Service Medal.

Mr. Wilson earned a Bachelor's degree in fine arts in 1974 from Our Lady of the Lake University, San Antonio, Texas, and a Masters degree in Public Administration in 1988 from Troy State University, Troy, Ala.

Mr. Wilson and his wife, Belle, reside in Arlington, Va.