STATEMENT OF
THE AMERICAN LEGION
TO THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
CONFIRMATION HEARING OF
MR. ANTHONY J. PRINCIPI
NOMINEE FOR SECRETARY
DEPARTMENT OF VETERANS AFFAIRS (VA)

JANUARY 18, 2001

Mr. Chairman and Members of the Committee:

The American Legion greatly appreciates the opportunity to provide written testimony regarding the appointment of Mr. Anthony J. Principi as the Secretary of Veterans Affairs. While The American Legion's legislative agenda contains several resolutions directly related to policies and procedures within VA, which will be addressed in today's hearing, this testimony is in no way an endorsement or denouncement of Mr. Principi's nomination. Section 2, Article II of The American Legion Constitution states: **The American Legion shall be absolutely nonpolitical and shall not be used for the dissemination of partisan principles nor for the promotion of the candidacy of any person seeking public office or preferment.**

By providing written testimony for this important hearing, The American Legion hopes to bring attention to key issues affecting the quality and timeliness of services provided to America's veterans through VA programs and services. The recommendations outlined in this testimony will assist the new Secretary in carrying out his obligations.

The past eight years have witnessed a significant reorganization and realignment of Veterans Health Administration (VHA) resources and programs. More has been done to improve VA health care in the past five years than was accomplished over the past several decades. Quality, efficiency and effectiveness are the hallmarks of today's VHA. In order to sustain the progress made in VHA since 1992, several additional objectives must be met. These essential actions include Medicare subvention and greater cooperation with the Department of Defense (DoD) health care system.

Congress must continue to increase VHA funding to maintain a world-class health care system. There are precious little additional efficiency savings expected throughout the system. Yet, those veterans now enrolled and using the system will continue to rely on VHA for the foreseeable future. Therefore, The American Legion believes Congress must examine how to balance the annual appropriations process with additional funding that will not be offset by the Office of Management and Budget (OMB). *The American*

Legion believes that a strategic goal of VHA should be to seek opportunities to increase non-appropriated funding. The now invalid 30-20-10 strategic goals sought to enhance the annual appropriations process by increasing non-appropriated revenues by ten percent by the year 2002. This goal should be revived.

The guiding principle for VA must be improved service to veterans and to their dependents and survivors. This requires improving access to and the timeliness of veterans' health care, increasing quality in the benefit claims process, and enhancing access to national and state veterans' cemeteries. Specific goals yet to be achieved include:

- **Set the veterans' health care system on a sound financial footing for meaningful long-term strategic planning and program performance,**
- **Improve clinic appointment scheduling for access to medical treatment,**
- **Enact Medicare subvention legislation,**
- **Establish pilot programs to provide health care to certain dependents of eligible veterans,**
- **Improve cooperative arrangements between VA and DoD's Tricare system,**
- **Reduce the benefits claims backlog and improve the quality of the claims process,**
- **Continuous enhancement of the Montgomery GI Education Bill,**
- **Repeal of section 1103, title 38, United States Code, concerning service connection of tobacco-related illnesses,**
- **Increase the rate of beneficiary travel reimbursement.**

VETERANS HEALTH ADMINISTRATION

The American Legion commends VHA for the evolutionary changes made over the past several years. Most, if not all, of these alterations were long overdue and necessary. This includes eligibility reform, enrollment, the reorganization of the 172 medical centers into 22 integrated service networks, the elimination of certain fiscal inefficiencies, and the expansion of community-based outpatient clinics. For many years, VHA's annual budget appropriation was the guiding principle behind its management decisions. To a degree this is still true. However, today there is growing evidence that VHA strategic planning will help guide future budget development.

The primary short-term objectives of VHA must be to improve patient access and health services delivery. The American Legion's VA Local User Evaluation (VALUE) guidebook cites patient access as the largest single source of continuing veteran complaints. Paradoxically, as VA annual inpatient admissions have decreased by 32 percent since 1994, ambulatory care visits have increased 35 percent. This phenomenon, along with a large decrease in administrative and clinical staff and a significant increase in patient enrollments over the past few years, has placed a tremendous strain on VHA's ability to meet its workload in a timely and consistent manner. As VHA becomes more proficient in attracting new patients, it must also provide consistent access to care across all 22 Veterans Integrated Service Networks (VISNs).

Currently, the national average waiting time for a routine, next-available appointment for Primary Care/Medicine is 64 days (with a range of 36-80 days). The next available appointments for specialty care:

Specialty Care	Average Days	Range
Eye Care (combined Ophthalmology & Optometry)	94	42-141
Audiology	50	22-91
Cardiology	53	19-78
Orthopedics	47	12-69
Urology	79	39-108

There are additional concerns about the average clinic appointment waiting times for dermatology and pulmonary clinics. However, these specialty clinics are not included in the VISN director's performance standards. Therefore, no national average waiting times were reported. In the main, these waiting times indicate that there are serious access differences between VA health care and private sector health care.

There are also reported concerns about large distances that veterans in rural areas have to travel for certain care. For example, veterans in eastern Montana must travel nearly 700 miles to Fort Harrison, Montana for routine inpatient surgery. For complex surgical procedures, these same veterans are required to travel to Salt Lake City or Denver. This excessive travel places great strain on veterans and their families. Since 1994, the Miles City, Montana VA Medical Center has reduced its payroll over $7 million per year by eliminating nearly 145 full time employee positions. The American Legion questions why contract services for required surgery have not been acquired to reduce excessive travel requirements?

In some cases, The American Legion believes VHA has gone too far, too fast in attempting to improve its fiscal efficiency. Veterans should not have to increase their travel time for the benefit of VA. Rather, VHA needs to improve its cooperation with other federal, states and private health care providers to improve the quality and timeliness of care for veterans.

GI BILL OF HEALTH

Several years ago, The American Legion created a blueprint for meeting the current and future health care needs of America's veterans and for supplementing VHA's annual health care appropriation. By now, Members of this Committee should be familiar with the proposed GI Bill of Health. Once fully implemented, the GI Bill of Health would expand VHA's patient base and increase its non-appropriated funding through new revenue sources.

VHA's short-term and long-term future must be clearly defined to be responsive to the veterans' community. All individuals who enter military service should be assured that there is a health care system dedicated to serving their needs upon leaving the military. That concept is especially important to disabled veterans and to military retirees. The GI Bill of Health would ensure that all honorably discharged veterans would be eligible for VA health care on a permanent basis, as they would fall into one of the core entitlement categories. A unique feature of the GI Bill of Health is that it would also permit certain dependents of veterans to enroll in the VA health care system. The American Legion advocates that dependents and surviving spouses of veterans be allowed to use the system and that all monies recovered from any source based on such treatment be returned to VA. An additional significant step will be to enact VA-Medicare subvention.

At the current workload level, VHA requires an annual appropriation increase of approximately $1 billion to maintain current services and meet its prosthetics and pharmacy costs. The amount of potential efficiency savings is decreasing yearly. The projected $3 billion funding increase over FY 2000-2001 must compensate for the flat line budgets of FY 1997-99 and fully fund the provisions of the Millennium Act. Consequently, there is a continuing need to adequately fund VHA's uncontrollable cost increases at an acceptable level.

Change within VHA, over the past several years, has been the result of a series of small steps. The American Legion acknowledges that the progress made within VHA has been extraordinary. However, this progress has to be sustained and reinforced. In order to accomplish this goal, Congress must unlock the creative potential of VHA to develop alternative revenue sources to complement the annual appropriations process.

At a recent VA planning meeting, VHA unveiled six strategic goals to be accomplished by 2006:

- Put quality first,
- Provide easy access to medical knowledge, expertise and care,
- Enhance, preserve and restore patient function,
- Exceed customers' expectations,
- Maximize resource use to benefit veterans, and
- Build healthy communities.

The American Legion believes these are important goals. We also think VHA must continue to improve its efficiency. *However, we believe VHA must explore all opportunities to develop alternative revenue sources to complement its annual appropriations*. To do less will continue to force VHA to solely rely on the annual budget process to establish patient treatment priorities. There is a distinct possibility that if future funding does not keep pace with the needs the veterans who seek treatment through VHA, the current open access to all seven-priority groups will close.

MEDICARE SUBVENTION

Public Law 105-33, the Balanced Budget Act of 1997, established VA's Medical Care Collection Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited in this account. Beginning October 1, 1997, amounts collected in the fund are available only for furnishing (1) VA medical care and services during any fiscal year; and for (2) VA expenses for identification, billing, auditing and collection of amounts owed the government. Public Law 105-33 also extended to September 30, 2002, the following Omnibus Budget Reconciliation Act (OBRA) provisions:

- Authority to recover co-payments for outpatient medications, nursing home and hospital care;
- Authority for certain income verification; and
- Authority to recover third-party insurance payments from service-connected veterans for nonservice-connected conditions.

The Health Service Improvement Fund was established to serve as a depository for amounts received or collected under the following areas as authorized by title 38, U.S.C., Section 1729B:

- Reimbursements from DoD for Tricare-eligible military retirees;
- Enhanced-use lease proceeds; and
- Receipts attributable to increases in medication co-payments.

The Extended Care Revolving Fund was also established by the Millennium Act and was to receive per diems and co-pays from certain patients receiving extended care services authorized in title 38, USC, Section 1710B. Amounts deposited in the fund are used to provide extended care services.

Clearly, Congress is providing VA with the authority to bill, collect, retain and use revenues from sources other than direct, federal discretionary appropriations. However, one of the major health care payers (Medicare) is exempt from billing; yet, its beneficiaries are welcomed and encouraged to receive treatment in VA medical facilities.

Currently, approximately 10.1 million veterans are Medicare-eligible solely based on their age. Criteria for Medicare-eligibility are different than eligibility for treatment in VA. In the VA health care network, certain veterans are eligible for treatment at no cost for medical conditions determined to be service-connected. Other veterans are eligible for treatment at no cost because they are economically indigent. All other veterans must pay for treatment received.

Medicare subvention would allow VA to seek reimbursement from the Health Care Financing Administration (HCFA) for treatment of nonservice-connected medical conditions of Medicare-eligible veterans, especially those veterans who are military retirees.

More than 734,000 Medicare beneficiaries have lost HMO coverage over the past two years and another 934,000 seniors will be dropped by their HMO plans next year. Many VA eligible beneficiaries are included in those dropped from coverage and will eventually come to VA for care. The argument that VHA is already reimbursed for its Medicare population and that Medicare subvention will result in double funding is grossly mistaken. VHA is now mandated to provide care to all seven priority groups; Medicare eligibility is not a mandate for care or treatment. As more Medicare eligible veterans seek first time care in VHA, health care costs and subsequent waiting times will increase. It is imperative that Congress examines this issue and takes the actions necessary to ensure that VHA receives all funding necessary to execute its health care mission in a quality and timely manner.

TRICARE

The most significant recent change in military health care is the introduction of Tricare, the DoD regional managed care program. Introduced in 1995, Tricare today is being challenged to maintain a quality health care delivery system for active duty military personnel, certain military retirees, and dependents.

Today, DoD is having severe administrative problems with Tricare. The American Legion is extremely concerned how DoD will fix these problems and how favorably DoD Health Affairs can guarantee Tricare's long-term success.

There are multiple reasons why Tricare is failing to meet the expectations of its beneficiaries. Some of these include:

- Infrastructure and financial problems,
- Problems with provider networks – resulting in weak network links to subcontractors,
- The inability to attract and retain qualified health care contractors,
- No financial tracking system outside of the Military Treatment Facilities,
- Difficulties in processing claims in a timely manner,
- Tricare lacks portability between all 12 regions,

The American Legion believes that VHA can greatly assist DoD through expanded authority to provide care to Tricare beneficiaries. With limited budgets, both VA and DoD must discover innovative ways to provide care to active duty personnel, to all veterans and military retirees, and to eligible dependents.

Congress recognized the utility of having VHA play a greater role in the treatment of Tricare beneficiaries when it passed the Veterans Millennium Health Care and Benefits Act (PL 106-117). This legislation requires VA and DoD to enter into an agreement to reimburse VA for the cost of care provided to retired servicemembers who

are eligible for Tricare and who are enrolled as Priority 7 veterans. These veterans would not be required to pay VA inpatient and outpatient copayments.

Eight years ago, it was impractical to suggest that VHA was capable of assisting DoD in resolving many of its patient treatment problems. Today, although not without concerns of its own, VA is in a much better position, both financially and organizationally, to assist with the delivery of health care to DoD beneficiaries. The American Legion believes that VA and DoD should closely coordinate medical care services to the extent possible, thereby eliminating duplication of effort and achieving greater cost efficiencies. With active planning, VHA can become the largest single provider of health care to America's veterans, military retirees, and their dependents. DoD could then assume the responsibility of providing health care to active duty servicemembers, Reserve Component members, and their dependents.

VETERANS BENEFITS ADMINISTRATION

Given the number of veterans and other eligible beneficiaries who file claims each year and with an annual expenditure of over $19 billion in compensation and pension payments, it is imperative that Congress maintain strong oversight of the operations of the Veterans Benefits Administration's (VBA) Compensation and Pension Service.

Over the last several years, the backlog of pending claims has fallen from approximately 450,000 to less than 325,000 cases. However, it still routinely takes six months to a year or more to process disability compensation claims, because of the increased number of issues per claim and their legal complexity. In addition, annually, some 30,000 to 40,000 new appeals are initiated and it will take over two years for an appeal to reach the Board of Veterans Appeals (BVA or the Board). The Board is currently reviewing appeals docketed in April and May of 1999. Of the cases decided by the Board during the first nine months of FY 2000, 25.9 percent were allowed and 29.3 percent were sent back to the regional office for further development and readjudication. Remanded cases may be pending for another year or two in the regional office, and a substantial percentage will eventually be returned to the Board. Sometimes, cases are remanded two and three times, because the regional office fails to complete the specified corrective action, which adds several more years to the appeal. It is little wonder that veterans are angry and frustrated. The system appears all too often to be adversarial and unresponsive to their needs.

Despite this history, The American Legion believes VBA is committed to bringing about much needed change to the claims adjudication system with the overall goal of providing quality, timely service to veterans and its other stakeholders. In recent years, VBA's strategic plans have made many promises and we have, in fact, seen the implementation of a variety of programmatic and procedural changes. However, it is obvious that progress toward major improvements in service continues to be slow and that much remains to be done. Unfortunately for thousands of veterans and other

claimants, the overall quality of regional office decision-making remains inconsistent and problematic.

Beginning in late 1997, The American Legion implemented a program of formal visits to VA regional offices (VAROs) to gain greater insight into the underlying causes for veterans' complaints about unacceptably long processing times, the high number of appeals, and the substantial overturn rate by the Board. These visits have provided our staff the opportunity to evaluate, firsthand, the quality of recently adjudicated Legion cases. We have been very pleased with the level of cooperation received and the support expressed for this program by VA Central Office and regional office officials. Over this period, our staff has reviewed approximately 350 claims involving original and reopened claims for service connection and entitlement to an increased rating for a service-connected disability at 15 VAROs. Some type of substantive error was found in 40 to 50 percent of the cases reviewed. An exit briefing has been held with the regional office director and the service center manager at the conclusion of each visit to discuss specific findings. Subsequently, the regional office director, the Under Secretary for Benefits, his staff and Legion officials are provided a written report covering management issues and the individual case review findings.

Comparing the reports of the past two years, The American Legion found there has been little overall improvement in the way claims are being adjudicated. At most of the offices, there has been a pattern of recurring problem issues, which continue to have a direct and adverse effect on the quality and timeliness of regional office claims adjudication. They relate to budget, staffing, training, quality assurance, accountability, and attitude. These findings confirm our long-held view that quality must be VBA's highest priority. Without guaranteed quality, along with personal and organizational accountability, thousands of claims will continue to revolve unnecessarily through the system. Much of VBA's valuable financial and personnel resources will be wasted, and veterans will not receive the benefits and services they are entitled to and that Congress intended they should have.

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

Currently, this nation is faced with the largest aging veterans' population in its history. VA estimates the number of veterans 65 years of age or older will peak at 9.3 million in the year 2000. By 2010, 42 percent of the entire veteran population, an estimated 8.5 million veterans, will be 65 or older, with half that number above 85 years of age. By 2030, most Vietnam Era veterans will be 80 years of age or older. The State Veterans' Home Program must therefore continue, and even expand its role as an extremely vital asset to VA. Additionally, state homes are in a unique position to help meet the long-term care requirements of the Veterans Millennium Health Care and Benefits Act.

State homes provide over 24,000 beds with a 90 percent occupancy rate that will generate more than seven million days of patient care each year. The authorized bed

capacity of these homes is 90 nursing care units in 40 states (17,844 beds); 46 domiciliaries in 32 states (5,841 beds); and 5 hospitals in 4 states (469 beds). For FY 1999, VA spent $255 per day to care for each of their long term nursing care residents, while paying private-sector contract nursing homes an average per diem of $149 per contract veteran. The national average daily cost of caring for a state veterans' home nursing care resident during FY 1999 was $137. VA reimbursed state veterans' homes a per diem of only $40 per nursing care resident.

As many VA facilities reduce long-term care beds and VA has no plans to construct new nursing homes, state veterans' homes are relied upon to absorb a greater share of the needs of an aging veteran population. If VA intends to provide care and treatment to greater numbers of aging veterans, it is essential to develop a proactive and aggressive long-term care plan. VA should work with the National State Veterans' Homes' Directors to convert some of its underutilized facilities on large multi-building campuses to increase the number of available long-term care beds.

PHARMACY

In 1997, VA established the National Formulary Policy that allows for pharmaceuticals listed on the formulary to be made available throughout the entire VA healthcare system. Once on the formulary, those pharmaceuticals listed on the formulary cannot be made non-formulary at the VISN or local level.

The Pharmacy Benefits Management Board (PBM) determines which pharmaceutical items are to be included in the formulary based on scientific evidence guidelines and prescribing privileges and not cost. Also, VA has established a policy for requesting a non-formulary drug and each VISN has a protocol for prescribing providers to request a patient be treated with a non-formulary medication which must be justified by the National PBM Board.

The American Legion is concerned that the justification process for the non-formulary prescriptions interferes with the doctor-patient relationship and causes doctors to fear poor performance evaluations if they prescribe non-formulary items. VA needs to be more proactive in communicating to the field its policy for pharmaceutical best practices associated with prescribing, purchasing, dispensing, administering, and tracking medications, so that providers can act in the best interests of their patients, reduce adverse medication events, and not worry about administrative ramifications.

The American Legion supports a program that will allow veteran-patients access to the most appropriate pharmaceuticals regardless of whether or not an item is formulary or non-formulary and providers should not be penalized on their performance measures for using non-formulary items.

GULF WAR VETERANS' ILLNESSES

The American Legion continues to actively support Gulf War veterans and their families, as it has since August 1990. The American Legion created two particular programs specifically for Gulf War veterans, the Family Support Network in October 1990, and the Persian Gulf Task Force in October 1995. Today, The American Legion serves Gulf War veterans and their families at the community, state, and national levels through 15,000 local posts and an array of programs and services.

Thousands of Gulf War veterans, who suffer undiagnosed illnesses with a range of symptoms, know as "Gulf War veterans' illnesses," are not receiving adequate care or compensation from VA and DoD. In this regard, The American Legion makes the following recommendations:

- VA and DoD should conduct their respective exams in a standard and uniform way as well as create a database that will merge the individual data from both exams so that patterns in health can be better analyzed,
- VA and DoD should aggressively move to educate its medical doctors about newly defined illnesses (Chronic Fatigue Syndrome, Fibromyalgia, etc.) that are commonly misdiagnosed as psychological conditions. VA should also discourage its doctors from giving diagnoses for common symptoms unless diagnosed properly and so that the Registry and CCEP data will be accurate,
- VA and DoD should conduct extensive follow-up to Gulf War veterans who participate in the Registry and CCEP examinations to monitor health status.

In the upcoming year, the American Legion will be pursuing legislation to amend Title 38 USC § 1117, Compensation for Disabilities Occurring in Persian Gulf War Veterans. In November 1994, the Persian Gulf War Veterans Benefits Act (Public Law 103-446) was enacted to compensate Gulf War veterans suffering from illnesses or symptoms that can not be diagnosed or clearly defined. As the number of sick Gulf War veterans continues to increase, it is quite apparent the VA is too narrowly implementing the law (38 C. F. R. § 3.317) and effectively denying compensation to veterans that the law was intended to help. It is clear that the intent of Congress was not only to compensate Gulf War veterans with conditions that can not be diagnosed but to also compensate sick veterans diagnosed with ill-defined conditions such as chronic fatigue syndrome or fibromyalgia. The American Legion, calls upon the VA to extend the presumptive period for service connection for undiagnosed illnesses indefinitely.

In September 2000, in response to DoD disclosure that South Korean troops sprayed the herbicide Agent Orange along the demilitarized zone between North and South Korea in 1968 and 1969, VA expanded its Agent Orange registry program to include veterans who served in Korea during that time period. As approximately 80,000 troops may have been exposed, The American Legion strongly urges VA to take appropriate action to ensure that Agent Orange related compensation, currently afforded the Vietnam veterans is extended to these veterans.

HOMELESS VETERANS PROGRAMS

On any given night, there are approximately 750,000 homeless people in America. Of that number, at least one third are veterans. Furthermore, in most major cities, the percentage of veterans in the homeless male population is over 50 percent.

While The American Legion is concerned about the homeless problem in general, it is particularly concerned about the plight of homeless veterans and is committed to bringing an end to this national disgrace.

The American Legion is monitoring the problem and is acting as a clearinghouse for information on the resources and programs that are available to assist homeless veterans. Representatives of the Economic and Veterans Affairs & rehabilitation Commissions within The American Legion are working with both the public and private sectors to find unique and effective ways of assisting homeless veterans and bringing an end to homelessness in America.

Resolution No. 144 from The American Legion's 82nd National Convention outlines our organizational support for the Homeless Chronically mentally Ill program, the Homeless Domiciliary program and the Compensated Therapy Rehabilitation program to be funded separately from general VA funding.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

Major Construction

The VA major construction program is not being funded in an adequate manner. The major construction appropriation over the past few years has allowed for only one or two projects per year. Meanwhile, the number of priority projects continues to accumulate. For FY 2001, 16 major ambulatory care or seismic correction projects were submitted to OMB. Of this number, only one major VHA project is recommended. For FY 2002, 28 major projects are submitted for funding.

VHA currently has 66 patient care and other related use buildings that require significant seismic correction. Along with the necessary ambulatory care and patient safety projects, it will require from $250 million to nearly $1 billion to address VHA's current major construction requirements. Of the 28 major projects submitted for funding consideration for FY 2002, 22 are ambulatory care related and six are seismic correction projects.

The American Legion objects to efforts to close VHA medical facilities for the sake of cost cutting. At a time that access to care and service delivery is eroding, the

Capital Asset Realignment Study (CARES) process may find that VHA needs to expand service in certain areas. It is unthinkable that the expansion of care option would not be part of the CARES review. No planning options should be excluded; that includes contraction, expansion, and maintaining the status quo. In the final analysis, the CARES process must consider what is best for the veteran, not what is best for VHA.

VHA needs to use the disposal authority it already has to begin to reduce its unused building inventory. The CARES process may be too time consuming to allow VHA to divest itself of unneeded buildings in an appropriate timeframe.

Currently, ten major medical center projects are considered high priority. Additionally, two parking structures are rated as priority projects. These are:

- Long Beach – Seismic Correction/Clinical -- $26.6 million
- San Diego – Seismic Correction/Bldg. 1 -- $51.7 million
- Miami – Hurricane and Flood Addition -- $23.6 million
- Augusta – Spinal Cord Injury Modernization -- $18.3 million
- Cleveland (Brecksville) – Buildings for Special Emphasis Programs -- $39 million
- VISN 6 – Special Emphasis Beds -- $28.9 million
- Dallas – Mental Health Enhancement -- $27.2 million
- Atlanta – Modernize Patient Wards -- $12.8 million
- Fargo – Ambulatory Care/Patient Environment -- $18.4 million
- Cleveland (Wade Park) – Clinical Consolidation -- $18.6 million
- West Haven – Patient Environment -- $13.8 million
- St. Louis – Parking Structure -- $5.2 million
- Tampa – Parking Structure -- $10.7 million

Minor Construction

Annually, VHA must meet the infrastructure requirements of a system with approximately 4,700 buildings, 600,000 admissions and over 35 million outpatient visits. To do so requires a substantial inventory investment. For the past several years, minor construction has been funded in the annual range of $175 million. It is penny wise and pound-foolish to reduce this investment. If Congress fails to appropriate $175 million for minor construction in FY 2002, VHA will have to delay approximately one-third of its priority minor projects.

SUMMARY

Mr. Chairman, VHA and VBA have made considerable progress in addressing many of their shortcomings over the past several years. In this statement, The American Legion has laid out the priority issues still facing VA. Many of the issues cited will not be resolved overnight. There is a lot of agreement within VA and among Members of

Congress that many of the subjects discussed justly require priority attention. That being so, let's commit to developing effective short-term and long-range strategies to address these matters and as a result, improve the services and programs of the Department for current and future generations of America's veterans.

There are many important issues before the Congress of the United States. However, The American Legion believes that Congress must focus on finding effective solutions to veterans' concerns. The veterans of this nation have always answered when their country called. It is time to make a fundamental commitment to make the programs and services of VA second to none in helpfulness, effectiveness and efficiency. The priority challenges facing VA today:

- Increase access to VA health care and improve the timeliness of such care,
- Develop new non-appropriated revenue streams to complement the VA health care appropriations process, without OMB funding offsets,
- Enact the Medicare subvention provision of the GI Bill of Health,
- Enact the dependents care provision of the GI Bill of Health,
- Increase resource sharing and cooperation between VA and DoD health care,
- Provide adequate medical research and medical construction funding,
- Maintain strong oversight of Persian Gulf War statutes,
- Make veteran friendly improvements to the Montgomery GI Bill,
- Continue the recent expansion of newly constructed national and state veterans' cemeteries,
- Amend the current statute that restricts veterans' eligibility to obtain an appropriate VA headstone or marker for previously marked graves,
- Ensure qualitative improvements are made in VA Compensation and Pension Service,
- Provide necessary funding support for the General Operating Expenses of the Veterans Benefits Administration,
- Develop a realistic and viable short-term and long-range strategic plan to include all VA programs and services,
- Establish initiatives to persuade civilian employers to recognize formal military training.

Mr. Chairman and Members of the Committee, in this statement, we have laid out the priorities of The American Legion regarding the many programs and services made available to the veterans of this nation and to their dependents and survivors. As this nation begins a new century, let us never forget those brave men and women who have honorably served this nation and those who are still serving. Let us agree that this nation will always make the right decisions regarding earned benefits for our veterans, their dependents and survivors.

Thank you for allowing The American Legion to provide testimony for this important confirmation hearing.