DEPARTMENT OF VETERANS AFFAIRS

The President's Proposal:

- Fulfills commitments to the nation's veterans by
  - guaranteeing that veterans' disability claims are processed accurately and quickly; and
  - improving health care delivery by coordinating the medical care systems of the Departments of Veterans Affairs and Defense.
- Focuses medical care resources on treating disabled and low-income veterans; and
- Funds major expansion in cemeteries to prepare for increased demands.

Department of Veterans Affairs

Anthony J. Principi, Secretary

www.va.gov 202–273–4800

Number of Employees: 207,028

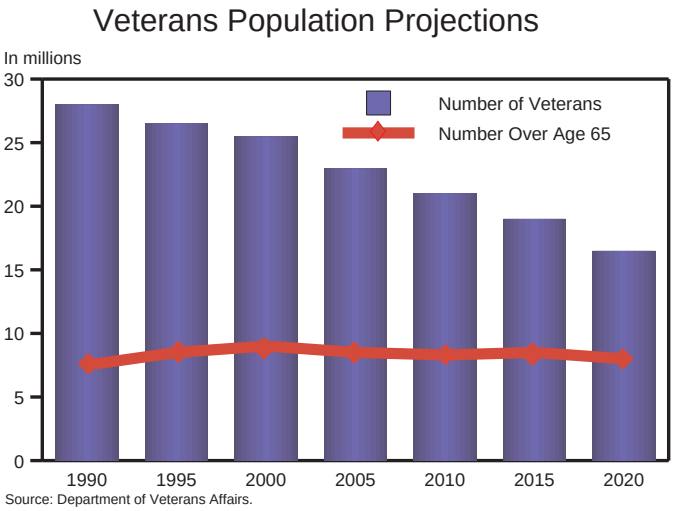
2002 Spending: $51.5 billion

Organization: Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration.

The Department of Veterans Affairs (VA) operates the largest direct health care delivery system in the country; administers veterans' benefits, including monthly disability payments, education assistance, life insurance, home loans, and vocational rehabilitation; and runs a nationwide system of veterans' cemeteries while awarding other burial benefits.

Overview

Today, there are 25 million veterans, but in the next 20 years this number will decline by one-third, to 17 million (as shown in the accompanying chart). Although VA is charged with providing services to the entire veteran population, fewer than one in five veterans participate in VA programs. The decline in population ultimately will mean that fewer veterans will seek medical care, monthly disability benefits, and burials at VA cemeteries. However, on the immediate horizon, there will be increased usage of some VA benefits and services, as veterans age and more women draw on them. The imperative of recognizing veterans' contributions to the nation means that VA's strategy, business plan, and infrastructure will need to adapt to ensure top-quality services and be flexible enough to handle changing dynamics and waning population.



Status Report on Select Programs

The Administration is reviewing the management of programs throughout the government. Poor performing programs that are not mission critical will be eliminated, cut back, or reconfigured so that their funding can be redirected to be more effectively used. The accompanying table rates the performance of some of VA's most important programs. Those with ineffective ratings are targeted for rapid improvement.

Program	Assessment	Explanation
Disability and Pension Claims Processing	**Ineffective**	VA systems and processes should be flexible to address an ever-changing, demand-driven environment. VA is automating its existing processes slowly but needs to identify and remedy the underlying causes of sluggish processing. It must modernize its information technology capabilities.
Care for Disabled and Low-Income Veterans	**Ineffective**	VA's medical care system's ability to provide timely and high-quality care to its core disabled and low-income veterans is being jeopardized by the rapid increase of other veterans receiving VA care.
Cemetery Benefits	**Effective**	The National Cemetery Administration strives to provide high quality, courteous, and responsive service in all of its contacts with veterans and their families. Of survey respondents, 92 percent rate the services provided by the national cemeteries as excellent. However, improvements can be made in cemetery system planning.

Program	Assessment	Explanation
Health Care Quality	**Effective**	VA is a recognized leader in health care quality and has been at the forefront of innovations such as bar coding of prescription drugs, computerized patient records, and medical error reporting.
Medical Care Infrastructure Assessment (CARES)	**Unknown**	VA has fallen eight months behind schedule on the first of 22 regional studies, and it is yet unclear whether future studies will benefit from correcting weaknesses identified in the first study.

Guarantee that Veterans' Disability Claims are Processed Accurately and Quickly

> *I must say that I think the VA has the necessary resources right now to do the job…the Agency can't justify asking for more people right now.*
>
> Vice Admiral Cooper (retired)
> *Government Executive*,
> November 8, 2001

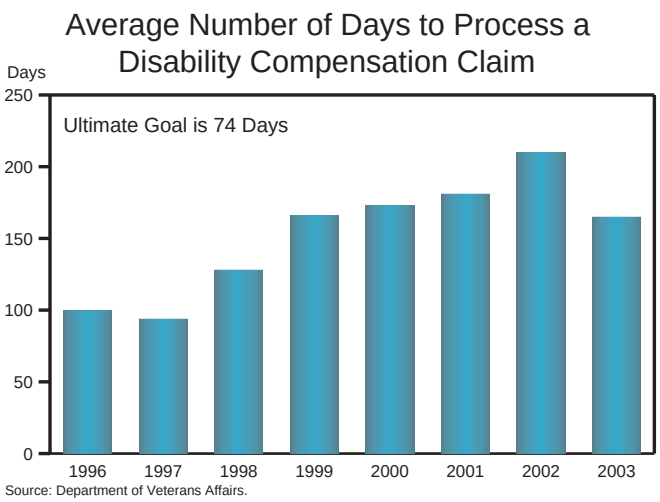
One of the President's top priorities is to make sure that when a veteran submits a claim for a disability, it is processed quickly and accurately. Disability benefits provide a monthly benefit to veterans who are disabled as a result of their military service. Currently, 2.3 million veterans receive these tax-free benefits. The amount awarded to a veteran depends on the severity of the disability. For 2002, the basic monthly benefit ranges from $103 for a 10 percent disability rating to $2,163 for a 100 percent disability rating. Roughly half of veterans receiving compensation are less than 30 percent disabled.

Improving the quality of life of the disabled is a national responsibility. And yet, the time and cost of processing disability claims have steadily increased. The average number of days to process a claim has risen from 100 days in 1996 to 181 days in 2001, and the number of claims awaiting a decision has jumped from 343,000 to over 644,000 during that same period. Meanwhile, the level of benefits paid increased by 27 percent in the past five years, while the cost of administering these benefits more than doubled.

VA benefits help veterans lead active lives.

There are three main reasons for continued poor performance. First, the complexity of the claims has increased because veterans are requesting benefits for more than one disability at a time. Second, laws and regulations are passed with immediate start dates—giving VA no lead time to handle the wave of new work required. Finally, VA has failed to effectively manage its nation-wide system of benefit offices.

To handle a growing backlog of claims, VA has repeatedly turned to hiring more and more employees. Since 1998, nearly 2,000 people have been hired to help process claims. Success, however, will ultimately depend not on hiring new employees, but on the application of modern information tools and, most of all, the establishment of true organizational accountability.



In October 2001, Vice Admiral Daniel L. Cooper (retired), who led the 14-member *Department of Veterans Affairs Claims Processing Task Force*, presented a final report to VA. The report concluded that, as a result of basic flaws in organization and communication, VA is unable to handle the effects of judicial decisions and legislative changes on workload. Productivity is poor, and so far management has proven incapable of introducing change and flexibility into the workplace.

VA should concentrate on radically changing the way it does business. These changes include identifying practices that work best at VA and enforcing their use across the country; allocating both work and funds to the best regional offices; creating specialized processing centers; and developing a computer system that allows people throughout the country to work on individual claims at the same time.

The success of these initiatives must and will be measurable. Speed should not come at the sacrifice of accuracy, or vice versa. VA will use the following two critical performance measures to ensure that its efforts are balanced:

- Process disability compensation and pension claims in an average of 165 days in 2003 (ultimate goal is 74 days—given the legal and medical complexities and VA's responsibility to help prepare claims); and
- Attain an 88 percent national accuracy rate for core rating work in 2003 (ultimate goal is 96 percent)

To deliver services quickly and effectively, it is just as important to establish a relationship between performance and resources, but VA has not done this. The Department cannot, for example, say that for every $500,000 increase in funding, timeliness and accuracy improve by measurable percentages. Until relationships like these are defined, it is impossible to figure out the optimal amount of funding for veterans' services.

Improve Health Care Delivery by Coordinating the Medical Care Systems of the Departments of Veterans Affairs and Defense

Although VA and the Department of Defense (DoD) both operate very large medical care systems with a combined cost of over $40 billion yearly, historically there has been little cooperation between the Departments. The Departments assert that the most common barriers have been different missions, patient populations, and cultures, as well as differing opinions on who would lead the effort. However, both Departments describe sharing efforts. Only $100 million—or one-quarter of one percent—of $40 billion in expenses passes from one to the other.

Unnecessary Paperwork

All veterans, by definition, were members of the Armed Services. While on active duty their (and their families') information was tracked by a system that covered everything from security clearances, to health care entitlements, to commissary privileges.

In an era of rapid high-tech changes, the minute veterans want to apply for VA benefits, they must provide pages of information on paper, that was already on computers at DoD. Likewise, when these same veterans later apply for other VA benefits, they start the process all over again.

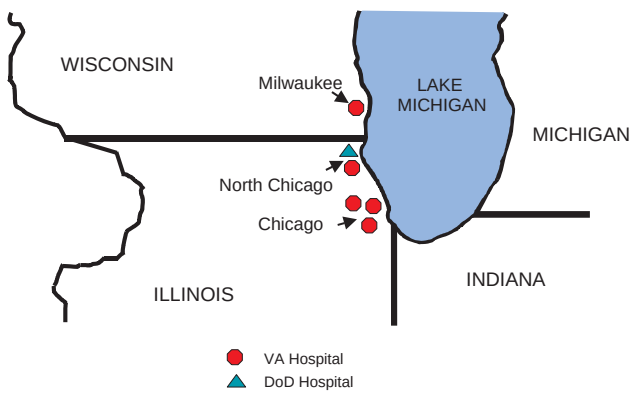
Sharing information and technology can make a world of difference to the military and veteran communities. It can speed up service, ensure veterans' safety, and inform veterans of entitlements that they are due. In addition, information sharing can transmit important knowledge through the departments' walls—replacing the myth that they have little in common.

In many communities, VA and DoD hospitals are close to each other and offer similar services (e.g., primary care, surgery, or eye care). However, traditionally neither has considered the other as an option in determining construction or health delivery needs. In light of the new emphasis on sharing, the DoD and VA are working together to solve mutual problems in the Greater Chicago area, where currently there are five VA hospitals and one DoD hospital as shown in the map. DoD needs more space and had plans to build a new hospital within walking distance of a near-empty VA hospital. Now VA and DoD are planning to jointly share this hospital and save a significant amount of money by reducing construction of new buildings.

Failure to Communicate

Military retirees can use both DoD and VA medical care systems. Today, many selectively use both. When a retiree goes to VA for services one week and DoD the next, serious errors can result if the doctors do not know what others have done. Despite information sharing efforts within VA, if drugs ordered in each system have adverse interactions, patients may become gravely ill or die.

Chicago Area VA/DoD Hospitals



Source: Department of Veterans Affairs.

The lack of sharing resources and information also results in a waste of the taxpayers' money. This has frustrated the Congress, which has mandated experimental programs for sharing buildings and people. In addition, the Congress has asked VA and DoD to work together to purchase drugs and other medical supplies at a lower price, resulting in savings to the government.

Patient Transportation

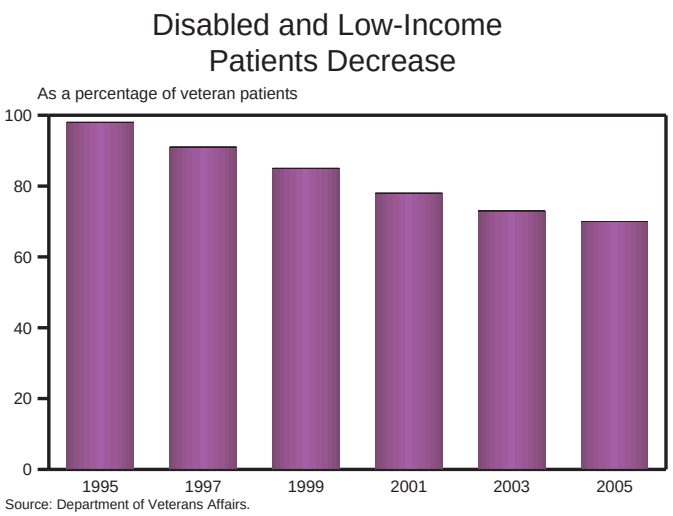
If a veteran needs to be moved long distances from one VA hospital to another, he is typically transported via commercial airline. This is very expensive. DoD routinely transports military patients in planes with unused space. VA and DoD are negotiating how to put VA patients on DoD planes, thereby lowering the cost to both departments.

President Bush made it one of his top priorities to coordinate the two systems. Four areas have been identified as high-priority for coordination: veteran enrollment; computerized patient records; cooperation on air transportation of patients; and facility sharing instead of new construction. The President established a task force that will make recommendations this year to improve the coordination between the two Departments' health care systems.

Moreover, the President's Management Agenda includes an initiative to increase coordination and delivery by VA and DoD of veterans' benefits and services. Over the past year, VA and DoD have undertaken an effort to improve cooperation and sharing in several areas by a reinvigorated VA/DoD Executive Council.

Focuses Medical Care Resources on Treating Disabled and Low-Income Veterans

A 1996 law, allowing VA to treat patients in the most practical settings, changed the way VA delivers care to veterans in very much the same way as the private sector changed. For example, the Department now provides most of its care in clinics and homes instead of in hospitals. This shift has allowed VA to spend its resources more effectively and has provided patients with more convenient service. At the same time, patients have also benefited from new innovative safety and quality systems. Today, VA is recognized as a world leader in quality medical care.



The same 1996 law also required VA to enroll veterans for medical care in one of seven distinct priority levels. Veterans with military disabilities or low-incomes are in the higher priority levels to preserve VA's core mission. All other veterans fall into the lowest level. The enrollment process requires VA's Secretary to announce, prior to the beginning of each fiscal year, what priority levels of veterans are eligible to receive care given the level of funding enacted into law. Each year since, VA has announced that all veterans are eligible to receive care. When eligible for care, a veteran is entitled to receive the full basic benefits package of services.

Prior to the 1996 law, veterans in the lowest priority level were only treated on a space-available basis, and were restricted as to what care they could receive and where they could receive it. However, since the law took effect, these veterans have grown from two percent to over 21 percent of VA patients as shown in the chart above. They have always been required to pay for a minor portion of their care by the use of co-payments. But given their rapidly escalating numbers, these veterans will consume a critical portion of VA resources at the expense of the disabled, poorer veteran population unless they are required to pay a greater portion of their care. The budget proposes a new $1,500 annual deductible amount for these veterans, whereby they would pay 45 percent of the charge until their out-of-pocket expenses total $1,500.

Although VA has changed the way it provides care to veterans, its buildings are relics of the past. VA's buildings are not located where most veterans live. Although many veterans have moved to the South and Southwest (where waiting times for appointments have grown), VA still maintains underused hospitals throughout the North and East regions of the country (where few seek such services). The General Accounting Office (GAO) reported that VA was wasting up to $1 million a day in keeping these hospitals operating. VA should be expanding the number of clinics where disabled and low-income veterans are living and converting many of its massive hospitals to more efficient clinics, where needed. To do this, VA began a review process in the first of its 22 regions in the fall of 2000. This process is known as Capital Asset Realignment for Enhanced Services (CARES).

The contractor's recommendations were completed June 2001, but VA has not yet decided how to proceed in the other 21 regions. In addition, VA has not modified its contract methods to correct some deficiencies identified in the first study. Savings identified will be used to provide care to veterans in the same or other geographical areas.

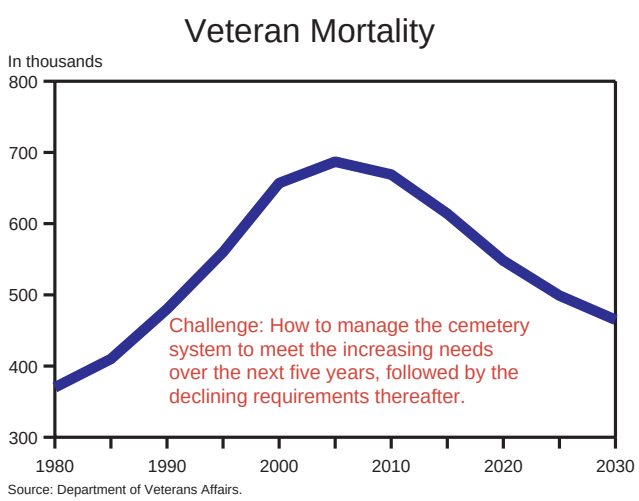
Funds Major Expansion in Cemeteries to Prepare for Increased Burial Demands

VA cemeteries are rated excellent by almost all.

Over 90 percent of family members and funeral directors who have recently received services from a national cemetery rate the quality of VA's burial services as excellent. By the end of 2002, VA will operate 120 national cemeteries and over 40 VA-funded state cemeteries providing burial services for almost 100,000 veterans and eligible family members per year. VA's goal is to ensure compassionate and good service, while searching for more efficient ways of doing business. For example, kiosk information centers are being placed in cemeteries to assist visitors in finding exact gravesite locations. In addition, VA orders almost all headstones by computer to shorten the waiting times for families.

Soon, VA will have a major challenge in determining the appropriate number, location, and mix of national and state cemeteries as the veteran population continues to decline and as deaths peak over the next decade (see accompanying chart).

One of VA's key goals is to ensure that most veterans have a national or state veterans' cemetery within 75 miles of their home. The recent opening of several new cemeteries, with more on the way, has helped improve veteran access to burial to 73 percent in 2001. Planned performance for 2003 is 76 percent. VA will never be able to accomplish 100 percent, nor should it. It is not cost-effective to construct new national cemeteries in regions with few veterans. Therefore, VA must reevaluate how best to economically maximize caring for the largest number of deceased veterans and their families. To date, though, VA has not defined the minimum number of veterans that national and state cemeteries should serve before construction is justified. Nor has the department suggested substitute benefits that might be appropriate for veterans in under-populated areas.



Strengthening Management

Although VA has made some progress in addressing its financial performance shortcomings, it has made little progress elsewhere. The Department is working to develop a satisfactory plan to achieve the President's goals for competitive sourcing, E-Government, and human resources. The scorecard below shows VA's 2001 status on the President's management initiatives.

Initiative	2001 Status
Human Capital—VA, like most other federal agencies, faces human capital challenges when its aging workforce retires and leaves gaps in critical skills such as disability claims adjudicators (where it takes several years to train new employees in complex medical and legal skills). The Department will revise its current plan to incorporate more detailed methods of tackling this challenge with clear deliverables and deadlines. In addition, VA will examine the different pay options it has available in order to ensure that geographic shortages of critical medical care providers can be addressed.	
Competitive Sourcing—Nearly half of all federal employees perform tasks that are readily available in the commercial marketplace. The Department is developing a plan to meet the Administration's goal of allowing the private sector to compete commercial functions currently done by the government.	
Financial Management—VA has persistent problems with internal controls, which include nine material weaknesses, all of which have been carried over from prior years. However, VA has developed a financial management plan to address its problems, and is now moving towards implementing an acceptable financial system.	
E-Government—Historically, VA has made major information technology (IT) decisions without thorough analysis. For example, the Department does not coordinate its planning and investment processes, and does not fully develop its justifications for major IT projects. It also lacks an enterprise architecture to make IT investment decisions. In early 2002, VA will produce a timetable for completion of its enterprise architecture. The department also is committed to providing qualified business cases by March 2002.	
Budget/Performance Integration—VA cannot monitor with sufficient precision the cost and effectiveness of many of its programs. For example, VA used the Hepatitis C crisis to argue for, and receive, $0.7 billion of additional funding specific to this cause for the three years beginning with 2000. However, VA has been unable to track the expenditure of this amount to Hepatitis C care, to determine how and if the funding changed performance, or report on how veterans have been served nationwide. While VA is working on a comprehensive patient Hepatitis C tracking system, no plans to link this performance with budget have been addressed. VA will present a timetable and plan to link key performance goals throughout the Department with funding levels by June 2002.	

Department of Veterans Affairs

(In millions of dollars)

	2001 Actual	Estimate 2002	Estimate 2003
Spending:			
Discretionary budget authority:			
Medical Programs:	*21,352*	*22,529*	*24,023*
Medical Care	20,920	22,071	23,537
Medical Collections (non-add)	*771*	*1,051*	*1,489*
Medical Administration	69	74	77
Medical and Prosthetic Research	363	384	409
Construction:	*361*	*523*	*536*
Major Construction	66	183	194
Minor Construction	170	211	211
Other Construction	125	129	132
Veterans Benefits Administration:	*1,049*	*1,166*	*1,408*
Benefits Administration:			
Existing Law	883	998	1,039
Legislative Proposal	—	—	20
Credit Administration	166	168	172
VETS State Grant Awards:			
Existing Law	—	—	—
Legislative Proposal	—	—	177
Other:	*401*	*439*	*479*
General Administration	235	253	278
General Administration (credit)	4	5	5
Inspector General	48	55	58
National Cemetery Administration	114	126	138
Subtotal, Discretionary budget authority adjusted [1]	23,164	24,657	26,447
Remove contingent adjustments	–789	–831	–891
Total, Discretionary budget authority	22,375	23,826	25,556
Emergency Response Fund, Budgetary resources	—	2	—
Mandatory Outlays:			
Veterans Benefits Administration:			
Compensation and Pensions	21,420	24,905	26,421
Montgomery GI Bill Benefits	1,623	2,235	2,569
Insurance	1,231	1,287	1,315
Credit	333	704	342
All other programs and receipt accounts	–1,923	–2,181	–368
Subtotal, Mandatory outlays	22,684	26,950	30,279
Credit activity:			
Direct Loan Disbursements:			
Veterans Benefits Administration:			
Native American Direct Loans and Transitional Housing for Homeless Veterans Loans	2	3	15

	2001 Actual	Estimate 2002	Estimate 2003
Vendee and Acquired Loans	1,470	1,815	1,922
Education and Vocational Rehabilitation Loans	2	3	3
Subtotal, Direct loan disbursements	1,474	1,821	1,940
Guaranteed Loans:			
Veterans Benefits Administration:			
Veterans Home Loan Program	31,138	32,067	32,665
Subtotal, Guaranteed loans	31,138	32,067	32,665

[1] Adjusted to include the full share of accruing employee pensions and annuitants health benefits. For more information, see Chapter 14, "Preview Report," in *Analytical Perspectives*.

DEPARTMENT OF VETERANS AFFAIRS

The President's Proposal:

- Is the largest annual increase ever requested by a President;
- Refocuses medical care resources on treating veterans with military disabilities, low-income or special needs;
- Fulfills commitments to the nation's veterans by:
  - — Guaranteeing that veterans' disability claims are processed accurately and quickly; and
  - — Improving health care delivery by coordinating the medical care systems of the Departments of Defense and Veterans Affairs; and
- Funds a major expansion in cemeteries to prepare for increased burial demands, due to the aging of veterans.

The Department's Major Challenge:

- Managing the large increase in demand for health care services.

Department of Veterans Affairs

Anthony J. Principi, Secretary

www.va.gov 202–273–4800

Number of Employees: 211,764

2003 Spending: $56.9 billion

Infrastructure: VA owns 30,217 acres of land and 5,558 buildings; VA operates 163 hospitals, 850 ambulatory care and community-based outpatient clinics, and 120 national cemeteries.

Organization: Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration.

The Department of Veterans Affairs (VA) operates the largest direct health care delivery system in the country. VA also supports medical research; administers veterans' benefits including monthly disability payments, education assistance, life insurance, home loans, and vocational rehabilitation and employment services to veterans. In addition, VA runs veterans' cemeteries across the country. The President's 2004 request for VA represents more than a 30-percent increase over the 2001 level and is the largest annual increase ever requested by a President.

Overview

Today, there are 26 million veterans, but in the next 20 years this number will fall by one-third, to 17 million. Although all veterans are eligible for VA services, fewer than six million veterans

participate in its programs. A declining population eventually will mean that fewer veterans will seek medical care, monthly disability benefits, and burials at VA cemeteries. On the immediate horizon, however, veterans healthcare and other costs have continued to rise.

Refocusing Medical Care's Core Mission

VA benefits help veterans lead active lives.

In 1996, a law was passed allowing VA to treat all veterans in the most practical settings. This law permitted VA to deliver care similar to the private sector. As a result, most VA care is now provided in clinics and homes instead of hospitals. Patients have also benefited from new innovative safety and quality systems. Today, VA is recognized as a world leader in quality medical care, as described by an Institute of Medicine October 2002 report.

VA is working to ensure its facilities are located where most veterans live to support this new way of delivering services. Many veterans have moved to the South and Southwest resulting in increased waiting times for appointments. At the same time, VA maintains many underused hospitals throughout the North and East. VA needs to increase services where veterans with military disabilities or low-incomes live and convert many of its massive hospitals to more efficient clinics, where needed. To do this, in June 2001, the Department completed a review process in the first of 21 regions, the Chicago region, and is now implementing the recommendations. Work has begun in the remaining 20 regions, and a nationwide plan for change is expected this fall. The budget provides $225 million of needed construction funding.

The 1996 law also required VA to assign veterans receiving medical care to one of seven priority levels. An eighth priority level was later added. These levels are designed to prioritize the need for care among veterans, thus giving greatest preference to those with the most severe health problems and the least financial resources. Veterans with military disabilities, low incomes or special needs are given higher priority levels in line with VA's core mission. Veterans without these characteristics fall into the lowest levels (Priority Levels 7 and 8). Based on the level of funding provided by the Congress, the VA Secretary announces annually which priority levels of veterans are eligible to receive care. Each year since 1998, VA has announced that all veterans are eligible to receive care. Eligible veterans, regardless of income or the nature of their illness or injury, are entitled to receive the full basic benefits package of services. Prior to the 1996 law, veterans in the lowest two priority levels were only treated if space was available, and they were restricted as to the kind of care they could receive and where they could receive it. However, since the law passed, these veterans have grown from two percent to over 31 percent of VA enrollees in 2002. The rapidly escalating numbers of these veterans will require a growing portion of VA resources, reducing the resources available for veterans with disabilities or low incomes. As a result, 236,000 veterans now must wait six months or longer for an appointment.

The President's Budget includes a number of changes that refocus attention on VA's core medical care mission of providing needed services to veterans with military disabilities or low incomes as well as those with special needs. It assumes that, in early 2003, Priority Level 8 veterans will not be able to enroll if they are not yet using VA medical care. However, Priority Level 8 veterans currently enrolled will not lose that status. Priority Level 7 and Priority Level 8 veterans will pay an annual enrollment fee, and increased drug co-payments. Institutional long-term care will only be available

The VA Company Store

Congress created the Veterans Canteen Service in 1946 to furnish merchandise and services for the comfort of veterans in VA hospitals and nursing homes. In 57 years the Canteens have evolved from a collection of soda fountains and closet-sized hospital gift shops into a nationwide system of 148 commercial food courts and/or retail outlets—where one can even buy computers, large-screen televisions, tires, and refrigerators. The 3,000 employees that work in this "VA Company Store" provide services commonly found in local markets. Taxpayers pay since VA provides below-market rental space to more than half of the Canteens, and because purchases from the Canteen are tax-free. The Canteen Service should be open to private competition—on an equal basis with other bidders—to ensure the best use of taxpayer funds.

to veterans with disability ratings of 70 percent or greater. No veterans currently receiving care will be displaced.

Increasing Coordination between VA and the Department of Defense (DoD)

Initiative	Status	Progress
Coordination of VA and DoD Programs and Systems		

Over 700,000 veterans each year use both VA and DoD for medical care services. However, neither Department can access the other's computerized enrollment information or patient records. This causes an increased burden on veterans, an inability to manage a patient's care safely, and duplication of effort and cost. In addition, there are scores of VA and DoD facilities in the same geographic areas that would benefit from sharing services and space.

In the past year, top leadership at DoD and VA created a joint Executive Council that began to implement changes in five key areas:

Information Technology: VA has agreed to use DoD's eligibility and enrollment system—providing veterans with seamless services as they leave the military and apply for benefits at VA. The Departments also are working on computerized patient medical records that will allow instant exchange of patient information by the end of 2005. Both joint efforts will reduce costs, increase efficiency, and escalate the pace of coordination.

Common Medical Business Practices: The Departments recently agreed upon the costs of sharing specific services. In the future they will address common business processes for medical coding, billing and collection, financial management, and budget development.

Shared Hospitals and Equipment: Despite administering a combined 240 hospitals, DoD and VA operate only seven joint ventures. These existing ventures include a hospital that shares services and staff as well as sites where DoD and VA hospitals are co-located. This year, VA and DoD will test sharing arrangements that use the same business practices and medical supplies and drugs.

Coordinated Human Resources: Currently, staff coordination is limited to a few locations. The Departments have recently initiated coordinated staff training programs. As a first step, the Army is sending four cardiac surgeons to work in VA hospitals on a three-year training assignment for increasing skills, reducing costs, and providing VA with additional support.

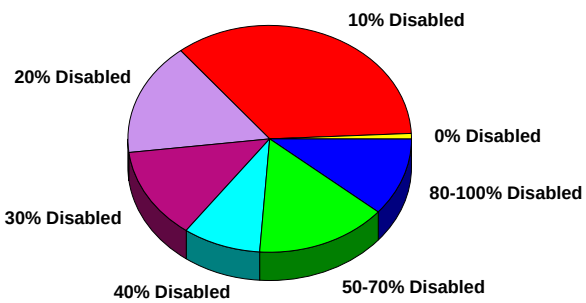
Other Cooperation: High-level DoD and VA officials have made medical care coordination a high priority. It is also one of the 14 priorities in the President's Management Agenda. In the past year, the Departments increased VA's use of DoD's patient air transport system. Early results have generated savings for VA while providing DoD with more training opportunities. The two Departments have increased joint procurement activities for medical supplies, equipment, and pharmaceuticals, and are testing whether DoD should use VA's mail order pharmacy system.

Readying Veterans' Disability Compensation for the Future

Monthly veterans' disability compensation checks are a benefit to veterans who have a disability connected to their military service. It is the workers' compensation program for the armed forces. Like other federal and state workers' compensation programs, VA's benefits complement retired pay and disability annuities provided by DoD. Currently, 2.3 million veterans are receiving these tax-free benefits from VA. The amount awarded to a veteran depends on the severity or degree of the disability. For 2003, the basic monthly benefit, set in law, ranges from $104 for a 10 percent disability rating to $2,193 for a 100 percent disability rating. Many veterans receive additional amounts for having dependents, severe disabilities, or being housebound—as much as 70 percent above the basic benefit. As the accompanying chart indicates, 65 percent of veterans receiving compensation are rated at 30 percent disabled or less—with diseases such as arthritis, diabetes, and high blood pressure.

Improving the quality of life of veterans with disabilities is a national responsibility. To this end, veterans' disability claims should be quickly processed. The processing of disability claims has been especially challenging for VA, not only because of the sheer scope and size of the program, but also because new legislation and regulation further expanded benefits and, therefore, the number of claims needing review. As such, much of VA's focus in 2002 was on reducing the backlog of claims from 644,000 to 501,000.

Over Half of Veterans Receiving Benefits Are Less Than 30% Disabled



Source: Department of Veterans Affairs, 2001 data.

Is Yesterday's Disability Today's?

Disabled veterans are assumed to earn less after military service than non-disabled veterans. Yet no study to measure the income loss associated with each specific disability has been conducted since 1945. Over the years, new types of disabilities have been added continually, but old ones are rarely removed. Many of the covered disabilities are not commonly associated with a loss of earnings today—such as acne scars, hemorrhoids, arthritis and ulcers. As such, benefit payments are unlikely to reflect actual income loss; in fact, they may be too low or too high.

VA's aggressive management and hiring of new claims examiners accounts for the reduction in the backlog. Both claims examiners and their supervisors have been subject to increased accountability and held to performance standards with real consequences. Performing offices get more resources and more work. Non-performing offices are continually monitored and challenged to improve—risking the loss of resources, work, and ultimately, their top management. VA has both timeliness and accuracy performance measures to ensure that its efforts are balanced. As a result of VA's focus, the number of days to process a claim will drop from 209 in 2002 to 100 in 2004. During this same timeframe accuracy will increase from 80 percent to 90 percent.

Having dealt effectively with a tidal wave of work, VA anticipates that both its workforce and workload will stabilize in 2004, and VA is poised to lay the groundwork for future challenges. For example, some automation has occurred at VA. The current process for reviewing claims looks very much the way it did in the 1940s, with voluminous paper files and examiners heavily dependent on retrieving

records from far-flung warehouses. Since veterans tend to apply for increased benefits decades after separation from the military, the location and quality of these records are often difficult to establish.

VA now has the opportunity to accelerate the development of a system where information is viewed on computers, thereby allowing people to work on a claim at the same time in different places around the country. This involves accepting all new claims electronically, making electronic copies of existing files, and sharing medical exams with DoD. In 2004, VA will conduct an evaluation of the disability compensation program, in part, to examine whether the program improves the quality of life of veterans with disabilities while truly replacing lost income. The evaluation will compare the income of veterans who are and those who are not receiving disability compensation payments.

Expanding the Cemetery System for Increased Burial Demands

In 2003, almost 110,000 veterans, service members, and eligible family members will be buried in 120 VA national cemeteries and 54 VA-funded state veteran's cemeteries. The veteran population continues to decline as veteran's mortality increases. VA's major challenge is determining the appropriate number, location, and mix of national and state cemeteries to address the increased need. VA seeks to ensure accessible and compassionate service, and it is succeeding. Over 90 percent of family members and funeral directors who have recently received services from a national cemetery rate the quality as excellent. For example, VA orders almost all headstones electronically to shorten the waiting times for families. And kiosks are placed in cemeteries to assist visitors in locating gravesites. VA will open four cemeteries in 2004.

The Burial Benefits program has earned a high rating using the Program Assessment Rating Tool (PART), due to the program's clear mission and effective management. Improvement, however, can be made in strategic planning. VA made great progress recently when it released an ultimate configuration of the cemetery system, which prioritized future construction efforts and defined the minimum number of veterans that national cemeteries should serve before construction is justified. Furthermore, to enhance the appearance of cemeteries to those befitting national shrines, VA has received $25 million in additional funds over the last three years. However, it lacks a way to define needs and performance measures. The Department is addressing this weakness.

Common Measures

Health Care

The federal government is developing a set of common measures for five functions performed in different departments. Such measures will allow comparisons regarding the effectiveness and efficiency of similar programs. The 2004 Budget takes the first step toward assessing the performance of federal health care systems by displaying newly developed access, quality, and efficiency common measures for VA's and DoD's health systems, as well as the Department of Health and Human Services' Community Health Centers and Indian Health Service.

When looking at the results of common measures, it is important to understand key differences in programs for a proper context. The cost and efficiency measures below have not been adjusted for differences between VA and other agencies— including risk/health status, socioeconomic status, age, gender, and benefit package differences. For example, VA's benefits package includes services such as spinal cord and traumatic brain injury care, long-term care, and care to the seriously mentally ill, which are not prevalent in all other programs and which impact resource needs.

Overview of the Veteran's Affairs Health Care System

	2004 estimate
Number of individual patients	4,836,298
Annual appropriations request (in millions of dollars)	27,547,424
Medical workers	19,318
Average age of individual patients	60.3
Male and female individual patients (percent)	91% (Male) 9% (Female)
Cost directed to in-house services, excluding contract services (percent)	95%

Health Care Common Measures

2001 and 2002

Measure/Description	Goal	2001 Actual	2002 Estimate
Cost—Average cost per unique patient (total federal and other obligations)	Under Development	$5,019	$4,928
Efficiency—Annual number of outpatient visits per medical worker	Under Development	2,487	2,719
Quality—The percentage of diabetic patients taking the HbA1c blood test in the past year	Under Development	93%	93%

Note: Research funding is excluded. Medical workers include the equivalent number of full time physicians, dentists, nurse practitioners, physician assistants, and nurse mid-wife providers, but exclude appointments by off-site contractors medical residents/interns and trainees. However, patient visit numbers include visits to medical residents, contracted employees, and trainees. Cost information includes all direct costs of military health care in the DoD budget and in the trust funds.

Job Training Common Measures

The job training measures, which will be applied to VA's Vocational Rehabilitation and Employment program, gauge program results in four areas: entered employment, retention in employment, earnings increase, and efficiency. VA has begun collecting information on these measures and will begin reporting results in 2005.

Performance Evaluation of Select Programs

The following table rates the performance effectiveness of some of VA's most important programs. Sometimes these factors fall outside a department's control, but in most instances the burden for delivering results appropriately rests on an agency's management. For further details on these programs, please see the VA chapter in the *Performance and Management Assessments* volume.

Program	Rating	Explanation	Recommendation
Disability Compensation	Results Not Demonstrated	The program provides financial benefits for income loss due to service-related disabilities. The PART revealed that VA currently provides benefits for disabilities that are not considered a barrier to productive employment, as it is based on 1945 standards.	The 2004 scheduled program evaluation should examine if the program reflects medical technology and changes in workplace conditions since 1945, if benefit amounts reflect income loss experienced by disabled veterans, and how it complements or conflicts with other programs.
Medical Care	Results Not Demonstrated	The VA provides health care to an estimated 4.4 million veterans. While the quality of care for those veterans in the system is exceptional, results cannot be demonstrated because there is no clear consensus among Congress, the Administration, and the public on who should be offered care. While all veterans are currently offered care, waiting lists are growing and VA can not easily focus on poor and disabled veterans. VA's medical care mission, its goals, and how to achieve them need to be clarified.	VA should continue to realign the infrastructure crucial to caring for veterans' needs. Services and resources should be re-focused on veterans with service-connected disabilities, those with low incomes, and those with special needs.
Burial Benefits	Moderately Effective	This program provides high quality, courteous, and responsive service to veterans and their families. Of surveyed respondents, 92 percent rate the services as excellent. However, strategic planning improvements can be made.	Areas for improvement identified in the PART are: additional performance measures for the National Shrine Commitment and monetary benefit; a management accountability system; and a cost accounting system. VA is working on these items.

Update on the President's Management Agenda

	Human Capital	Competitive Sourcing	Financial Performance	E-Government	Budget and Performance Integration
Status					
Progress					

Arrows indicate change in status since baseline evaluation on September 30, 2001.

VA has made significant progress in these areas. The Department will compete 52,000 jobs over the next five years (such as laundry, food and sanitation services), with an estimated cost savings of approximately $3 billion. VA initiated the first phase of its new electronic financial management system and is resolving most material weaknesses reported in its audit. The Department developed an overarching Enterprise Architecture for all its Information Technology (IT), successfully justified IT projects in the budget, and expanded its participation in E-Gov initiatives. VA not only submitted its 2004 budget on time, but also completed a comprehensive budget restructuring.

Department of Veterans Affairs

(In millions of dollars)

	2002 Actual	Estimate	
		2003	2004
Spending:			
Discretionary budget authority:			
Medical Programs	22,256	23,609	26,228
Medical Care	21,500	22,815	25,406
[Medical Care Collections] (non-add)	*985*	*1,616*	*2,141*
Research	756	794	822
Benefit Programs	1,378	1,422	1,483
Disability Compensation	603	610	621
Pension	156	155	152
Education	75	97	99
Vocational Rehabilitation and Employment	120	132	135
Housing	168	171	207
Insurance	4	4	4
Burial Benefits	252	253	265
Departmental Administration	306	327	346
General Administration	252	271	284
Inspector General	54	56	62
Total, discretionary budget authority	23,940	25,358	28,057
Mandatory outlays:			
Medical Programs	36	32	34
Benefits Programs and Receipts	27,070	31,860	34,042
Disability Compensation			
Existing Law	22,418	25,013	26,906
Legislative Proposal	—	—	−124
Pension	3,166	3,290	3,384
Education	1,440	1,957	2,144
Vocational Rehabilitation and Employment	484	529	561
Housing	754	1,119	301
Insurance	1,198	1,236	1,248
Burial Benefits	134	157	162
Other receipts and transactions	−2,524	−1,441	−540
Departmental Administration	−214	−4	13
Total, mandatory outlays	26,892	31,888	34,089
Credit activity:			
Direct loan disbursements:			
Benefits Programs			
Vocational Rehabilitation Loans	3	3	4
Native American Veteran Housing Loans	6	13	13
Vendee and Acquired Loans	1,058	311	284
Total, direct loan disbursements	1,067	327	301
Guaranteed loans:			
Benefits Programs			
Veterans Home Loans	37,071	34,800	35,247
Loan Sales	967	471	—
Total, guaranteed loans	38,038	35,271	35,247