New Jersey State Council, Inc.
Vietnam Veterans of America
2014 Position Paper

New Jersey Veterans Nursing Homes

1. We oppose the privatization of Veterans Facilities. We continue to call for adequate funding at our New Jersey Veterans Nursing Homes to cover all services and amenities to guarantee our veterans a dignified quality of life. We continue to seek the full occupation and staffing of the three New Jersey Veterans Nursing Homes in Paramus, Menlo Park and Vineland. We support adequate funding to ensure that the staff be adequately trained and qualified in the care of special needs patients. With the continued budget crisis and the number of veterans in need of nursing home care expected to rise in the next several years, this position anticipates the worst. Time and again veterans of New Jersey have had to bear more than their share of the financial shortcomings that impact all of our citizens. Now is the time for all veterans to advocate for the veterans who reside in the facilities in Paramus, Menlo Park and Vineland.

2. We urge that funding be provided to ensure "safe areas" at the nursing homes to serve those residents who suffer from Alzheimer's or other forms of dementia. By bringing these patients to one supervised area, they will not be hazards to themselves and others, thereby increasing staff efficiency and cost efficiency. Special needs veterans should have their needs addressed as a matter of necessity as well as patient and staff safety. The ability of the staff to respond and adapt to changing health care needs of our veterans should not be subjected to financial constraints. Sufficient funding to provide for everyone's safety should be a priority.

3. All veterans should be considered for admission to veterans' homes regardless of assets or income, with priority given to needy veterans. The commitment and obligation of the state and its citizens to our veterans should not be determined only by the veteran's financial status. Our veterans have served our country and protected our freedoms with honor and pride while in uniform. Many who have served and sacrificed still bear the scars of those battles in defense of our liberty. Our nation owes them so very much.

New Jersey State Legislature

1. In 2009 we gratefully acknowledged the passage of A2613/S1579; legislation that provided veterans' organizations the right to receive the cremains of a veteran which have not been claimed by a relative or friend of the deceased within twelve months after cremation upon certification, to the Commissioner of Health and Senior Services' satisfaction, that a diligent effort has been made to identify, locate and notify a relative or friend of the deceased within that twelve month period.

Under current law, if a war veteran dies without leaving means sufficient to defray funeral expenses, the veteran's county of residence is responsible for burial, up to a cost of $250. Legislation that would provide additional funding for the burial or cremation of all indigent veterans, including those who did not serve at a time of war was initially introduced in the Assembly December 5th, 2005.

After eight years we gratefully acknowledge the passage of A1898/S1075 January 2014. This legislation requiring the State to cover burial and cremation costs above $250, with total costs not to exceed $1,250 for cremation or burial was a long time in the making.

This legislation will ensure that those who honorably served our country are treated with dignity and respect as they are laid to rest.

2. The Legislature and Governor must continue to meet the growing needs of the veteran community through adequate funding of the Department of Military and Veterans Affairs to provide for capital improvements to the state nursing homes and the vocational/transitional housing program for homeless vets, adequate staffing levels to allow maximum bed space at our state nursing homes,

increased funding for transportation needs for our veterans in the nursing homes and adequate funding to provide for staffing, maintenance and operations of the state's veterans' cemetery and memorials. We gratefully acknowledge the continued success of Vet Haven South and Vet Haven North.

3. The veteran real estate exemption should be increased to reflect inflation and cost of living allowances (COLA), annually and automatically. At age 65, all veterans, regardless of income, should receive the senior citizen exemption in addition to the veteran exemption. The value of a veteran's service to his country should not be diminished by rising property taxes, inflation or attainment of a certain age. When one benefit must be relinquished to achieve another, the value of the benefit diminishes. No veteran should be required to forfeit one benefit to obtain another to which he/she is entitled. If a veteran is entitled to two benefits, he/she should receive both.

4. We continue to urge the legislature to fund a cost-effective Home Health Care program for veterans designed to alleviate the critical nursing home shortage and state budget crunch. Our veteran community is made up of many older veterans who could benefit from home health care which could be provided at a lesser cost than institutionalized care resulting in a savings for the taxpayers while lessening the pressure to make more institutional beds available. Maintaining an individual in his/her own home has been proven to be cost-effective and considerably more beneficial to the individual. We were pleased with the passage of P.L. 2007, c.123 which required the Department of Military Affairs to evaluate resources, costs and benefits of providing home health care aides for qualified veterans. We are mindful of similar legislation in 1975 that also provided for a study to evaluate resources, costs and benefits of providing home health care aides for qualified veterans. We call for introduction and passage of legislation similar to the Veteran Home Health Care Demonstration Program (A-535, S-343 introduced during the 2008-2009 session), legislation originally introduced in May 2003 that will provide home health care services to frail and elderly and disabled veterans who would otherwise require long-term institutional care and who are not eligible for coverage under the Medicaid program.

5. We urge the legislature to continue to promote programs to identify and assist our homeless veteran population. Eradicating homelessness among our veterans must be a priority. Breaking the cycle of poverty and isolation and moving from the streets to self-sufficiency for many veterans requires the assistance of our government. This requires a consistent ongoing effort to not only deal with the current homelessness crisis in America, but to also maintain a program to prevent to the extent possible the root causes that lead to homelessness.

There are a number of bills listed below that have the potential to ease the homeless veteran problem if they become law. Each in it's own way is a step in the right direction.

We are pleased with the passage of A1744/A2490/S829 (P.L. 2013 c.6) which requires COAH to promulgate rules and regulations providing for veterans' affordable housing assistance preference.

Other legislation targeting veterans' homelessness and housing issues did not fare as well. We urge reintroduction of the following legislation from the 215th legislative session:

- A628 requires reservation of portion of tenant vouchers under State rental assistance program for veterans.
- A629/S1039 permits certain portion of municipal development trust funds to be spent on housing affordability assistance to veterans.
- A1472 authorizes COAH to credit municipalities with 1.5 units of fair share affordable housing obligation for each housing unit occupied by a veteran; permits municipalities to satisfy fair share affordable housing obligation through 35 percent set aside for veterans.
- A2092 grants credit against business taxes to developer of rental housing reserved for occupancy by veterans.

6. We must continue the New Jersey State Civil Service "absolute preference" granted to veterans, as enacted by state law, including all veterans who were in service during armed conflicts. Every effort

should be made to help veterans apply for and establish entitlement to absolute preference employment opportunities.

Legislation that would expand eligibility for veterans' hiring preference in the civil service so that individuals who are eligible for veterans' preference in the federal civil service but are not eligible for preference in the state civil service would receive additional points above the individual's earned score on state civil service examinations originally was introduced in January 2005 as A3661.

We call for the reintroduction of A1803/S1880 from the 215th legislative session that would expand eligibility for veterans' hiring preference in the civil service so that individuals who are eligible for veterans' preference in the federal civil service, but are not eligible for preference in the State civil service, would receive additional points above the individual's earned score on State civil service examinations.

We call for the reintroduction of ACR17/SCR48 from the 215th session that proposes a constitutional amendment to permit disabled veterans who served in U.S. Armed Forces at any time to receive civil service preference. Currently, only disabled veterans who served in the United States Armed Forces during a time of war may receive civil service hiring preference. This amendment would permit all disabled veterans, including those who did not serve during a time of war, to also receive such preference. To qualify, the veteran must have become disabled while performing active service in the military. Wartime service would still be required for veterans who are not disabled.

We acknowledge the passage of both ACR199/SCR158 and ACR215/SCR166, legislation that serves to invalidate the “Job Banding Program” rule proposed by the Civil Service Commission that according to the resolutions stated the finding of the Legislature that the proposed rule is not consistent with legislative intent. We find any attempt to reduce or eliminate veterans preference not in the best interests of the veteran community.

7. We continue to support legislation that will exempt military retirement pay from state income tax for those military retirees who are permanent residents of New Jersey. This position does not require additional explanation.

8. We urge the legislature to continue to appropriate funds for a program of assistance for those seeking to be guardians of incompetent veterans needing nursing care to enter one of our three New Jersey veterans’ nursing homes, as well as the federal facilities located in New Jersey. Unfortunately, not every veteran has a family member to advocate for his or her needs resulting in the necessity of a competent guardian to protect the interests of the veteran. Funding for the continuance of this program is the right thing to do on behalf of veterans who fall into a situation requiring such assistance.

9. We urge the necessary appropriations to computerize all the state Veterans Service Offices (VSO). This will foster better and more cost-effective programs for veterans and their families. The ability to share and integrate information from one end of the state to the other on behalf of veterans and their dependents should be mandated without additional delay.

Last session saw the introduction of A1852, legislation that requires each county governing body to establish and maintain a veterans’ service office for providing information concerning services for the State’s veterans and their dependents, ensuring that they can find all of the information they need in one central location. The office is to also make the information available on the internet.

This is an unfunded mandate that does not take into accounting the existence of the Department of Military and Veterans Affairs services or those provided by the veterans service organizations such as but not limited to American Legion, AMVETS, Catholic War Veterans, Disabled American Veterans, Eastern Paralyzed Veterans, Jewish War Veterans, Military Order Of The Purple Heart, Veterans Of Foreign Wars, or Vietnam Veterans Of America.

Requiring duplication of services is not beneficial to the respective taxpayers of the counties involved. Ensuring that veterans and their dependents can find all of the information they need in one central location is an admiral goal. However practical experience would indicate that many affiliated local,

county, state and federal offices are not available at one central county location. This goal is not achievable.

10. We support legislation that would provide veterans preference for student loans administered under Higher Education Authority Law and the NJ Department of Military and Veterans Affairs. This shall include all veterans who were in service during armed conflicts. Veterans are a sound investment. Our indebtedness as citizens to those who serve and our deep appreciation for the contributions and sacrifices our veterans have made can be expressed by affording our veterans student loan preference in their quest to continue their life goals via higher education. Additionally, the receipt of veterans' benefits should not be considered as income or assets when determining eligibility for other student financial aid. Previously we were pleased to note the passage of P.L.2007, c.214 which provides a military service exception to the requirement of continuous enrollment under the NJ STARS and NJ STARS II Programs. Additionally we were pleased to note the passage of P.L.2009, c.125 which establishes the Troops to College Program in the Commission on Higher Education to assist veterans in making the transition into the college classroom.

Legislation introduced in 2004 urged the federal government to enact legislation lessening the disparity in education benefits between members of the National Guard and Reserves and active military personnel by increasing the amount of basic educational assistance for which guardsmen and reservists may qualify.

Four times this resolution that urges action by the federal government on behalf of those who serve our state in uniform has been introduced and referred to the Assembly Education Committee. It was last introduced 1/12/2010 and referred to the Assembly Education Committee. Once, March 7th, 2005, it was reported favorably out of the Assembly Education Committee, Yes {8} No {0} Not Voting {2} Abstains {0}. This legislation, which requires no large expenditure of state funds, has remained stagnant for too long a time period. Is this the best the New Jersey can do to advocate for those who serve our state in uniform?

In the 216th legislative session we have seen as of mid-January 2014 the introduction of:

- A340/S730 which would allow a military member to qualify for resident tuition rate a county college
- A2109/S822 which requires public institution of higher education to waive or reimburse application fees and transcript fees for veterans and members of the military
- S162 which requires institution of higher education to provide greater assistance to certain students with military obligations
- S848 "New Jersey Tuition Equality for America's Military (NJTEAM) Act:" provides in-state tuition at New Jersey public institutions of higher education to military veterans

We encourage holding hearings on these bills and the passage accordingly of this legislation without further delay,

11. We support the "Advisory Commission on Women Veterans" as it continues to identify how best to recognize and meet the needs of female veterans in New Jersey. Throughout history, women have served our country with pride, patriotism and honor. Today women are an integral and essential component of our Armed Forces. The contribution of women to the defense of our nation has long been overlooked, as well as our failure to recognize the special needs of women veterans and the development of specific programs to address those needs. We need to increase the priority given to women veterans programs to ensure that quality health care is provided, that services for women are maintained, that women veterans' right to privacy is maintained and that the policies, practices and programs are responsive to the needs of women veterans. In 2008 we applauded the passage of A2726/S1946 which established a 15-member Commission on Women Veterans. The purpose of the commission will be to assess the needs of women veterans and the benefits and programs provided to meet those needs. The commission will work in collaboration with other state agencies and appropriate groups to study and review the needs, priorities, programs and policies relating to women

veterans, and provide recommendations, including recommendations for administrative and legislative actions. It will draw upon its members' shared knowledge and expertise to facilitate programs and activities designed to better educate all citizens of New Jersey as to women veterans' issues.

12. We urge and encourage local Workforce Investment Boards (WIB) to target eligible veterans within locally designated priority groups for educational and vocational programs and for employment. Placing veterans in realistic employment opportunities tailored to the needs of the 21st century veteran is in the communities' best interests as well as the veteran's interest. Improving employment and training for veterans, providing employers with a labor pool of quality applicants with marketable and transferable job skills, and assisting in the transition from military service to the civilian labor market has wide spread benefits for all.

We also encourage full participation in the national campaign called "Hire Vets First", to recruit and connect veterans with local businesses. The campaign highlights the skills veterans bring to the workforce and encourages employers to hire them.

The President's National Hire Veterans Committee (PNHVC) is the result of historic legislation passed by bipartisan majorities in the 107th Congress and signed into law by President George W. Bush on November 7, 2002. The Jobs for Veterans Act, Public Law 107-288, established the President's National Hire Veterans Committee within the Department of Labor and authorized the Secretary of Labor to appoint its members.

The mission of the committee is to furnish employers with information on the training and skills of veterans and disabled veterans, and the advantages afforded employers by hiring veterans with such training and skills; and to facilitate employment of veterans and disabled veterans through participation in America's national labor exchange and other means.

13. We support legislation that has the purpose of requiring that local taxes mistakenly paid by permanently disabled veterans and their survivors are repaid by the locality. It is unfortunate that this situation occurs and it is even more troubling that it apparently cannot be readily addressed without some type of legislation mandating the refunding of payments made erroneously. We therefore support the prompt enactment of such enabling legislation.

14. We support the continued tax check off for donations to the USS New Jersey, the New Jersey World War II Memorial, the Korean War Veterans Memorial and the Vietnam Veterans Memorial and Vietnam Era Education Center. This cost effective manner of raising funds from those who volunteer such funds should be continued without question.

15. We urge the Legislature to provide funding that will permit the expansion of qualifications that determine eligibility for "veterans' status" in New Jersey resulting in broadened eligibility for veterans' benefits.

16. Each session numerous bills benefiting veterans are introduced in Trenton. During the 2006-2007 session almost 8,400 bills were introduced, 233 of which dealt with veterans or military issues. During the 2008-2009 session, 8,064 bills were introduced, 254 of which dealt with veterans or military issues. 2010-2011 this number reached 8,240; 277 of which dealt with military and veterans' affairs. During the 215th session, the number of bills introduced was 8,382 with 300 dealing with military and veterans' affairs. Many never came out of committee for debate or action leading up to a vote. A high number of these bills are bills that were previously introduced and relegated to collecting dust in some corner of a committee. The mere introduction of legislation on behalf of veterans and their dependents is no longer sufficient grounds for declaring that legislators support veterans. Submitting bills without a funding mechanism, thus assuring their relegation to collecting dust in committee or defeat due to insufficient funding is disingenuous. Meaningful action and results will continue to be the new measuring stick employed by the Vietnam Veterans of America, New Jersey State Council, Inc.

POW/MIA

1. We urge the Congress and the Joint POW/MIA Accounting Command to continue all efforts to achieve the fullest possible accounting of all Armed Forces personnel from all conflicts, deployments and wars. We urge Congress to demand a full accounting for the missing and negotiated remains of Americans worldwide. We urge Congress to enact economic sanctions against those governments that refuse to reveal the whereabouts or assist in the recovery of our POW/MIAs. We support legislation that requires the Secretary of Defense to ensure that the Defense POW/Missing Personnel Office (DPMO) is provided sufficient military and civilian personnel, sufficient funding to enable the office to fully perform the complete range of missions of the office and to ensure that Department of Defense programming, planning, and budgeting procedures are structured so as to fully support DPMO with the minimum level of manpower and funding mandated by law. During the lapse in appropriations and government shutdown in October 2013, several POW/MIA cases previously scheduled to occur by the Joint POW/MIA Accountability Command in November and December were postponed due to the lack of funding from an annual appropriations bill. We urge Congress to strive to prevent such scenarios from happening again and make certain these cases stay on schedule for excavation through other funding vehicles as necessary, including continuing resolutions.

2. We thankfully acknowledge the policy change to expand eligibility for the Purple Heart award to prisoners of war who died in captivity; such change represents the right decision that recognizes their sacrifice. The revision maintains the integrity of the award while allowing a reasonable presumption that servicemembers who die in captivity did so as a result of enemy action or complicity

3. We urge the introduction and passage of legislation that would require the displaying of the POW/MIA flag on every United States Federal building any day when the flag of the United States is displayed.

4. We continue to urge the establishment of, in the House of Representatives, a select committee to be known as the Select Committee on POW and MIA Affairs, to conduct a full investigation of all unresolved matters relating to any United States personnel unaccounted for from the Vietnam era, the Korean conflict, World War II, Cold War Missions, or Gulf War, including MIA's and POW's.

War-Caused Infirmities

1. We noted previously that according to the Department of Defense Contingency Tracking System (CTS) Deployment File for Operations Enduring Freedom & Iraqi Freedom as of January, 2012, 2,333,972 American service members have deployed to OIF and OEF, and 1,002,106 have deployed more than once. The signature wounds of the Afghanistan and Iraq theatre of operations are the psychological traumas and traumatic brain injuries. Tens of thousands of service members have suffered physical wounds. Hundreds of thousands more have sustained mental injuries and/or mild traumatic brain injuries, many of which have not been properly diagnosed. The U.S. Government and the American people must do everything possible to rectify the shortcomings in mental health and neurological care many service members face upon their return from duty. Treatment for service-connected traumatic brain injury should be tailored to individual injuries. Service-connected posttraumatic stress disorder and its effects must be treated as seriously as physical wounds.

Hundreds of thousands of veterans are required to wait up to four years for the government to process their disability claims, delays that are contributing to economic devastation, the breakup of families and even suicide for returning warriors. Over the past several years, we have witnessed a long train of official criticism of the Department of Veterans Affairs. Delays in VA disability claims processing have been cited by the U.S. Government Accountability Office as well as two independent, bipartisan commissions that have reviewed the situation in recent years.

We continue to urge that improvements to the timely and correct handling of claims for service-connected injuries remain a priority.

2. One of "the ironies of modern warfare" is that because of improved first aid and training, more troops survive grave injuries, but they may require extensive rehabilitation and expensive prosthetics

However, those are just the visible wounds. Closed head injuries from explosive devices are terribly common in Iraq and Afghanistan and psychological wounds may not surface until a soldier is well out of uniform. To the extent their situation may be a byproduct of war, this is utterly unacceptable.

The wars overseas rarely make front-page news these days, but they still loom large for families left behind during tours of duty and dealing with the war's aftermath in the form of veterans returning with post-traumatic stress disorder, anxiety, depression and substance abuse.

During the 112th Congress, 2nd session, Congress worked on projects like making sure there is adequate health care treatment for all veterans, streamlining the disability claims process and doing medical evaluations on all veterans. We urge the continuation of this focus by the VA. Veterans' issues need to get the attention they deserve because they aren't going away. It's far too easy ... to forget them as the U.S. concentrates on the economy.

The increasing number of families of disabled veterans who are seeking compensation for their roles as caregivers needs to be adequately addressed. Compensation for family members of disabled veterans has become a "pressing issue" due to the availability of better medical technology which has allowed more soldiers to survive with serious injuries. In 2007, there were 3,000 disabled veterans who required full-time clinical- and care-management services, according to the Dole-Shalala Commission. Families today are more proactive in their care of disabled veterans, and it’s time to address their concerns.

Some programs are already evolving. Under a program implemented in the 1990s, family members can train with companies with which the government contracts to provide home health aides. Certain disabled veterans are permitted to hire those family members to provide care. However, the program allows veterans to hire family members only for four hours per day, which obviously is not enough due to the fact they often spend significantly more time caring for the veteran. In addition, the arrangement subjects the families to a third party receiving a portion of their pay. The VA needs to compile data on how many families use the program, as well as how many more would if the program was improved and expanded.

With the backing and support of Congress in 2011, VA began implementing a comprehensive Family Caregiver program that provides a monthly stipend to help offset the significant financial impact on families with severely injured post 9/11-eligible veterans.

We acknowledge the VA efforts in establishing the VA Caregiver Support services involving the various programs: Adult Day Health Care (ADHC) Centers, Home-Based Primary Care, Skilled Home Care, Homemaker and Home Health Aide Program, Home Telehealth, Respite Care and Home Hospice Care.

We call on Congress to require the VA to extend these services to veterans of all combat operations.

We acknowledge the establishment of the Department of Veterans Affairs new initiative: Patient-Centered Community Care (PCCC). The VA has indicated this is an innovative solution that helps VA medical centers continue to provide quality care efficiently and be a valuable option for VA medical centers to use to expand our veterans’ access to care. Under PCCC, VA medical centers will have the ability to purchase non-VA medical care for Veterans through contracted medical providers when they cannot readily provide the needed care due to geographic inaccessibility or limited capacity. PCCC will provide a regional contracting vehicle for VA to work with local community providers to give veterans access to high quality care in a continued efforts to ensure timely and accessible services are provided to Veterans for non-VA medical care. We will reserve judgment until such time as this new program is up and running.

3. We urge the United States government to fund independent research analyzing data concerning the location of veterans during the Gulf War and claims for VA compensation and pension benefits. Asking the Defense Department, who may bear responsibility for injuries or the VA, who would fund claims; to do this vital research presents a conflict of interest. We urge the expedited research to ascertain what toxic and radioactive exposure Gulf War veterans received and what illnesses may be associated with such exposures. We acknowledge the *Gulf War Illness and the Health of Gulf War Veterans: Scientific*

Findings and Recommendations as presented by the Research Advisory Committee on Gulf War Veterans' Illnesses. We urge a renewed federal research commitment to identify effective treatments for Gulf War illness and address other priority Gulf War health issues without further delay.

4. We support legislation that would enhance treatment for veterans suffering from exposure to Agent Orange, ionizing radiation and the toxic agents used, or suspected of being used, during the Gulf War, as well as fumes from burning oil wells. Possible exposure to chemical, biological, radiological or nuclear agents or materials should be thoroughly and properly investigated and prompt and complete treatment afforded to all exposed veterans. The history of linking ailments to actions within certain theaters of operations and then funding treatment for those who have proudly served America is dismal. This trend should not be allowed to continue. From the beginnings of our great nation, our citizens have recognized the importance of a strong military as being fundamental. Through Congress, our citizens have accorded veterans special treatment and advantages over those citizens who did not serve on the principle that those who devote part of their youth and place themselves in harm's way to defend our country and her ideals deserve special consideration. However, the practice of requiring unattainable proofs of exposure and establishing concrete connections between possible exposure and manifestation of symptoms results in many veterans being denied the health care to which they are entitled. A panel advising past Veterans Affairs Secretary Anthony J. Principi on Persian Gulf War illness has urged the investigation of neurological problems of veterans, more spending for studies, and a better plan for carrying them out. Research in Gulf War illnesses has yielded few answers for ailments more than a decade after the war. The connection of Agent Orange to many diseases took too many decades to establish, adding needlessly to the suffering of thousands of Vietnam Veterans and their families. We demand that appropriate priority be placed on the implementations of the recommendation of the panel. Any further delay in providing relief to the problems of Gulf War veterans is not acceptable.

5. We continue to support efforts for the permanent and independent New Jersey Agent Orange Commission to determine the effects of Agent Orange and other herbicides on New Jersey Vietnam Veterans and their families. As warfare shifts form from the battlegrounds of the past to clandestine attacks utilizing chemical, biological, radiological or nuclear materials; the need for such a commission to study, determine the effects of and provide policy for dealing with these issues will increase.

6. We urge New Jersey, in conjunction with the federal government, to continue to fund a Post-Traumatic Stress Disorder (PTSD) program. Left undiagnosed and untreated, PTSD compounds many problems not only for the veterans who are suffering from PTSD; but also the community in which they attempt to survive. Violence, relationship and family difficulties, substance abuse and the commission of crimes that may result from PTSD reach out in a negative manner to the very core of a community.

7. We urge the continued research into programs designed to improve the treatment modalities for war-caused injuries. The quality of VA health care is comparable, and in many cases exceeds the care provided by the private sector at a fraction of Medicare and private sector costs. The VA is considered the world leader in specialized care programs such as spinal cord injury and blind rehabilitation. Some of the most powerful and life changing advances in medical science continue to come from VA research such as the cardiac pacemaker, the CT scan, magnetic source imaging and improvements in various prosthetics. This life altering research should continue to receive the necessary funding and support.

8. We urge the introduction and passage of legislation to establish a presumption of service-connection for certain veterans with hepatitis C, thus enabling veterans who contracted Hepatitis C in military service to receive treatment for this condition by the Department of Veterans Affairs. Additionally, we urge legislation that directs the VA to develop and implement a standardized, national Hepatitis C policy for its testing protocol, treatment options and education and notification efforts. We urge legislation that requires the VA to develop an outreach program to notify veterans who have not been tested for the Hepatitis C virus of the need for such testing and the availability of such testing through the VA. We support legislation that improves access to Hepatitis C testing and treatment for all veterans, ensures that the VA spends all allocated Hepatitis C funds on testing and treatment, and sets new, national policies for Hepatitis C care. Such legislation should direct the VA to provide a

blood test for the Hepatitis C virus to: (1) each veteran who served on active military duty during the Vietnam era, or who is considered to be "at risk," and who is enrolled to receive veterans' medical care and requests such care or is otherwise receiving a physical examination or any other care or treatment from the VA; and (2) any other veteran who requests such test. Provisions for follow-up tests and appropriate treatment for any veteran who tests positive and the prohibition of a co-payment being charged for such treatment should be incorporated into any Hep C legislation.

9. We urge the passage of legislation (introduced 10/15/2007) that has been proposed which would give our OIF/OEF veterans better resources, benefits and assistance when it comes to pain and its impact on their lives. Modern warfare has produced a new range of battlefield injuries. This is due to factors such as the use of body armor, the prevalence of improvised explosive devices, and improvements in battlefield medicine. Today's servicemembers are surviving injuries that would have been fatal in previous conflicts. Traumatic brain injury and polytrauma are among the hallmark injuries of the military operations in Iraq and Afghanistan. In many cases, these wounded servicemembers suffer from damage to the central and peripheral nervous system, necessitating a better understanding of pain and more effective management techniques.

Veterans Pain Care Act of 2007 S.2160 - Directs the Secretary of Veterans Affairs to carry out at each Department of Veterans Affairs (VA) health care facility an initiative on pain care which shall include, for each individual receiving treatment at such facility: (1) an assessment for pain at the time of admission or initial treatment, and periodic assessments thereafter; and (2) appropriate pain care including, when necessary, access to specialty pain management services.

This legislation also directs the Secretary to carry out within the Medical and Prosthetic Research Service of the Veterans Health Administration a program of research and training on acute and chronic pain. It also requires the Secretary, under such program, to designate cooperative centers for research and education on pain, with at least one center as a lead center for research on pain attributable to central and peripheral nervous system damage commonly associated with battlefield injuries characteristic of modern warfare.

VA has had a pain management program in place for some time, although the program's focus was initially directed towards pain associated with end-of-life care. The lack of standardized implementation of VA's own pain care management strategy has limited the effectiveness of pain care for veterans. VA's current program is decentralized and has languished since its inception in 2003, despite the growing need for pain care management and research.

Inconsistent and ineffective pain care provided by the Department of Veterans Affairs leads to pain-related impairments, occupational disability, and medical and mental complications for veterans with acute and chronic pain, with long-term costs for the health care and disability systems of the Department and for society at large.

We support the introduction of legislation that would provide a Congressional mandate for VA's existing efforts in the area of pain care management and significantly enhance VA's pain management research and education. We support the establishment of a pain care initiative at each health care facility of the Department of Veterans Affairs. We support legislation that will require the Secretary of Veterans Affairs to designate an appropriate number of facilities of the Department as cooperative centers for research and education on pain. Further, we support legislation that establishes the designation of an appropriate officer to manage the program's operations.

Military Absentee Ballots

1. The ballots of each and every service member voting by absentee ballot must be counted in any election where the service member participates in the election process. We have failed to adequately protect the right of our troops to participate in our democratic process by not providing adequate assistance to service members and their families who are away from their homes in the United States or overseas. It is unconscionable that a service member’s ballot is not counted due to the fact that it bears no postmark on the envelope of a service member’s ballot due to the member being stationed in a postage-free hostile combat location. Local election officials must not be permitted to defeat the

democratic process, especially in regards to the service personnel serving in hostile environments, due to their own lack of knowledge of postage-free privileges provided for those serving in hostile–fire or imminent danger environments. Safeguards must be provided to protect the voting rights of our Armed Forces personnel world-wide. The current military voting system, as implemented by Federal Voting Assistance Program and its current leadership, is too cumbersome and convoluted to effectively serve those who serve in the cause of freedom. A September 2007 report by the Election Assistance Commission's inspector general showed that much work remained to be done to protect the rights of overseas voters.

We acknowledge the passing of the Military and Overseas Voter Empowerment Act, signed into law during November 2009 as part of a larger defense authorization bill. The law will remove obstacles that have blocked as many as one-quarter of uniformed and overseas voters from successfully casting their absentee ballots. However we note that more needs to be done to ensure that those servicemembers serving away from their communities can be assured their votes will count.

Department of Veterans Affairs

1. We previously noted the funding for the VA Fiscal Year 2009 was approved before the beginning of the fiscal year. At that time, only twice in the last 14 years, and three times in the last 20 years, had the VA budget been approved by the start of the new fiscal year. On average, the funding bill has been 3½ months late over the last six years. No matter which party enjoyed a majority in Congress or which party elected the President, this problem has persisted. FY 2010 again proved to be another in the long, sordid history of late budgets. We gratefully acknowledge President Obama signing the Veterans Health Care Budget Reform and Transparency Act (also known as "advanced funding"), into law October 22, 2009.

We call for passage of the Putting Veterans Funding First Act of 2013 - (Sec. 3) Authorizes the provision of advance appropriations for the following discretionary (under current law, medical care) accounts of the Department of Veterans Affairs (VA): (1) Veterans Health Administration Medical Services, Medical Support and Compliance, Medical Facilities, and Medical and Prosthetic Research; (2) National Cemetery Administration; and (3) Veterans Benefits Administration, Native American Veteran Housing Loan Program.

2. We must set a realistic goal for increased sharing that could be achieved by coordinating the medical care systems of the Departments of Veterans Affairs and Defense to improve health care delivery. DOD and VA have worked on developing the capability to share medical data for 25 years. GAO has monitored the agencies' data-sharing development since 1998. The Veterans Affairs and Defense departments apparently will take several more years to develop modernized electronic health records systems that can seamlessly exchange medical data. The departments expected to accomplish that goal in 2011 or 2012, but they have not given the Government Accountability Office a certain end date because of changes to the milestone schedule. The project has experienced repeated changes in strategy, repeated changes in milestones and a lack of clarity. The medical data-sharing initiative needs a more defined timeline and risk-management activities. Without realistic goals being set and performance being measured progress in this area will be non-existent. Both Departments conduct similar missions in the area of health care, but they do it separately which results in duplication of services in some regions with all the inherent costs involved. Joint ventures such as shared staffing, buying or selling services, joint purchasing of pharmaceuticals and medical/surgical supplies, education and training, joint research, consolidated procurement programs and advanced information technology are a few examples of sharing that would result in dividends for both departments. All savings realized as a result of a sharing agreement should be immediately reinvested into their respective health care system without offset from congressional appropriation. VA and DoD have increased sharing in sheer dollar volume and added many new agreements over the past twenty years, however, the total amount of sharing remains miniscule as a percentage of the two departments' combined health care outlays. According to VA's Office of Medical Sharing, in fiscal year 2001 VA and DoD shared services valued at only $58 million out of the two departments' total health care budgets of approximately $35 billion – about two-tenths of one percent of their medical spending. H.R. 1911, introduced May 1st, 2003 would have established an interagency committee to be known as the Department of Veterans Affairs-Department of Defense Joint Executive Committee to: (1)

recommend to the Secretary of each department strategic direction for joint health-care resources coordination and sharing efforts between and within such departments; and (2) oversee implementation of those efforts. In 1982, Congress enacted Public Law 97-174, (`the Sharing Act') to foster more effective sharing of health care resources between the former Veterans Administration, now the Department of Veterans Affairs (VA), and the Department of Defense (DOD). The law was introduced not only to remove legal barriers, but also to provide incentives for military and VA health care executives to engage in health resources sharing through local agreements, joint ventures, national sharing initiatives, and other collaborative efforts pointed to better and more efficient use of Federal health care resources.

The Sharing Act provides virtually unlimited authority to both VA and DOD to share health resources across the entire spectrum of health care and health related activities. With the advent of the Sharing Act, a flurry of VA-DOD sharing activity occurred, with hundreds of agreements having been executed between military and VA medical centers and clinics. However, over the succeeding years, sharing waned because military health care shifted from a facilities-based system to a very large contract effort through the advent of the TRICARE program.

The Sharing Act gave local health care executives flexibility in establishing sharing agreements, including conducting negotiations, developing reimbursement methods and bartering services, as well as governing review and approval processes to minimize bureaucratic delay from Washington. As an incentive to share, it provided that a facility furnishing the services would be permitted to retain funds earned from such sharing. To encourage establishment of sharing as an important priority, the Sharing Act required the VA's Chief Medical Director (now the Under Secretary for Health) and DOD's Assistant Secretary for Health Affairs to recognize health resources sharing as an ongoing responsibility. The Sharing Act established a VA-DOD committee that was charged with reviewing policies and practices relating to sharing, identifying new or potential opportunities, and making recommendations to the Under Secretary, Assistant Secretary and Congress to promote increased sharing. However, we believe that the Joint Committee has not achieved its full potential.

On July 27, 2001, the Honorable Christopher H. Smith, Chairman of the Veterans' Affairs Committee, introduced H.R. 2667, the Department of Defense-Department of Veterans Affairs Health Resources Access Improvement Act of 2001. We hoped this bill would spur new opportunities for sharing across both Departments. H.R. 2667 sought to establish a health care facilities sharing demonstration project in keeping with the intent of the original legislation for VA-DOD sharing. Under the bill, five qualifying sites across the country would be selected for participation in a demonstration project. The purpose of the demonstration project was to identify and measure the advantages of sharing, and work through the challenges of the two systems becoming true partners in health care delivery. The two Departments' medical information systems are incompatible, but this legislation would have created a framework for greater technology compatibility. By making such systems communicate better, the Departments could better ensure continuity of care, equality of access, uniform quality of service and seamless transmission of data.

On March 7, 2002, the Subcommittee on Health and the Committee on Armed Services Subcommittee on Military Personnel held a joint hearing to examine collaboration and health resources sharing by the two Departments, including consideration of H.R. 2667. Chairman Smith testified to urge both Subcommittees to aggressively increase resource sharing between these two massive health care systems. Under Secretary Chu of DOD assured the Committees that he and Deputy Secretary Mackay share a common vision of quality health care for the men and women serving our country, their families, and those that have served. According to Secretary Chu, the cooperative efforts of DOD and VA are focused on a proactive partnership that meets the missions of both agencies while benefiting the service member, veteran and taxpayer with new initiatives and increased efficiency. Most of the original concepts and objectives of H.R. 2667 were incorporated in Subtitle VII of Public Law 107-314, the Bob Stump National Defense Authorization Act for Fiscal Year 2003.

H.R. 1911, introduced by Honorable John Boozman, would have modified section 8111(c) of title 38, United States Code, concerning the sharing of Department of Veterans Affairs (VA) and Department of Defense (DOD) health care resources. Section 721 of the Bob Stump National Defense Authorization Act for Fiscal Year 2003 amended section 8111(c) to create a DOD-VA Health Executive Committee

with certain mandates for collaborative activities between the Departments. It provides for oversight of health care issues by the Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary of Veterans Affairs. This bill would establish a DOD-VA Joint Executive Committee to expand oversight of collaborative efforts to include health, benefits, and other areas as determined by the co-chairs, and to promote increased resource sharing.

Existing law allows each Department to determine individually the number of employees each would designate to support the committee, but requires each one to share equally in the cost, notwithstanding parity in the numbers. It also requires a permanent staff be assigned to the committee. This bill would delete these personnel requirements, thereby enhancing the flexibility of each Department to use their personnel in the most efficient manner possible, while at the same time authorizing the establishment of subordinate committees and work groups as deemed appropriate by the co-chairs.

Existing law specifically authorizes the recommendations of the committee for sharing of resources to improve access, quality, and cost effectiveness. Under H.R. 1911, the committee would also identify changes in policies to improve services, efficiencies, and opportunities for collaboration for delivery of benefits and services to beneficiaries of both Departments. HR 1911 was agreed to in the House by a vote of 426 to 0, and then referred to the Senate Committee on Veterans Affairs. This legislation should be re-introduced and passed by both chambers.

Despite years of public pressure and Congressional scrutiny, the Department of Defense (DoD) and the Department of Veterans Affairs (VA) have failed to craft and implement an interdepartmental data-sharing agreement to allow the two agencies to share the health care information of patients transitioning from active duty to veteran status. That more combat-wounded are making that transition-traveling from Afghanistan and Iraq to Landstuhl, Germany to Walter Reed Army Medical Center and then on to their local VA medical center (VAMC) has only sharpened the focus on this issue.

While VA has taken steps to expedite services to seriously injured OEF/OIF servicemembers, the VA does not have systematic data from DOD on those servicemembers who may need vocational rehabilitation and other benefits from the VA.

At a Subcommittee on Disability Assistance and Memorial Affairs (DAMA) March 28, 2012 hearing:
Re-evaluating the Transition from Service Member to Veteran: Honoring a Shared Commitment to Care for Those Who Defend our Freedom; John Medve, Office of VA-DOD Collaboration, U.S. Department of Veterans Affairs testified in regards to the Integrated Disability System (IDES), the Federal Recovery Coordination Program (FRCP), and Veterans Affairs Schedule for Ratings Disabilities (VASRD) modernization efforts, noting despite the overall reduction in combined processing time achieved to date, challenges remain and there is room for significant improvement in IDES execution. We concur with his testimony.

3. Improve VA procurement processes and improve coordination between the VA & DoD in such areas as health care services, benefits delivery, information sharing and capital asset coordination, standardize billing and reimbursements, joint procurement, computer-based patient records and coordination of capital investments. Costs will continue to rise and the potential for cost savings that could be realized here are substantial. More importantly, these savings could be recycled back into the processes to provide additional benefits to the programs and the veteran community they serve. Each of the past 10 years there have been calls from Congress and the GAO seeking this improvement in the procurement process and improved coordination between the VA & DoD.

4. We must continue to improve VA services for women. We previously noted the total veteran population in the United States and Puerto Rico, as of October 2007, was approximately 23.4 million. The population of women veterans numbered 1,802,000. The total veteran population in the United States and Puerto Rico, as of Sept. 30, 2011, was approximately 22.2 million. The population of women veterans numbered 1,853,690.

As of September 2013 the veteran population was 21,973,000 with 10% of this group women.
34,000 women served in World War I, 400,000 served in World War II, 120,000 served in the Korean War, over 7,000 served in the Vietnam War, and more than 41,000 served in the first Gulf War. More

than 185,000 women have been deployed in support of Operation Enduring Freedom, Operation Iraqi Freedom, and other missions since 2001. Over 350 servicewomen have given their lives for the Nation in combat zones since World War I, and more than 85 have been held as prisoners of war. With over 350,000 women serving in the Armed Forces making up approximately 15 percent of active duty personnel, 15 percent of Reserves, and 17 percent of the National Guard; the VA must improve their services and facilities to accommodate even more women veterans in the coming years.

Since 2001, the roles of women in the military have changed. More than 225,000 women have deployed to Iraq and Afghanistan, and women now comprise 15% of America's armed forces. Many of these women served unofficially in combat roles. Women in the navy have, for the first time, served aboard submarines. An estimated 153 women fighting in these two wars have died.

The VA must continue to re-position itself to welcome and outreach to women veterans, be sensitive to their needs, and ensure their health needs are being met with high quality programs. For years the VA healthcare system has been a Men’s Club, due to its mostly male clientele. However, the make-up of the military is changing and the VA needs to facilitate the changing needs of our service personnel. The VA has designated friendly areas specifically for female patients in the larger VA Centers. However, there are not complete female services in every clinic. VA policies, practices and programs must be responsive to the special needs of women veterans. This requires increasing the priority given to women’s programs to ensure that quality health care is provided and that adequate facilities are provided. VA needs to ensure and secure appropriate facilities and resources for the diagnosis and treatment of women veterans at all VA hospitals and clinics. The VA must address the barriers to care that women veterans face and issues that negatively impact women veterans’ decisions to seek health care form VA. Women veterans’ right to privacy at every VA health-care facility must be ensured.

5. We must continue to reduce the huge backlog in claims and appeals for benefits submitted by veterans while increasing the quality of decision-making. The time to alleviate the hardship and frustration that thousands of veterans experience while waiting for their claim or appeal to be decided is too long overdue. Veterans from World War II and the Korean War are waiting for their cases to be resolved. The number of Agent Orange-related claims, Hepatitis C claims, radiation-related claims, and those resulting from the Gulf War continually add to the current overload. Additional resources must be allocated to handle the backlog and the influx of new cases. Our government must make an investment in VA programs to ensure that our veterans and their families receive, in a timely fashion, the benefits and services promised them. Recommendations cited in GAO-02-806 Veterans’ Benefits - Quality Assurance for Disability Claims and Appeal Processing Can Be Further Improved need to be implemented in order to achieve a reduction in the large and persistent backlog of claims and appeals.

The VA must implement:

A. programs that support improvements in training and regulations,
B. procedures or policies that enhance the quality of decision making across the continuum of adjudication,
C. improvements that provide adequate assurance to veterans that they will receive consistent and fair decisions in a timely fashion.

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

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

6. The VA must reduce claims processing time without sacrificing decision-making quality or VA's statutory duty to assist veterans develop their claims. No veteran or survivor should have to incur the tremendous delays that are all too common in the current system. Both the level and the quality of the service provided in this aspect of veteran benefits need improvement to reduce the number of cases going to appeal. Rationing health care with lengthy waiting times or delaying service is unacceptable.

Recommendations cited in GAO-05-47 More Transparency Needed to Improve Oversight of VBA's Compensation and Pension Staffing Levels, November 2004, need to be implemented in order to achieve a reduction in the large and persistent backlog of claims and appeals. VBA's fiscal year 2005 budget justification did not clearly explain how the agency would achieve the productivity improvements needed to meet its compensation and pension claims processing performance goals with fewer employees.

To assist the Congress in its oversight of VBA's compensation and pension claims processing operations, GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Benefits to prepare several types of information and work with the appropriate congressional committees and subcommittees on how best to make it available for their use. This includes information on (1) the expected impact of specific initiatives and changes in incoming claims workload on requested staffing levels; (2) claims processing productivity, including how VBA plans to improve productivity; and (3) how claims complexity is expected to change and the impact of these changes on productivity and requested staffing levels.

7. The huge backlog of veterans' benefits claims, one that is steadily growing, is hardly a secret in the veteran community. Not as well known, however, is the other side of this perplexing situation — the appeals process that follows when veterans challenge initial decisions on their claims.

The U.S. Court of Appeals for Veterans Claims has the highest caseload of any federal appeals court. Any! Unbelievable; but that is the case. In fiscal 2007, it received 4,644 cases and decided 4,877 — both all-time records for a court that boasts just seven judges even though the appeals backlog is at 6,300 and counting. This partially explains why it takes an average of two years, and often longer, for a decision to be rendered. In FY 2011 3,948 appeals were filed with the Court, 137 petitions were filed with the Court and 2,537 applications were filed with the Court under the Equal Access to Justice Act (EAJA) section 2412 of title 28. The Court disposed of4,620 appeals, 167 petitions and 2,517 EAJA applications, with the requests for Reconsideration/Panel Decision: 235 appeals, 23 petitions.

Given the complexity of disability claims, especially those involving PTSD and traumatic brain injury, and the often murky details associated with mental health claims, this astonishing caseload makes it hard to believe veterans get a fair, much less timely hearing on their appeals.

Chief Judge William Greene Jr. has asked Congress to approve the hiring of more support staff, and to allow decisions to be made using condensed records rather than more extensive documents that can take months to gather. A bill to add two more judges to the court is also pending. However there is no apparent urgency to deal with the matter. The legislation to add more judges is mired in the Senate Veterans' Affairs Committee.

The odds are that things will get worse before they get better. After years of delay, the VA is finally hiring more claims processors — which will speed initial decisions and likely add to the appeals, as well. Additionally, many new hires will be coming onboard as the baby boomers make their exodus to the land of the retired. A lot of experience will be leaving the VBA in the next five years alone.

Now that the VA has been convinced to hire more claims processors, Congress must now add more judges and staff to the appeals court. The backlog is too long, and the time judges have to render a fair decision is taking too long for justice to be served to our deserving veterans.

The issue of presumption of regularity continues to penalize veterans. The VA can merely claim that pertinent documents were sent to a veteran's address of record on a timely fashion and were not returned to the Regional Office by the postal service. When the matter is brought up under appeal, the presumption of regularity is regularly supported in the conclusion that the VA officials complied with their official duty to mail the notification and absent clear evidence to the contrary that would be

necessary to rebut that presumption the ruling is finalized at the expense of the veteran. When a veteran claims notification was not timely mailed due to the veteran's assertion that the veteran did not receive the notification; that assertion is ruled as insufficient to overcome the presumption of regularity. This horrendous situation should not be permitted to continue.

8. October 31, 2013 in the Federal Register, the VA published it's proposal to amend its adjudication regulations, appeals regulations and rules of practice of the Board of Veterans Appeals. There are two major components of these proposed changes:

1) Require all claims to be filed on standard forms prescribed by the Secretary, regardless of the type of claim or posture in which the claim arises.

2) Provide that VA would accept an expression of dissatisfaction or disagreement with an adjudicative determination by AOJ as an NOD only if it is submitted on a standardized form provided by VA for the purpose of appealing the decision, in cases where such a form is provided.

We understand the VA's stated intent to improve the quality and timeliness of the processing of veterans' claims for benefits and appeals, and in principle, we do not oppose VA modernizing its claims system and use of standardized forms. However, we find many of these proposed rule changes, as currently written, do NOT have the intended effect of increasing efficiency, and are in fact adverse to veterans' interests by formalizing the claims and appeals processes to the point where benefits are unfairly restricted.

We have serious concerns that these proposed changes are adverse to many classes of veterans--especially Vietnam Veterans--seeking VA benefits under Title 38, and some of these proposed changes may be in direct violation of existing court rulings. Furthermore, some of these proposed changes may not pass Constitutional muster given they appear to run afoul with the Due Process and Equal Protection Clauses of the U.S. Constitution. The end result of these proposed changes, if enacted, would be a significant departure from the longstanding, non-adversarial and pro-claimant VA system originally intended by the U.S. Congress.

Although VA is granted authority under 38 U.S.C. 501(a) to make regulatory changes, these proposed regulatory changes appear to be beyond the scope of that authority.

9. The VA currently provides over 1,400 sites of care and other services in 21 Veterans Integrated Service Networks utilizing some 4,700 buildings on over 18,000 acres. The VA medical facilities need to be repaired and renovated, or in some cases, - razed and rebuilt. The VHA's physical infrastructure is in urgent need of sufficient funding and provisions to address seismic corrections, compliance with Americans with Disabilities Act and the Joint Commission on Accreditation of Healthcare Organizations standards, replacing aging physical plant equipment, capital assessment realignment and much needed maintenance. Construction budgets are still being held hostage to the Capital Assets Realignment for Enhanced Services (CARES) process. Services and benefits are provided through a nationwide network of 152 hospitals, 817 community-based outpatient clinics, 135 nursing homes, 47 residential rehabilitation treatment programs, 300 readjustment counseling centers, 108 comprehensive home-care programs, 56 veterans benefits regional offices, and 131 national cemeteries. The funding for routine maintenance and upkeep, improvements, minor and major construction projects is insufficient to sustain and improve the facilities. Increased numbers of veterans enrolled in the VA health care system will add to the burden.

10. There must be a continuation of the budget and programs of the VA for geriatric research, education and clinics for older veterans. Geriatrics is an emerging discipline important to the VA as well as the country. Our rapidly aging veteran population is deserving of all the resources we can provide to make their lives as comfortable as possible. They sacrificed their innocence for the lifestyle and freedoms we now enjoy and we need to provide for their needs without further delay. Fellowship training in the discipline of geriatric medicine is important to meet the needs of the growing older veteran community.

11. The VA should continue to provide scholarship grants to deserving individuals attending medical schools and nursing schools on the condition that they contract to serve in VA facilities or state veterans' homes upon graduation. VA has become the largest provider of health care training in the United States. VA's medical and dental program is conducted primarily through affiliations with

University Schools of Medicine and also with teaching hospitals. Currently 119 VHA medical facilities offer graduate medical education (GME) or undergraduate medical education through affiliations with 117 of the nation's 129 allopathic medical schools and 15 of the 25 osteopathic medical schools. The VA trains much of the nation's healthcare workforce who leave the VA for more lucrative employment opportunities. This program would help increase the number of students seeking a medical career and improve staffing level at VA facilities.

12. Congress should mandate that HMO's accept VA facilities as treatment centers under their respective plans for third-party payments. The very idea that any insurance provider can decide not to honor our commitment to provide veterans with the healthcare they have earned goes against the concept of veterans benefits. Again, we reiterate that the quality of VA health care is comparable, and in many cases exceeds the care provided by the private sector at a fraction of Medicare and private sector costs. We urge the President and Congress to direct the Veterans Administration to accept the Medicare Assignment and Supplemental Insurance as well as obtain reimbursements and payment for medical services from all veterans service connected and non-service connected. It is blatantly unrealistic, unfair and unreasonable to create two classes of veterans, those who receive Medicare, SSI, or are members of HMOs and all other veterans and give financial support to one but not the other.

13. We support the presumption of service-connected disability for those who were involved in instances of chemical, bacteriological, radiological or nuclear exposure. Our government seeks to keep classified much of the information that would be useful in pursuing claims dealing with radiation experiments, Gulf War illnesses, the Shipboard Hazard and Defense program from the 1960's, Project 112 and various other actions. Requiring veterans to provide an overwhelming burden of proof while withholding vital information virtually assures the claim will not be processed favorably for the veteran. The days of the pro-claimant bias are history. The Federal courts have reaffirmed on many occasions the principle that laws governing veterans' benefits are to be liberally construed in favor of veterans.

14. It is clear that Medicare, Medicaid and Medigap funds paid to VA facilities should remain within the VA system and not be reassigned to the general treasury. The VA health care system must provide all veterans access to a full continuum of care, a task made more difficult each year due to chronic under-funding. This under-funding has severely limited VA's ability to properly care for its current workload. The VA health care system provides care to millions of Medicare-eligible veterans, many of who pay a monthly premium to Medicare but receive all of their health care services through VA health care. Medicare-eligible veterans who enroll in VA health care would still remain fully eligible for Medicare services, and Part B premiums could not be increased due to this transfer. All funds received by the VA should be recycled in the VA programs without exception. It is now absolutely essential that VA be authorized to capture and retain federal dollars in addition to its annual appropriation so as to revamp and revitalize its health care system; and, a large number of VA's potential patients are Medicare eligible. Unlike in the private sector, Medicare-eligible veterans cannot use their Medicare benefits in a VHA facility. When Medicare-eligible veterans receive health care treatment for any medical condition in the private sector, the federal government reimburses the health care provider for a portion of that service. When Medicare-eligible veterans receive health care treatment for the same medical conditions within the VHA; the federal government will not reimburse the VHA for any portion of that service. This equates to a restriction on veterans' right to access health care of their choice using Medicare insurance coverage. Federal health care funds should go to the actual providers of health care services, and that includes VA health care. What is needed is a simple, equitable proposal that would help to ensure that resources allocated for health care go where the patient is receiving care, which would provide a new, steady, and dependable stream of funding for VA health care to prevent the annual funding crises of the past decade merely by allowing veterans' own funds to follow them to the VA.

S. 963, introduced in 2005, would amend Title XVIII (Medicare) of the Social Security Act (SSA) to direct the Secretary and the Secretary of Health and Human Services (HHS) to establish a Medicare subvention project under which HHS shall reimburse the VA for Medicare health care services furnished to Medicare-eligible veterans in VA facilities. This project has been discussed for over ten years with no formal action to determine its viability. HR814 introduced February 18, 2011, also know as the Medicare VA Reimbursement Act of 2011 - amends title XVIII (Medicare) of the Social Security

Act to direct the Secretary of Health and Human Services (HHS), in cooperation with the Secretary of Veterans Affairs (VA), to establish a Medicare VA reimbursement program under which the HHS Secretary shall reimburse the VA Secretary, from the Medicare trust funds, for any item or service: (1) furnished to a Medicare-eligible veteran by a VA medical facility for the treatment of a non-service-connected condition; and (2) covered by Medicare or determined to be medically necessary by the VA Secretary. This legislation requires the HHS Secretary to enter a memorandum of understanding with the VA Secretary concerning administration of the program. It specifies required conditions in the memorandum. It directs the Comptroller General to report to Congress on the program every three years and it declares the sense of Congress that the amount of funds appropriated to the VA for medical care in any fiscal year should not be reduced as a result of the implementation of the Medicare VA reimbursement program.

15. We oppose any reduction in presently approved veterans' disability benefits, including elimination of any disability entitlements. Through extraordinary sacrifices and contributions, veterans have earned the right to certain benefits. As the beneficiaries of veterans' service and sacrifices, the citizens of a grateful nation require that our government fully honor our obligation to care for those who have answered the call to arms. Asking veterans to assume the partial costs of their benefits is fundamentally contrary to the spirit and principles underlying the provision of benefits to veterans. Veterans are still being charged co-payments for health-care services and medications and the continued call for increases in these co-payments and new annual enrollment fees is a move in the wrong direction. De facto devaluation of veterans' sacrifices to balance the budget or otherwise ration health care to veterans is absolutely unacceptable. Every year the current administration has sought to impose higher co-payments and enrollment fees. The Congress needs to continue to prevent the higher co-payment and enrollment fees from being enacted.

16. Disability payments should be based on service-connected disability and not be related to the veteran's income or any means test. We continue to support the premise that disability benefits should not be included as part of the veteran's taxable income. We urge Congress to enact legislation to exempt VA disability compensation from countable income for purposes of determining eligibility for any federally funded programs. Disability compensation payments fulfill our primary obligation to make up for economic and other losses veterans suffer due to the effects of service-connected diseases and injuries. Current policy at the Department of Housing and Urban Development (HUD) considers nontaxable service-connected disability compensation provided by VA to be countable income when determining a veteran's eligibility for HUD's Assisted Senior Housing Program.

17. Veteran Outreach Centers throughout New Jersey and the nation should continue to be open to all veterans. Vet Centers help relationships stay healthy, help veterans surmount problems that threaten their employability, and help those unemployed become more ready for the ever-increasing challenges in today's job market. Funds spent in Vet Centers pay large dividends to the veterans themselves and their communities by extension. This is a sound investment in America.

18. There must be proper and adequate staffing of the VA Regional Offices in New Jersey, Wilmington and Philadelphia for those cases from southern New Jersey to expedite service and care of New Jersey veterans. Caring, dedicated individuals with the proper training, improved processes, new technology and real accountability are the most important element in delivery of services to eligible veterans. Returning to a pro-veteran bias as originally set forth in the laws implementing veterans benefits and returning to the benefit-of-the-doubt rule will reduce the backlog of appeals and provide veterans with the benefits to which the are rightfully entitled. Staffing and funding should reflect the debt of gratitude our nation has to those who have served our country with honor and it should signal the enduring commitment to the men and women in uniform today who defend our freedom all around the world.

19. We support the necessary action to continue the authority and adequate funding for the Vietnam Veterans Readjustment Counseling Program to enhance organizational capacity and to deal more effectively with the increased caseload due to the terrorist attacks of September 11, 2001, the war on terrorism, Operation Iraqi Freedom, Operation Enduring Freedom and Operation New Dawn. These events have and will continue to result in an increased caseload for readjustment counseling services. Public Law 106-117, The Veterans Millennium Health Care and Benefits Act, signed into law on

November 30, 1999 required the VA to dedicate not less than $15 million to expand and improve specialized mental health services, particularly programs for the treatment of PTSD and substance abuse disorders. Yet in the very year that Congress directed VA to provide this supplemental funding; VA expenditures for substance abuse care actually declined by more than $11 million. Additional personnel and funding to provide necessary counseling to all veterans is overdue. It was the VA that developed the finest protocols for identifying and treating PTSD. These achievements should not be forgotten.

We stand opposed to the siphoning off of veterans who would otherwise be directed to the Vet Center by the behavioral health staff at the community based outpatient clinic and the medical centers. The 300 Vet Centers have a long history of providing both individual and group counseling for combat veterans and their families through readjustment counseling that is unparalleled in the mental health community.

As we continue the Global War on Terrorism, incidents resulting in PTSD for the participants will increase substantially. The VA must be in a position financially and with adequate staff to provide treatment accordingly.

20. We must provide adequate funding for programs to address the root causes of homelessness and help veterans. We must release funding to make available transitional housing to give veterans, who want to win their lives back, and escape from the streets. We must increase outreach programs that offer medical care and treatment that fill the serious gaps in services for the homeless men and women who have served our nation. We must encourage a broad cooperation among the departments and agencies of our federal, state, and local governments, private and public sector organizations, community-based experts, and individuals to end homelessness and help veterans regain their lives; and, we must provide comprehensive medical care, mental and psychiatric assistance, vocational training and rehabilitation, employment and family counseling to transform homeless veterans into productive members of society.

21. We continue to support the Montgomery GI Bill, as revised by the Post-9/11 Veterans Educational Assistance Act of 2008, in perpetuity. Our nation needs to improve Veterans' Education Benefits by:

1) indexing benefits to the average cost of a four-year public college /university educations;
2) transferring MGIB from 10 USC to 38 USC and adjusting benefits proportionally to MGIB and;
3) accelerating benefit delivery for high-cost training/courses;
4) guaranteeing that the educational benefit for the Guard and Reserve be increased proportionally with the active duty benefit and that it be regularly increased in accordance with the active duty benefit.

We also support the authorization to refund contributions to veterans who become ineligible for the Montgomery GI Bill by reason of discharges characterized as "general" or "under honorable conditions". Currently, eligibility is subject to an honorable discharge. Discharges characterized as “under honorable conditions” or “general” do not qualify. We believe that in the case of a discharge that involves minor infractions or deficiency in the performance of duty, the individual should at least be entitled to a full refund of his or her contributions to the program.

Previously, Senators Jim Webb (D-VA), Chuck Hagel (R-NE) and Frank Lautenberg (D-NJ) joined representatives of the nation’s leading veterans’ organizations to advocate comprehensive educational benefits for post-9/11 veterans in the fiscal year 2009 budget. The groups unveiled their Independent Budget to the Committee on Veterans’ Affairs, advocating a “21st Century GI Bill,” similar to the Webb-Hagel bill (S.22) that enjoys widespread support in Congress.

This was the first time in twenty-two years of presenting an Independent Budget to Congress that the participating veterans’ organizations have advocated a new, comprehensive GI Bill, as opposed to a mere enhancement. The Independent Budget has carried great weight in years past in terms of instructing the Committee on Veterans’ Affairs budget priorities.

We gratefully acknowledge the Executive Order that protects military families and veterans from aggressive and deceptive recruiting by higher education institutions by requiring colleges to provide more information about their student outcomes and financial aid, create a centralized complaint

system and direct the Veterans Administration to trademark the term "G.I. Bill" to make it harder for colleges to create Web sites resembling official government sites or falsely suggest that they offer special access to veterans' benefits.

22. We call for the improvement of burial benefits. We support an increase in the VA burial and plot allowance to a level reflecting the inflationary impact years of stagnation have had on the allowance. We support the restoration of entitlement to the VA burial allowance for those categories of veterans eliminated under Public Law 97-35. We support the restoration of entitlement to the VA plot allowance to those categories of veterans eliminated under Public Law 101-508 (applies to deaths as of or after November 1, 1990.) We support the requirement of at least one open national cemetery in every state. We strongly support the end of the practice of indigent veterans' pauper's burial. As a nation, we should be doing all we can do to honor the service and sacrifice of our veterans. Putting an end to pauper's burials is without question a much-needed priority that should be resolved immediately by expanding the eligibility for the plot allowance, by increasing the plot allowance, by increasing the allowance for burial expenses and by enacting legislation to automatically adjust these burial benefits for inflation annually. Pauper's burial of veterans is a national shame and a travesty against their honor. The VA should develop an effective outreach program for medical examiners/coroners that will make sure that the unclaimed remains of veterans are given the respect they have earned. The 2003 VBA Survey of Medical Examiners' And Coroners' Process In Identification Of Unclaimed Remains For Veteran Status has revealed that only 15% of medical examiners and coroners reported that they attempted to verify the veteran status of identified, unclaimed decedents all of the time during the period from January 1997 to August 2001. Conversely, 75% never made such an attempt. It is important to make sure that every veteran is treated with the respect they have earned in the service of our country. Currently there is no legislative mandate requiring medical examiners or coroners to verify veteran status for each identified, unclaimed decedent.

23. We urge the Congress to amend PL 106-117 to mandate and provide funding for the provision of nursing home care for all veterans. We call upon Congress to bring order to, and expand eligibility for VA health care and provide all veterans with mandated access to the full continuum of VA health care services, which include nursing home care. Public Law 106-117, known as the "Millennium Act," expands VA eligibility for nursing home care to those veterans who are service connected 70% or above or who need nursing home care for their service connected conditions, but will still leave as discretionary, nursing home care for all other veterans. The demand for VA nursing home care is increasing as the veteran population continues to age; and will continue to do so for some time. Access to long-term care can be expected to be an issue that will become more critical as our veteran population ages and on average, we live longer than in previous generations.

The estimated total veteran population was 21,972,964 as of September 30, 2013. This included 7,330,032 Vietnam era veterans, representing the single largest period-of-service component of the veteran population. Gulf War era veterans now comprise 6,4484,914, World War II veterans numbered 1,128,873, while Korean conflict veterans totaled 1,777,902. Veterans serving only in peacetime numbered 5,497,681, about one-in-four veterans.

According to the National Center for Veterans Analysis and Statistics in 2009, the median age of all veterans was 64 years. Veterans under age 45 constituted 16.5 percent of the total, while those aged 45 to 64 represented 40.4 percent, and those 65 or older were 43 percent of the total.

Female veterans numbered 2,721.222 as of September 2013, representing 10 percent of the total veteran population.

VA nursing home care units are VA hospital based and provide an intensive and extensive level of nursing home care supported by the clinical specialties and other services within the host hospital. VA nursing home care is considered the "safety net" for VA outpatient services such as Residential Care, Respite Care, Hospital Based Home Care, Adult Day Health Care and Homemaker/Home Health Aid Services and other extended care programs. VA, through their own statements, recognizes the difference in eligibility for nursing home care and inpatient hospital care as inconsistent with the principles of sound medical practice, which support continuity of care for veterans. We urge the VA to open its doors to any needy veteran suffering dementia. Dementia cannot be proven to be service-

connected, but, too many veterans in need are being underserved or not served at all because of their dementia.

24. We support legislation to allow lenders to pick appraisers of their choice from the VA's list of approved appraisers. We support the National Association of Mortgage Brokers in their effort to pass legislation designed to expand the list of VA appraisers and allow the lenders to pick an appraiser of their choice from the VA approved list of appraisers. Veterans trying to buy a home are at a competitive disadvantage versus non-veterans due to the current process that is causing the problem called "random select". A small modification to the current law expanding the number of appraisers on the VA approved list and allowing lenders to pick an appraiser of their choice from the VA approved list will eliminate the problem; thereby creating a level playing field for veterans

25. There needs to be an increase in the rates of DIC payable to disabled children of deceased veterans and a cola adjustment for inflation annually. We urge Congress to enact enabling legislation to increase the rates of Dependency and Indemnity Compensation payable to disabled children of deceased veterans to at least three fourths of the amount payable to the surviving spouse. The amount of Dependency and Indemnity Compensation paid to disabled children of deceased veterans is roughly one third the monthly benefits that a spouse receives; and yet after the veteran's spouse dies, the monthly benefits to the remaining eligible claimants do not increase even though the hardships that disabled children face are increased significantly. Additionally; benefits payments to the disabled survivors have, over the years, become seriously eroded by inflation.

26. We urge that veterans' priority of service be expanded to include any agency or organization, state or federal, that receives federal funding for employment and training, i.e. directly or through federal grants through the states (including the Workforce Investment Act (WIA)). We strongly urge that the Secretary of Labor be directed to bring together the appropriate departments to establish Department of Labor wide policy of veterans' priority of service in Employment and Training Programs and the Secretary of Labor must vigorously implement such policy. We urge the Secretary of Labor meet with other Secretaries of the Cabinet to review and establish veterans preference and priority of service in their programs, such as HUD for housing and homeless veterans and their families, etc. to help eliminate social personal, and society barriers related to employment and training to enable veterans to become productive citizens in their communities. We urge Congress to pass legislation that will bar delimiting language on veterans' preference because to limit preference would restrict a lifetime earned benefit. The need for the lifetime preference and priority in employment and training has been historically demonstrated for those most in need; and we strongly oppose any legislation, which seeks to eliminate the Disabled Veterans Outreach Program (DVOP) and the Local Veterans Employment Representatives (LVER) and replace them with a Veterans Case Manager (VCM) and a Veterans Employment Facilitator (VEF) which is a duplicate of an existing programs. We urge that Congress provide sufficient funding to the National Veterans' Training Institute to ensure training of personnel to assist veterans in finding employment in an ever-changing work environment. Veterans preference and priority of service for veterans has been afforded to veterans since the days of our colonies to present day, and these rights have been earned by the sacrifices of men and women who have served in the military service and protected our inalienable rights and nation. Throughout the years veterans preference and priority of services has been challenged, tested, and upheld by the Supreme Court many times, only to be strengthened. The environment, legislation, technology, configuration and funding of employment and training programs has been ever changing, and the Employment Service, under the Wagner-Peysner Act, has the responsibility of providing priority of service to special disabled veterans, disabled veterans, Vietnam veterans, veterans, other eligible and non veterans prior to other applicants. Under Title 38, veterans and other eligible shall be provided maximum opportunities of employment, training, counseling, and other services prior to other applicants, and yet Service Delivery Points as defined by federal regulations are ever changing into One Stop Career Centers or Customer Service Centers, whereby several agencies, i.e., Employment Services, JTPA, Human Services, and other agencies/organizations are co-located and/or electronically linked to provide streamlined and seamless services to their customers with no veterans preference or priority of services to veterans. This is not acceptable.

27. Dental care needs to be included as part of the veterans uniform benefits package. We urge that Congress authorize and fund VA to provide dental care to all enrolled veterans. In October 1996,

Congress passed Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996; legislation that provided the mechanism for creation of the Veterans Uniform Benefits Package – a standard, enhanced health care benefit plan that offers all enrolled veterans a full continuum of comprehensive health care through the Department of Veterans Affairs. The Veterans Uniform Benefits Package emphasizes preventive and primary care, offering a full range of outpatient and inpatient services to all veterans but neglects to include one of the most needed services for an aging veteran population – dental care.

28. We support legislation such as H.R. 2033, the Medicare Equity and Access Act, (introduced in the 108th Congress on May 8th, 2003). Continued reductions in reimbursements to Medicare providers has contributed to a health care crisis for both beneficiaries and providers in many areas of the country. Ever-increasing numbers of American citizens are finding it more difficult to find a Medicare provider. Doctors are simply cutting back on their participation in Medicare and many are refusing to take new Medicare patients. If Congress fails to address this situation now, our Nation's elderly will be denied access to health care services when they need it most. Because the military TRICARE reimbursement rates are aligned to Medicare's rates, uniformed services beneficiaries are also being adversely impacted. The rate increases envisioned in H.R. 2033 would have reduced the difficulty both TRICARE and TRICARE For Life (TFL) beneficiaries are experiencing in finding participating providers.

H.R. 2033 would have amended part C (Medicare+Choice) of title XVIII (Medicare) of the Social Security Act to provide for: (1) a two-year increase in the minimum percentage increase used in the calculation of annual Medicare+Choice capitation rates; (2) inclusion in the calculation of Medicare+Choice payment rates of the costs of Department of Defense and Department of Veterans Affairs military facility services to Medicare-eligible beneficiaries; and (3) preemption of duplicative State regulation. This legislation need to be re-introduced, debated and passed by both chambers.

29. The VA must re-institute marketing and outreach programs. Secretary Principi endorsed the termination of the VA's outreach program, which sought to inform eligible veterans of their statutory rights to benefits and services. The Secretary was attempting to lessen the demand upon the VA by cutting off the flow of information to veterans who truly need to have access to the unique services the VA provides. The Secretary's approach of imposed benign ignorance did a disservice to the veterans' community and the VA. The appropriate solution is more funding rather than fewer patients.

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

Congress must provide adequate resources to ensure that the NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the nation.

Congress should substantially increase funeral expenses and the plot-interment allowances.

Congress must provide adequate resources to ensure that the NCA can construct new national cemeteries for the interment of veterans and maintain and renovate existing facilities.

The NCA must also identify sites for the addition of national cemeteries in areas that remain unserved.

Congress should establish a program similar to the NCA's State Cemetery Grants Program (SCGP) to provide funding for the establishment, expansion or improvement of county-operated veterans cemeteries.

Since1980, NCA's Veterans State Cemetery Grants Program has awarded more than $482 million to 41 states, territories and tribal organizations for the establishment, expansion or improvement of 86 state Veterans cemeteries. In fiscal year 2011, NCA-supported veterans cemeteries provided nearly 29,500 interments.

Active Duty Military Quality of Life Issues:

1. Provide increased funding for military housing.

2. Support the National Guard and Reserve. The National Guard and Reserve are now a major component of the war on terror and Iraqi Freedom. Members of the Reserve and National Guard have been supporting our country in huge numbers since 1990 (Gulf War). However, the Reserve Component retirement system was last changed in 1947. When the Reserve retirement system was created in 1947, the retirement age for Reservists was identical to the age for civilian government employees (age 60), but civilians can retire at age 55 and reservists must wait until age 60. According to the Department of Defense, as of August 21, 2012 855,057 personnel have been activated from the Reserve and National Guard. In the interests of fairness, Congress must act to restore parity between the retirement age for civilian Federal employees and their Reserve counterparts.

The disparate treatment of Federal employees and Reservists would have been serious enough had the nature of the work performed by the Reserves not changed substantially over the past five decades. But America has never placed greater demands on its ready Reserve than it does now. Almost 200,000 reservists are serving their country in the war against terrorism at home, abroad, and in the conflict with Iraq. America's dependence on our ready reserve has never been more obvious, as reservists are now providing security at our Nation's airports and air patrols over our major cities. As Charles Cragin, the Deputy Assistant Secretary of Defense, noted over five years ago; ``The nature and purpose of Reserve service has changed since the end of the cold war. They are no longer weekend warriors. They represent almost 50 percent of the total force.''

With call-ups that last 12 months or longer and take Reservists far from home, serving the Nation as a Reservist has taken on more of the trappings of active duty service than ever before. Operation Iraqi Freedom, Operation Enduring Freedom and Operation New Dawn hve only further underscored the demands placed on the National Guard and Reserve. Before the war on terrorism began, reservists were performing about 13 million man-days each year, more than a 10-fold increase over the one million man-days per year the Reserves averaged just 10 years ago. These statistics, the latest numbers available, do not even reflect the thousands of Reservists who have been deployed since September 11 nor do they take into account the number of Reservists who have been deployed in the current military action against Iraq.

The Commission on the National Guard and Reserves issued its final report on January 31st, 2008.The Commission concluded that there is no reasonable alternative to the nation's continued increased reliance on reserve components as part of its operational force for missions at home and abroad. However, the Commission also concluded that this change from their Cold War posture necessitates fundamental reforms to reserve components' homeland roles and missions, personnel management systems, equipping and training policies, policies affecting families and employers, and the organizations and structures used to manage the reserves. These reforms are essential to ensure that this operational reserve is feasible in the short term while sustainable over the long term. In fact, the future of the all-volunteer force depends for its success on policymakers' undertaking needed reforms to ensure that the reserve components are ready, capable, and available for both operational and strategic purposes.

In reviewing the past several decades of intense use of the reserve components, most notably as an integral part of operations in Iraq, Afghanistan, and the homeland, the Commission found indisputable and overwhelming evidence of the need for policymakers and the military to break with outdated policies and processes and implement fundamental, thorough reforms in these areas. We agree with their findings and recommendations.

3. Provide adequate manpower, training and equipment for all forces in Iraq, Afghanistan and other fronts in the war on terror. Continued shortfalls in manpower, equipment, training and other necessary resources are inexcusable. All members of our Armed Forces, including Guard and Reserve members should be treated as equal partners in America's total force structure, equipped with all the assets necessary to perform their mission. Force protection must be viewed as more than simply equipment; it must also include realistic training and evolving techniques, tactics and procedures.

The long delays in providing personnel with adequate protection in the form of state-of-the-art body armor and up-armored vehicles is inexcusable for a Nation with the capabilities, talent and skills required to manufacture such goods. Our valiant servicemen and women deserve the support of our industrial might.

WE URGE THE FOLLOWING:

a) The continued opportunity for veterans' service groups to present testimony regarding a wide range of legislative priorities before a joint session of the House and Senate Veterans' Affairs Committees.

b) Continued top priority for outpatient treatment for any veteran in need of such care for a service-connected disability to ensure the quality of care is maintained.

c) Preservation of the independence of the VA Medical Centers and that their programs be maintained and continually improved. We oppose the closing of any VA Hospital where such closing would adversely affect the delivery of medical services to our veterans. There is a legitimate need for the VA to manage its resources consistent with the latest knowledge and techniques of healthcare. However, there are expectations that some hospitals will be closed, simply because the VA will not permit two hospitals in any locality such as in Chicago, Detroit, Boston, and New York. The higher concentration of older veterans during the summer months in the north and during the winter in the south and the greater the need for inpatient care which is in part the result of the need for treatment for Alzheimer's disease and dementia cases, belies the approach now being proffered by the VA. Moreover, the example of military base closings reflects a tendency for political considerations to rise above economic considerations in determining which facilities will be closed.

d) Continuation of the programs for vocational rehabilitation benefits for service-connected disabled veterans in need of such training;

e) Preservation of concurrent payments of VA and Social Security burial allowances and restoration of VA Burial Benefits to all veterans;

f) Service-connected death benefits for eligible survivors of deceased veterans whom, at the time of death, were permanently or totally disabled;

g) Veteran's disability entitlement shall not be deducted from the earned military retirement pension of any veteran. Great strides have been made in this area over the past two years, however many veterans are forced to endure a ten-year phase in of their benefits and many veterans see no change whatsoever. This is unacceptable.

h) Continuation of a realistic COLA increase in VA disability compensation rates that would bring the standard of living of service-connected disabled veterans more in line with that enjoyed by their able-bodied contemporaries;

i) Maintain the accountability of the Department of Veterans Affairs to Congress in matters concerning adjustments in the Rating Schedule, in construction and in case of the planned closing of VA medical centers or regional offices.

j) Congress to continue legislation permitting veterans to receive realistic travel allowances to VA regional offices, medical centers, and our state-run veterans' facilities.

k) Creation of a National Institute of Veterans Health within the National Institute of Health.

l) We strongly support closer DoD – VA collaboration and planning, including billing, accounting, IT systems, and patient records.

m) Enact legislation to test VA Medicare Subvention. Forty percent of enrolled veterans are Medicare eligible. VA Medicare Subvention may enhance older, non-disabled veteran's access to VA health

care and potentially save the government money by reducing duplicate spending for same services (in Medicare HMOs and VA facilities). We support testing VA Subvention.

n) Establish a Survivors Office within the VA headquarters solely to oversee survivors' issues.

o) Establish Women Veteran Coordinator positions at each VA Medical Center and Regional Office and at the VISN level.

p) Improve Education Benefits for Survivors and Dependents. Continue to make improvements in Chapter 35 provisions for education benefits to DIC widows and children in tandem with changes in the MGIB.

q) We urge the continued use and expanded use of information and telecommunications technologies to deliver care when patient and practitioner are separated by distance and/or time.

The most prominent area of need that is driving telemedicine technology in VA today is its application in home health care. VA's active programs have demonstrated that they can work, and that they can be used beneficially from both clinical and economic standpoints. Considering the geographic shift in the veteran population, and in the population as a whole; veterans are moving to areas that are less expensive to live in and are often remote from VA's large fixed hospitals.

Between July 2003 and December 2007, the Veterans Health Administration (VHA) introduced a national home telehealth program, Care Coordination/Home Telehealth (CCHT). Its purpose was to coordinate the care of veteran patients with chronic conditions and avoid their unnecessary admission to long-term institutional care. Demographic changes in the veteran population necessitate VHA increase its noninstitutional care (NIC) services 100% above its 2007 level to provide care for 110,000 NIC patients by 2011. By 2011, CCHT will meet 50% of VHA's anticipated NIC provision. CCHT involves the systematic implementation of health informatics, home telehealth, and disease management technologies. It helps patients live independently at home. Between 2003 and 2007, the census figure (point prevalence) for VHA CCHT patients increased from 2,000 to 31,570 (1,500% growth). CCHT is now a routine NIC service provided by VHA to support veteran patients with chronic conditions as they age. CCHT patients are predominantly male (95%) and aged 65 years or older. Strict criteria determine patient eligibility for enrollment into the program and VHA internally assesses how well its CCHT programs meet standardized clinical, technology, and managerial requirements. VHA has trained 5,000 staff to provide CCHT. Routine analysis of data obtained for quality and performance purposes from a cohort of 17,025 CCHT patients shows the benefits of a 25% reduction in numbers of bed days of care, 19% reduction in numbers of hospital admissions, and mean satisfaction score rating of 86% after enrolment into the program. The cost of CCHT is $1,600 per patient per annum, substantially less than other NIC programs and nursing home care. VHA's experience is that an enterprise-wide home telehealth implementation is an appropriate and cost-effective way of managing chronic care patients in both urban and rural settings. These programs in VHA have demonstrated reduced hospital admissions, clinic and emergency room visits resulting in an improved quality of life for our veterans.

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