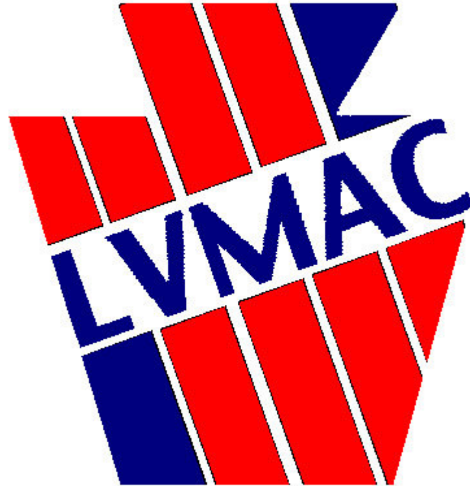
Lehigh Valley Military Affairs Council



Veterans Benefits Services Report:

A Study on Compensation and Pension Claims Services

in the

Lehigh Valley and Commonwealth of Pennsylvania

3 June 2004

Lehigh Valley Military Affairs Council
P.O. Box 22522, Lehigh Valley, PA 18002-2522
Email: info@lvmac.org Web: www.lvmac.org

Revision: 30 September 2004
(See Page 25 for list of revisions)

STUDY ON COMPENSATION AND PENSION SERVICES

TABLE OF CONTENTS

EXECUTIVE SUMMARY iii

PART 1: INTRODUCTION 1
- A. THE ORIGIN OF THIS STUDY 1
- B. THE PURPOSE 1
- C. THE SCOPE 1
- D. THE LIMITATIONS 2

PART 2: DISCUSSION – THE SITUATION FROM A STATISTICAL POINT OF VIEW 3
- A. THE "BUDGET" POINT OF VIEW 3
- B. THE UTILIZATION (USE OF THE SYSTEM) POINT OF VIEW 4
- C. RECAPPING THE SITUATION 5

PART 3: DISCUSSION – ANALYSIS FOR CAUSES FROM A STATISTICAL POINT OF VIEW 6
- A. THE FACTOR OF POPULATION SIZE – THE DENOMINATOR EFFECT 6
- B. THE AGE FACTOR 6
- C. THE PERIOD OF SERVICE FACTOR 7
- D. THE DISABILITY PROFILE FACTOR 7
- E. PERSONAL FINANCES AS A FACTOR 7
- F. THE EFFICIENCY OF THE REGIONAL OFFICE 9
- G. THE VOLUME OF CASES PER ANNUM 10
- H. AWARENESS AS A FACTOR 10
- I. MANPOWER AND ITS EFFECT 11
- J. THE EFFECT OF POINTS OF SERVICE (NODES) 15

PART 4: DISCUSSION – WHAT OTHER STATES DO 15
- A. THEMES FOR SUCCESS 15
- B. WHAT PENNSYLVANIA DOES 17

PART 5: DISCUSSION – WHERE WE COULD BE 19

PART 6: SYNOPSIS – ANECDOTAL EVIDENCE IS CONFIRMED 19

PART 7: CONCLUSION 22

PART 8: RECOMMENDATIONS – SEEKING SOLUTIONS 23

Appendices:
- A - Charts
- B - Tables
- C - Minutes of 18 November 2003 Meeting and Attendees
- D - Other States' SDVA Fact Sheets
- E - Benefits Goal for the Lehigh Valley
- F – Glossary

EXECUTIVE SUMMARY

This study examines the status of non-medical benefits being provided to, or spent on behalf of, Lehigh Valley (Lehigh and Northampton counties) veterans. It also provides medical benefits information for comparison and information purposes. It was prompted by discussions with various veterans and federal, state, county, and veteran organization officials, which raised serious concerns about the quality and quantity of support being provided to local veterans. The Lehigh Valley Military Affairs Council tasked its Veterans Affairs Committee to analyze these concerns and to make recommendations, where warranted, to improve veterans' support.

This report was not underwritten, sponsored or funded by any other agency, organization or individual. LVMAC is solely responsible for its content.

Since the two counties cannot be considered in isolation, the entire Commonwealth was included in the study. The study focused primarily on the compensation and pension program, one of the Department of Veterans Affairs' two major programs, and the typical "gateway" to the veterans' healthcare program, the DVA's other major program.

This study found that Lehigh and Northampton counties are near the bottom of Pennsylvania counties in non-medical benefits provided to veterans, and that Pennsylvania generally places in the lower third among its "peer" states. By one measure Lehigh Valley veterans receive $1,000 (53%) a year less in total compensation, pension and services than the national average. It is worth noting that Lehigh Valley veteran medical patients each receive $2,000 (39%) less annually in medical treatment than the national average.

Quantifying service to veterans in terms of caseload reveals similar results. The Lehigh Valley veteran population has fewer compensation and pension cases (38% less) than the national average and Pennsylvania ranks in the bottom fourth of all states (19% below the national average). Lehigh Valley veterans also have fewer medical patient recipients per veteran population (45% less) than the national average.

Why then, are Lehigh Valley veterans being underserved? Inconvenient access and the lack of accredited veterans service officers reduce the number of claims processed and reduce the benefit amounts of claims that are processed. This reinforces the fact that access (participation), for whatever reason, is the root of the problem.

This study also researched other factors that affect veterans' need for assistance: their relative health and wealth. Are local veterans healthier than their peers? No. Considering their age, period of service and disabilities, Lehigh Valley veterans should actually be heavier users of their entitlements. Are our veterans more affluent (as measured by median household income) than their peers, thus needing less reliance on a government-funded program? Yes, slightly so. But there are states with even more affluent populations that serve veterans much better than Pennsylvania.

A survey of states (good and poor performers) suggests that there is a relationship between the ratio of properly trained service officers per veteran to dollars and services received; that the quality of that service, as evidenced by accreditation, is even a stronger factor; that establishing local service centers has a bearing on the results, and that states that augment county service offices with state-level veteran service officers normally do better.

This study concludes that the major reasons why Lehigh Valley veterans are being under-served are:

- A lack of trained veterans service officers (used generically).
- Not enough veterans service officer positions.
- No organization that coordinates federal, state, regional and county efforts (no one in charge).
- Inconveniently located assistance offices.

This lack of an overreaching program has serious consequences for Lehigh Valley veterans. If the Lehigh Valley's veteran population was brought only to the national average for "properly" rated compensation and pensions, their benefits *would increase by an estimated $33,700,000 annually*. If medical and other benefits were brought to the national average, it would result in *an estimated increase of $36,500,000 annually*.

This study recommends that the DVA, the Commonwealth and the Lehigh Valley alter the way they serve veterans. Specifically:

- The DVA needs to establish professionally trained veterans service representative positions in the Lehigh Valley so it can provide hands-on management and local subject matter expertise.
- The Commonwealth should create a new cabinet-level Department of Veterans Affairs which is empowered with greater oversight and accountability, fund more state veteran service officers and require county service officers to meet DVA requirements – in other words, "to set the standards and take charge."
- The two counties, together with other local agencies, should jointly establish a "one-stop shopping" Veterans Service Center in the Lehigh Valley that brings together all of the non-medical assets dedicated to helping local veterans.

LVMAC has produced this study as a public service to Lehigh Valley veterans and their families and urges various government and elected officials to consider its recommendations. Our veterans deserve it and the entire community benefits by it.

PART 1: INTRODUCTION

A. THE ORIGIN OF THIS STUDY

In August of 2003 at a Veterans Affairs Committee meeting, a veteran complained of other veterans having problems with claims and of the lack of "veterans' service officers" at the Allentown Outpatient Clinic and in the Lehigh Valley. He went on to add that at one time the Department of Veterans Affairs (DVA or VA) had a fulltime representative stationed in the Valley – veterans have a long-term collective memory it seems. After looking into the problem, it was decided that the committee should hold a special meeting with county, state, federal, and veteran service organization officials to discuss veteran benefit services situation and what could be done to improve it, as needed.

That meeting was held on 18 November 2003 and confirmed anecdotal information that an improvement in the availability of veterans benefits services, both in qualified manpower and coordination of the existing assets, was required (Appendix C). No quick solutions were offered. Several participants recommended that a statistical analysis would be required to support any arguments for change. Unfortunately, none kept detailed county data that would quantitatively support the contention that there was a problem, and none could they say what information would prove most useful. At that point, the President of LVMAC agreed to take on the task, and that is how this study began.

B. THE PURPOSE

This study's purpose is to support or deny, through statistical analysis, the need for improved veterans benefits services generally and compensation and pension claims services specifically for veterans in the Lehigh Valley (defined as Lehigh and Northampton counties); and to recommend basic improvements to make these services more effective.

C. THE SCOPE

The term "veterans benefits services" covers a wide array of programs that involve more than one administrative agency and level of government. For example, Pennsylvania's Department of Military and Veterans Affairs (DMVA) administers veterans homes. However, the federal Departments of Veterans Affairs (DVA) and Labor (DOL) are the administrators and source of funds for the primary programs. The remaining programs mainly serve as adjuncts. Nonetheless, the range of benefits infers the services system is vast, complex and that knowledge is power. The problems of analysis are compounded.

By concentrating on what bothers the veterans most, it is possible to narrow the focus of the study to make it manageable and within the grasp of normal understanding. The DVA programs can be grouped into nine major program groupings (See glossary for a "major program" overview.):

- Medical care (a.k.a. healthcare)
- Medical Research
- Disability Compensation
- Pensions (combined with the disability compensation program for administration)
- Education
- Vocational Rehabilitation and Employment (VRE)
- Insurance (a.k.a. Insurance and Indemnity)
- Housing (a.k.a. Home Loan Guaranty Program)
- Cemetery Benefits (a.k.a. Burial Benefits)

When veterans talk about their benefits, they are more than likely speaking about the DVA administered education, disability compensation and pension, and medical care programs. When Lehigh Valley

veterans complain about the system, they are more than likely talking about the DVA's disability claims process or health care access. As it happens, the compensation and pension programs and the healthcare program are also the DVA's largest programs (Chart 1).

The importance of a claim in the DVA's system cannot be underestimated. Table 1 provides a not all-inclusive list of benefits and their reliance on claims processing. Compensation and pensions are tied at the hip to claims processing. One can not talk of one without the other. Healthcare itself is closely tied to the results of a claim being processed and the subsequent receipt of a disability rating under the compensation and pension programs. The system seems geared to the disabled or poor veteran.

Therefore, in focusing in on the compensation, pensions, and healthcare program category statistics, one could expect to sense the "health" of the veterans benefits services in general in the Lehigh Valley; and compensation and pension claims services in particular.

A word of caution: the purpose of examining healthcare statistics must not be misconstrued. Neither the capabilities nor the quality of health care system are part of this study. This study requires only those basic statistics reflecting access or use of the system. Again, healthcare utilization, in large part, reflects the success of compensation and pension actions, *i.e.* claims.

Insurance and educational programs, while important, have a lesser impact on perceived services in the Lehigh Valley, are smaller in size, and only in some selected instances require claims work -- this is consistent with the results of the DVA 2001 National Survey of Veterans. They will not be examined in any great detail. Table 1 shows examples of when they are affected by the claims process.

The cemetery program will not be discussed at all.

And finally, this study does not detail the claims process itself. It is not necessary to its statistical purpose.

D. THE LIMITATIONS

Pennsylvania does not publish an annual Performance and Accountability Report on veterans affairs. Lehigh and Northampton counties' Veterans Affairs Offices do not publish annual reports on veterans affairs. Therefore, the study relies upon Department of Veterans Affairs' data.

Access to useful data was often constrained or restricted, despite the DVA's penchant for numbers. The assessments are based on the best information available. While some details might be contested, it is believed the study's outcome will prove valid.

Fiscal Year 2002 (1 October 2001 – 30 September 2002) was chosen as the base year because the data for it was the most complete when the study began. However, some intermingling of data from other years was necessary because not all the necessary data was available for FY 2002. Additionally, when this study commenced, FY 2003 data was not available. The total effect on the general accuracy of the results is expected to be minor: significant differences in data over a two to three year period generally do not occur. Nevertheless, the potential problem was avoided whenever possible.

Data was primarily drawn from:

1) the 2000 U.S. Census
2) the 2001 DVA National Survey of Veterans (NSV)
3) the DVA Performance and Accountability Report for FY 2002
4) various FY 2002 DVA tables known as statistical appendixes to the Performance and Accountability Report for FY 2002 (found at www.va.gov/vetdata)

5) the DVA FY 2002 Annual Benefits Report
6) the DVA Monday Morning Workload Reports (VBA Claims Processing)
7) various DVA fact sheets and congressional testimonies

Other than for "regions" and hospital system service areas (VISN), the DVA frequently tracks its expenditures against zip codes, which themselves are not based upon geographic boundaries. Minor discrepancies will therefore always exist depending on how the zip codes are grouped to form political entities (states, counties, cities, etc.). The Census Bureau does not and will not have a "crosswalk" methodology to overcome this problem which exacerbates standardization of analysis.

PART 2: DISCUSSION – THE SITUATION FROM A STATISTICAL POINT OF VIEW

How well is the veterans benefit services situation in Lehigh Valley, particularly in the area of compensation and pension or claims processing services? How do Lehigh and Northampton counties stand relative to other counties and the Commonwealth of Pennsylvania?

Lehigh and Northampton counties (the Lehigh Valley) cannot be considered in isolation from the Commonwealth of Pennsylvania. The veterans benefit system extends from county level up through and including federal levels. What affects Pennsylvania, therefore affects its counties.

A. THE "BUDGET" POINT OF VIEW

While there are various ways to tackle the problem, it might be worthwhile to start with a dollars and cents approach and see where this leads. Although the DVA does not provide veterans budgets to the counties and states directly with a few exceptions, such as veterans homes, it is worth viewing the situation from a county and state budget perspective to determine if everyone is being treated fairly. To invite comparison it is common to unitize the data: to look at the expenditures from a per individual veteran perspective. Although this may oversimplify the information, it does allow a reasonable comparative analysis.

Eliminating general operating and construction expenses from the comparison, since not all counties have DVA facilities or administrative centers within their boundaries, was first necessary. Additionally, revolving fund expenditures, such as the mortgage guaranties, could not be captured. Nevertheless a reasonable stab at those appropriated expenses "directly" ascribed to the veteran himself could be made because the DVA tracts these expenses by the recipient and his home of domicile (zip code). The resulting, total "direct" expenditures, or "budgets," are shown in Charts 2 and 3.

As can be seen, Lehigh and Northampton counties are near the bottom in DVA total "direct" expenditures in the Commonwealth of Pennsylvania, which itself is close to the bottom of all the states (Charts 2 and 3). If the system were working properly, one might expect all to be closer to the average pending other factors. The Lehigh Valley's approximate $700 per veteran difference below the state norm and the additional $300 difference below the national norm are significant. Two possibilities exist at this point: area veterans are not collecting all they could in benefits or not enough veterans are receiving benefits. Looking at the individual programs on a per recipient basis and not against all veterans in a geographic area might be fairer and might address the former possibility. DVA data for counties was lacking in that regard, but a peek is possible at a more general level.

Tables 2 and 3, while only a sampling of key counties and states examined, reinforce the suggestion of Table 1 that compensation and pensions and healthcare services dominate total direct expenditures. These Tables are sorted on compensation and pensions amounts, to demonstrate the significance of that program in any discussion *vis a vis* Total Expenditures. The use of insurance seems fairly uniform, but would require further examination (See the 2001 DVA NSV if interested). Only West Virginia has a sizeable

educational and vocational rehabilitation program payout. Some states and Pennsylvania counties appear to use their educational benefits better. In general, education seems to lack emphasis in Pennsylvania and falls well below the national average. The sampled counties show the degree of it, from a DVA "County Budget" perspective.

As Table 4 shows, the majority of the compensation and pension in terms of numbers of people affected lies in the combination of service-connected disability compensation and disability pensions (both service- and non-service connected). The other subcategories related to death benefits do not apply to the veteran himself, but to his recognized dependents. Detailed data for death benefits by state and county was not found although they are sizeable programs. [See the glossary for an explanation of these categories.]

While death benefits do affect the Total Expenditure situation (Charts 2 and 3), each individual case is ultimately the direct, follow-on result of the veteran's compensation or pension status after the veteran dies. Chart 4 shows a rough proportionality exists between the number of disability compensation and pension cases (claims approved for living veterans) and the balance of the compensation program cases The correlation is confirmed in Supplemental Chart 41. Concentrating on disability compensation and pensions is therefore acceptable.

Pennsylvania's veterans appear to receive on average approximately $400 less per service-connected disability compensation case than the U.S. average and less than the majority of states (Chart 5). This partially explains the total expenditure discrepancy.

Referring to Chart 6, veterans' pension amounts in the Commonwealth of Pennsylvania do not appear to be a problem. In fact the Pennsylvania average case is $300 better than the national average. Since disability pensions account for 10.5% of disabled veterans, its overall impact on total expenditures would appear to be minor. Unfortunately, compensation and pension expenditure data per recipient was not available for the counties.

Pertaining to medical expenditures (Charts 7), the average cost per patient recipient per year is about $600 dollars less in Pennsylvania than the national average. Medical expenditures include the administrative costs of the medical system and are probably subject to regional cost variations. This is unlike compensation and pensions where the expenditures are based upon the degree of disability unadjusted for the cost of living in the geographical area. Perhaps also the Vertically Integrated System Networks (VISN), the DVA term for a health care regions, roll up some special programs against the budget of the Veteran Administration Medical Center (VAMC), a hospital in normal parlance, which administratively discharges the program. In theory, these figures for FY 2002 do not reflect non-veterans it treats (DVA employees in particular), according to the DVA. These explanations only mitigate and do not explain away the discrepancy.

Here county level data exists; and the picture defies the above explanations for total mitigation (Chart 8). Lehigh and Northampton counties are significantly below the national and state norms for medical costs per patient. Combined they are about $1500 per patient below the norm for the state and another $500 below the national average, for a total of $2,000 per average patient.

B. THE UTILIZATION (USE OF THE SYSTEM) POINT OF VIEW

At this point, it seems that for service-connected disability compensation and pensions and medical expenditures, the Lehigh Valley is below the norm in recoupment or service provided per veteran. But perhaps this is not the real story and as mentioned above a second possibility exists: utilization of the system. The logic goes as follows: the more individual veterans that use the system or receive benefits

from it, the greater the total amount to be disbursed over the same, entire veteran population, thus raising the total expenditures per veteran population (users and non-users).

Referring to Chart 9, approximately 7.4% of Pennsylvania's veterans qualify for service-connected disability compensation as compared to the 9.3% national average. Pennsylvania is also virtually at the bottom of the list in the distribution of compensable ratings among its veterans.

If this were not bad enough, the Lehigh Valley at about 6.0% (Lehigh: 5.8%, Northampton: 6.2%) is virtually at the bottom of all counties in the state (Chart 10). Only four Pennsylvania counties exceed the national average for disability compensations awards. They are Luzerne, Lackawanna, Cumberland and Wayne.

The situation is better in service and non-service connected pensions for the state (Chart 11): 1.2% versus the national average of 1.3%, yet the Lehigh Valley (Chart 12) at about .65% (Lehigh: 0.6%, Northampton 0.7%) is less than half again. Only because disability pensions affect but 11.5% of the veteran population is the overall effect mitigated statistically.

When both disability compensation and disability pensions are summed as in the two charts below (Charts 13 and 14), it can be seen that fewer living veterans in proportion to their overall numbers in the Lehigh Valley (Lehigh: 6.4%, Northampton: 6.8%) receive their probable compensation and pension entitlements than those who live in the vast majority of other counties. Unfortunately, the State also falls significantly short of the majority of other states, as reflected in the 8.6% versus 10.6% national average figure – about 19% below that national average and consequently significant and important. Consequently, the Lehigh Valley falls about 38% below the national average.

Since healthcare is not entirely dependent on claims work, medical utilization should be expected to be higher than the compensation and pension rate (Table 5). In terms of DVA medical usage by veterans in the state (Chart 15), while most states do better, Pennsylvania is not far off the national average (17.3% versus 17.8%).

The same can not be said of the Lehigh Valley, however (Chart 16). At 10.4% and 9.1% respectively, Lehigh and Northampton counties (about 9.8% for the Lehigh Valley) fall at the very bottom of the counties in Pennsylvania. The disparity of being about 45% below the national average is larger than those shown in the other utilization charts (Charts 11 through 14) and is unexpected. One must question why this statistic is so low for the Lehigh Valley. [See glossary for an explanation of Healthcare Priority Groups.]

All that might be proposed in mitigation at this point is that no more than two-thirds of those enrolled use the medical system in any given year, according to the VISN reports (Table 5). Even if the "no-shows" were added for the Lehigh Valley alone, it would continue to fall significantly below the state and national averages, let alone among the vast majority of other counties.

C. RECAPPING THE SITUATION

Thus far we have seen that the Lehigh and Northampton county "budgets" fall far below most others. Based upon the medical expenditure data per <u>recipient</u> which was available at county level, one might expect that the Lehigh Valley might have problems in the compensation and pension "budget" as well. Tables 2 and 3 suggest this. It is not so much the amounts but the relative positioning of Lehigh and Northampton counties with respect to others in the context of the state's relative situation that is perhaps most disturbing. The utilization data, more indicative of the use of the system, seems to support these contentions more completely. Not enough Lehigh Valley veterans appear to have gained access to the

system and this reinforces the notion that greater access produces greater monetary benefit. This is probably the fundamental cause of the problem first shown in Charts 2 and 3.

Charts 17 and 18 (scatter plots) best summarize the situation for the Lehigh Valley and Pennsylvania. They are effectively at or close to the bottom of the "pecking order" when it comes to using most benefits to the maximum. What is bad for Pennsylvania is even worse for Lehigh and Northampton counties. And while a compensation or pension claim is the gateway to most benefits for most veterans, it is not the only way into the medical system. Here another problem may exist beyond that of claims processing.

In terms of money, the Lehigh Valley falls $1,000 below the national average in total "direct" expenditures per veteran. This involves being $400 below the national average in service-connected disability compensation per <u>recipient</u> and, amazingly, $2,000 per patient served. In terms of use or access to the system, the Lehigh Valley falls 38% below the national average in compensation and pensions and about 45% below the national average in using the medical system. Something is wrong. An explanation(s) must exist.

PART 3: DISCUSSION – ANALYSIS FOR CAUSES FROM A STATISTICAL POINT OF VIEW

Many factors can affect any program. Manpower and budget immediately come to mind. However, other possibilities should be investigated as well before they are dismissed.

A. THE FACTOR OF POPULATION SIZE – THE DENOMINATOR EFFECT

Simply the shear size of the veteran population in a county or state can have an unreasonable effect on unitized expenditures and percentages: the denominator effect. A few more claims here and there have a greater impact in a small county or state than in a larger one. Therefore, population can have an unintended influence on the findings.

Charts 19 and 20 depict the relative veteran population sizes. For comparison, two larger states, New York and Texas, and two larger counties, Berks and Luzerne, were selected. Although larger, they do better. [Look at the preceding expenditure and utilization charts] Many other similarly sized or larger entities do better. Population size itself is not a prime cause of the disparities.

B. THE AGE FACTOR

The aging of a veteran population must be considered. As people age, their use of medical services generally increases. This is borne out by medical studies and the DVA itself. If two veteran population groups are of the same size and both are equally savvy, the older one should have a higher medical utilization rate. As veterans age, they are also more likely to open or reopen an existing claim for an increased disability rating, or apt to apply for a pension. Consequently, compensation and pension recoupment and usage will increase in the general veteran population.

It is frequently asserted that Pennsylvania has an aging population. In the case of veterans, Chart 21 confirms this. About 44.8% of Pennsylvanian veterans are 65 years or older. The national average is 38.2% and Texas' is 33.1%. The differences are significant. The Lehigh Valley is statistically similar to the Commonwealth and within 0.5% in the age 65 and over category (Chart 22). Both Berks and Luzerne are within 1% of the state average. By this criterion, the Lehigh Valley and Pennsylvania should be one of the heavier users of the DVA claims system and should be doing better than Texas.

C. THE PERIOD OF SERVICE FACTOR

But while Table 6 also confirms the view that older veterans have are more frequently disabled and, therefore, in greater need of services, it also shows that the oldest significantly sized group of veterans, the World War II veterans, are no longer the largest group. From a "claims business" point of view, Charts 23 and 24 indicate a younger group of veterans as being the predominate users: the Vietnam era veteran. The second largest group of service-connected disabilities exists among the peacetime era veterans from 1955-1964 and 1975-1980. The second largest group for pensions is World War II veterans.

Even by this measure, Charts 25 and 26 show that Pennsylvania and Lehigh and Northampton counties should also be heavier users of the compensation and pension claims system. Some 52.9% of Pennsylvania's veterans served during the peacetime or Vietnam eras as opposed to the national average of 54.7% and Texas' 54.7%. When World War II veterans are added, that total climbs to 74.5% for Pennsylvania, 71.5% for the national average, and 68.5% for Texas (consistent with its younger population). Data for the counties could only be obtained for the year 2000, but the Lehigh Valley has a slightly higher concentration of Vietnam and peacetime era veterans (by 1.5%) and the same concentration of World War II veterans as the state. Luzerne and Berks are slightly lower than the state averages.

D. THE DISABILITY PROFILE FACTOR

Approximately 47.4% of rated veterans in Pennsylvania have a disability compensation or pension rating of 30% or greater versus 49.4% in the national average (Chart 27). In comparison, the figure is 51.9% for Texas. Pennsylvania has a significantly older population and the expectation would be that it would have the higher percentage. Since the profile is based upon those already rated, the difference may be more indicative of the quality of the claims submissions than the health of the veterans. A statistical difference of 4.5% may be considered small. However, monetarily the impact is larger, since those veterans rated 30% or better not only receive additional income for themselves but also income for their dependents.

Examining the service-connected disability profile of recipients in the counties of Pennsylvania reveals that Lehigh and Northampton counties are within one per cent of the state average and not significantly different from the majority of the other counties (Chart 28). Therefore, since compensation income is tied to a disability rating, Lehigh and Northampton counties should not be under-represented, at least not in comparison with the Commonwealth as a whole.

E. PERSONAL FINANCES AS A FACTOR

Other factors might explain the apparent under-performance. Some are not as obvious as others. Personal finances may be one of these. At least some veterans consider the DVA as a last resort for medical services, a place to come to when they can afford no better. In a community with many fine private hospitals, the inconvenience of traveling to the Wilkes-Barre VAMC for major services and to the more robust major DVA facilities in Philadelphia, personal finances comes into play. Also, personal finances push some veterans into seeking compensation and pensions – the pension program specifically exists for the most severely distressed.

Table 6 suggests that veterans in general are less likely to be in poverty. However, while the 2001 NSV[1] reported that 34.7% of the survey respondents stated their family incomes were over $50,000, 30.3% revealed family incomes of $30,000 or less (17.4% have incomes of $20,000 or less). It is likely the

[1] 2001 National Survey of Veterans, conducted for the DVA, Part 3-7, and Table 3-6.

situation is slightly worse, since the results are based on what the veterans themselves reported and pride is involved; especially since only 50.4% of the respondents were employed. Therefore, the possibility exists that personal finances are a factor.

The question now becomes how to measure the level of "economic risk" to which veterans are subject, since veteran financial data is not commonly available at state and county level. However, veterans are a subset of their communities and community statistics are available from the 2000 U.S. Census and Bureau of Labor. Changes over the span of a year or two are unlikely to affect the results more than a few hundred dollars either way, and where percentages are used, a percent or less difference is not unreasonable to expect.

There are at least four general indicators that can be used to portray the "economic risk," the economic well-being of a community's citizens: median income, poverty rate, cost of living, and unemployment rate. The unemployment rate was not used in this study, since it is a particularly contentious and misleading statistic. The cost of living must be inferred from income levels, since the standards for poverty are not geographical and because such information was not available for this study.

Median income should not be viewed in isolation. It needs to be checked against the poverty rate to get a better picture of the community's economic situation. For example, a high median income and a high poverty rate would suggest a smaller middle class; a low median income and a high poverty rate would suggest an economically depressed area.

This study uses median household income as more representative of the average domestic situation than median family income. Either due to deaths or the moving away of the grown children, many veterans would not be represented under the family statistic. The average number of people in a household (which includes families) in Pennsylvania is about 2.48 and for a family, 3.04. The difference is small. Most other states fall within a quarter percent. The US average is 2.59 and 3.14 respectively. Pennsylvania is not far off the mark but it reaffirms that it has a slightly older population. The same could be said of Lehigh and Northampton counties. For this analysis, the size of households is therefore fairly uniform across the board and not a major factor.

As shown in Chart 29, Pennsylvania's median household income is slightly below (about $600 less) the national average of about $42,000 and at the middle of the pack in the state comparison. Lehigh and Northampton counties (particularly Northampton) are well enough above the national average to be significantly different at $44,200 and $47,800 (Chart 30) respectively. [Note that New York and Berks County closely parallel Pennsylvania and Lehigh County, respectively. Texas and Luzerne counties are similarly below in income.]

Chart 31 demonstrates that there is a rough inverse correlation between a community's median household income and the number of compensation and pension cases in the veteran population. The trend line shows the central tendency. Supplemental Chart 42 confirms a rough correlation. It is beyond this study to dig deeper.

In terms of the poverty rate, Pennsylvania (Chart 32) lies in the middle third of states and about 1.8% below the national average of 11.3%, while Lehigh and Northampton counties (Chart 33) lie in the lower third of the state counties and considerably below -- especially Northampton -- the national average (8.0% and 6.4%, respectively).

Chart 34 shows an extremely rough, almost non-existent central tendency for the number of compensation and pension cases in the veteran community to be related to the poverty rate. [See also Supplemental Chart 43.]

The relationship with median income seems to be tighter than that with poverty, confirming the idea that veterans are less prone to poverty. From this information, one might also conclude that Pennsylvania is an average state, not doing well or poorly, and the Lehigh Valley is relatively healthy in the area of personal financial well-being. The concomitant result would be less utilization of the system.

Of all the possible factors analyzed thus far, personal finances seem to have the strongest effect on utilization of the system and expenditures. An exact, proportional correlation can not be shown and variations exist. Nor do personal finances totally explain the situation away. Compare Pennsylvania with New York, two states similar in these and most other respects, except slightly higher in poverty. Take a look at Virginia and Massachusetts. Both states have higher incomes and lower poverty than Pennsylvania, indicating a more even distribution of wealth and a healthier economic environment, but also have a considerably higher compensation and pension cases per veteran population. Perhaps a cost of living factor is also at play, but this is would be difficult to assess. Median income somewhat reflects it anyway.

Ironically, the claims award system in the majority of instances is not based on level of income. Only about 10.5% of all veterans' claims involve pensions (Table 4) for which income is a factor normally, especially as a veteran ages or lacks employability. To repeat, Table 6 shows that veterans are less likely to be in poverty compared to their peers, even despite advancing disability. Therefore, it is simplistic to say that the DVA is for the poor or hard-pressed veteran, those most likely in need, when a major part of the system is built upon disability and active service.

F. THE EFFICIENCY OF THE REGIONAL OFFICE

The efforts of the DVA to reduce the backlog of claims are well documented. The average processing times have been a key issue and used as measures of performance in DVA Performance and Accountability Reports. It was not possible to obtain this information through direct inquiry for county and state levels. However, using the Veteran Benefits Administration "Monday Morning Workload Reports," based upon Regional Office reporting, one can get a sense (but not a thorough one) of how well the states and their counties are supported. Claims processing times are a management indicator of the performance and efficiency of the system.

Processing times exceeding 180 days are a subject of worry to the DVA. Charts 35 and 36 are the End of the Year 2002 and a three-point moving average based upon reports for the end of years 2001, 2002, and 2003. The three point average was used to confirm the performances as systemic.

The Lehigh Valley is serviced by the Philadelphia Regional Office. The results are mixed. Looking at Texas, one would expect that better processing times leads to a higher compensation and pension figures. Yet, New York does as well or better than Pennsylvania and its regional offices' turnaround times are worse. One could look at Allegheny County, served by the Pittsburgh Regional Office, and conclude that processing times have a decided effect on its relative performance. Yet, Luzerne County, served by the Philadelphia Regional Office does even better. Berks County does better than Lehigh Valley counties even though it is a demographically and economically similar county.

Chart 37 depicts a relationship between claims processing times and the number of disability compensation and pension claims per veteran population at state level. An assumption that a Regional Office is dedicated to one state had to be made. This is not the case as Regional Offices support veterans within their geographical area, regardless of state boundaries. Where more than one Regional Office existed in a State a straight average was used for claims processing times.

Only a slight linkage can be demonstrated. Supplemental Chart 44 reinforces that contention. To compare a measure of rate with a measure of volume, one must view claims processing time as not only an

indicator of efficiency but also as a measure of the effectiveness in building up the cumulative number of completed cases in a state. Perhaps the rate of death of veterans balances the rate of new cases being added to the system.

However, this statistic must stand for something or it would not be tracked. In its FY 2003 budget testimony, the DVA seems to rule out manpower as an issue. If this is true, the statistic may indicate the general complexity of the cases involved or the quality of the initial input. The latter point suggests that quality front-end service may be a problem.

In conclusion, the available data to establish the importance of the efficiency of the Regional Office is insufficient -- or it is not a key factor.

G. THE VOLUME OF CASES PER ANNUM

The direct consequence of the dying of veterans with approved claims was mentioned previously (Part 3.F). All systems need maintaining. Furthermore, volume measurements are a management indicator of activity in the system. This leads to considering the number of compensation <u>and</u> pension cases processed per annum as a factor. Unfortunately, this data at state and county level was not made available. However, the number of disability compensation claims opened and reopened per annum was obtained for FY 2002 by reading each state's Public Affairs Summary Fact Sheet. Chart 38 is the result of that compilation. There is an inherent error in it in that the numbers are for the Regional Offices in that state and as mentioned previously, Regional Offices extend their efforts beyond the state they reside in.

Pennsylvania is on the bottom end. Considering the size of its veteran populations, one of the five largest in the country, it has significantly less disability compensation claims processed per annum than the majority of states. The difference of .8% less from the national average of 2.5% claims per year per veteran population means about 32% less claims are being processed in Pennsylvania than the national average.

There is also a definite relationship between the number of claims processed in a year and the number of claims in the veteran population (Chart 39). The central tendency appears to exist, with exceptions possibly due to the lack of complete data. Supplemental Chart 45 shows a strong correlation.

H. AWARENESS AS A FACTOR

Awareness of entitlements is a possible contributing factor, but how is that measured? Little information exists at county and state level statistically, but inferences may be made from the 2001 DVA National Survey of Veterans. Much of the discussion that follows is paraphrased from that survey.

Table 7 addresses how veterans get their information and shows the DVA to be the major player and point of contact for veterans. Not only is the DVA responsible for providing veterans' benefits, it is also responsible for ensuring that veterans are aware of their benefits. Tables 8 through 10 reveal how well veterans know or are aware of their entitlements or benefits.

From Table 8, veterans with a disabling condition who did not apply for disability benefits most frequently gave the following reasons for not applying: (1) they didn't think they were entitled or eligible (40.6 percent); (2) they insisted they did not need the assistance (22.7 percent); and (3) they were not aware of DVA service-connected disability program (12.7 percent).

Table 9 shows that many veterans do not understand the system. Only 51 percent agreed that they thoroughly understood the benefits to which they were entitled.[2] While the percentage increased to 62.5% for those actually receiving disability compensation, these figures also suggest there still remains a large group of ill-informed veterans.

Additionally, whereas veterans are aware of the DVA and most know to go to it, Table 10 implies that they can be easily discouraged, partly because of their understanding of the system and partly because of the system itself. Only 38% of veterans surveyed thought getting a benefit to which they were entitled was or would be easy. Younger (and less experienced) veterans were somewhat more likely to agree with this statement than were older veterans.

The extent of the problem in the Lehigh Valley can only be surmised, since county and state-level data was unavailable, but anecdotal information and the 18 November 2003 conference support the supposition. Although the DVA is the principal source of information, the state does not distribute brochures or information on its DMVA web sites nearly to the level of several of the other sampled states who recognize it as a problem. In fact its web site can not be found going through the DVA's www.va.gov/vso site, the all-points access site.

Consequently, awareness would seem to be a factor, although difficult to quantify.

I. MANPOWER AND ITS EFFECT

Cautionary Note: The DVA often uses the term "veterans service organization" to refer to a chartered, nonprofit veterans organization like the American Legion. It uses the term "veteran(s) service officer" to mean a service officer performing benefits counseling and claims servicing from such an organization or from a county or state government agency. Both terms use the acronym "VSO." In this study, to prevent confusion, "VSO "will only be used to refer to the service officer and the term "veterans service organization" will refer to both chartered, nonprofits and governmental organizations. When referring to the nonprofit alone, the term "veterans organization will be used." See the glossary (Appendix F) for an expanded definition.

The preceding leads onto the simple concepts of manpower and locations.

From Page 1-7 of 2001 NSV:

> Two thirds (66.7 percent) of veterans reported that they would go to VA itself if they needed information about their VA benefits. About 12 percent of veterans said that they would use the VA toll free number and a similar proportion said they would use the VA web site. Less than 1 percent of veterans reported that they would use the VA benefits booklet. These responses suggest that veterans prefer to get their information directly from VA rather than from other agencies and that contact be personal or web-based rather than written …

Personal service is the preferred mode for veterans to get their benefits information. The term information can be read to mean "start or reopen a claim" in most instances. Starting a claim is best done with personal, face-to-face, across-the-table service (hereafter called "front-end service"). The system has become more demanding, especially since the institution of the badly needed, but adversarial nature of the Court of Veterans Appeals in 1988. Evidentiary requirements have increased and the law has become increasingly complex. What may have been easy in past times is no longer. Indeed, it is the worry of some

---

[2] 2001 National Survey of Veterans, conducted for DVA, 2001, p 7-8.

states that the promotion of internet claims filing and the like without the assistance of a qualified claims service officer is a recipe for delays and disenfranchisement.

> Of great concern to the TVC is the potential for a lack of representation of veterans who may use on-line means to file claims.[3]
>
> The veterans of Texas, like all veterans, are faced with the erosion of their federal entitlements. They must have an advocate to represent them.[4]
>
> Most people do not understand the eligibility criteria well enough to file their own claim. Without familiarity of rules and qualifications, supporting documentation and justifying evidence, a claim is often overlooked.[5]

The thrust of the DVA's 2001 and 2002 customer satisfaction reports[6] supports the contention that, despite improvements, communication and, consequently, service remain problems. About 58% of veterans seeking claim service state they are satisfied with the way the DVA handled their claims, but that figure also includes those who were "somewhat satisfied." Furthermore, the DVA keeps its claimants properly informed only about 40% of the time. This is perhaps why 40% of the time veterans seek the assistance of veterans service organizations.

The importance of having a personal DVA Veteran Service Representative (VSR) or Veterans Benefit Counselor (VBC, holdovers from an older system) or a state, county or veteran organization's Veterans Service Officer (VSO) should not be underestimated in starting and following up on a claim. The DVA provides some public contact officers (VSR or VBC), but the overall emphasis in its organization is not on the front end. The importance of these individuals may not be well understood by the DVA itself, since most of their work is done internally and is seen as perfunctory from the point of view of outsiders. Most public contact VSRs are rarely at convenient locations and they often do not provide the level of service provided by a VSO. Yet, both the VSR and the VSO ensure a good start to a claim.

As implied, VSOs often go a step further. For example, they can ensure that physicians, private or DVA, perform their examinations properly. Physicians often have an incomplete understanding of the importance of a compensatory examination, its fine points and turns of phrase, and the importance of complete documentation – they have enough worries on their mind in an over-strapped medical system. More cases are appealed because of the incomplete or inaccurate reporting of physicians than is commonly recognized. It is not just administrative documents and process that cause delays in correct findings. A properly trained VSO can expedite a claim by months. For the individual, this is extremely important. Most veterans (62%) report that their monthly disability compensation payments are very or extremely important to their financial needs.[7] Meanwhile, the DVA-accredited personnel in these organizations are too few and their pay frequently low, many of the most qualified are approaching retirement and the organizations' budgets do not support major increases in staffing.

How does the DVA really see the problem? From the FY 2003 Presidential budget submission[8]:

---

[3] Strategic Plan, 2003-2007, Texas Veterans Commission, 1 Jun 02, p.14

[4] Strategic Plan, 2003-2007, Texas Veterans Commission, 1 Jun 02, p.19

[5] Annual Report, 2002, New York State Division of Veterans' Affairs, 1 May 03, p. 6.

[6] Executive Summary, 2002 Survey of Veteran's Satisfaction with the VA Compensation and Pension Claims Process, undated, found at www.vba.va.gov/surveys/isrscpe.htm.

[7] 2001 National Survey of Veterans, conducted for DVA, pp. 7-5, 6.

[8] Extract from President's Budget for Fiscal Year 2003, "Status of Selected Programs", p. 280

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.

Four words and phrases leap from this assessment: sluggish processing; modernize information technology [as a solution]; core disabled and low-income veterans [being jeopardized]; [because] rapid increase [of veterans demanding care].

None of this speaks to manpower issues, often raised by various veteran service organizations to the DVA and Congress. More claims are now being processed per year than in the entire history of the DVA. The DVA has increased training because of turnovers of qualified personnel. It has hired about 2,000 new employees to expedite processing times since 1998. But the emphasis is on the "back office," as the DVA has tailored its organization. Tiger, Triage, Pre-determination, Rating, Post-Determination, and Appeals Teams use up the majority of the manpower. While all of this tackles the backlog of claims in a logical manner, it does not address its front-end service requirements as well. Public contact teams are limited in both function and manpower.

Attempts have been made to reach out veterans service organizations where DVA shares assets to streamline processing and to increase "ready-to-rate" cases coming through the front door of the DVA compensation and pensions claims processing office (Veterans Service Center). This frees up DVA manpower, to the point of adjudication, for other necessary work which includes servicing claims filed electronically by the individual and the previously mentioned backlog of claims. Until very recently, these efforts have been pilot projects. As a result of the recommendations of the "2001 VA Claims Processing Task Force" and others, the concept has gone mainstream. This is the reasoning behind the recent emphasis on and consolidation of TRIP training. Meanwhile, while the national claims processing time has been recently reduced, it is still about twice the 100 days it took in 1996.

Efforts at more personal, public contact have been made, but that effort has been selective. Most of the contact with veterans remains at arms length.

The previous dedicated Case Manager concept for the individual veteran (more words than reality) has been supplanted by the Public Contact Officer. All that remains is the job description: the "veteran service representative" (a combined veterans' benefit counselor and adjudicator). The redefinition, in theory, creates a more flexible and motivated employees in a system envisioned to "flow towards the hole in the dike." One of these redistribution plans involved supporting veterans homes better with dedicated employees (about 20 Full-time Equivalents).

The "one telephone number concept" known as 1-800-827-1000 routes a veteran to wherever available labor exists to answer the phone. One can be in Allentown and served that one time by a DVA employee in California, conceivably. For those veterans not in a major urban statistical area of a state, this is the most frequent means of contact with the DVA. This is also a great concern to states motivated to veteran advocacy.

Those front-end work initiatives that have occurred in the form of "outbasing" and "outreach" (see glossary) have been selective and limited, and do not generally benefit most existing veterans. Currently, there is a successful outreach initiative for disability examinations and benefits counseling of inactivating

soldiers at their military installations, called the Separation Examination Program or the Benefits Delivery on the Discharge Site Program.

Other efforts at "outbasing" and front-end service have been equally selective: concentrating on the southern and southwestern states where the DVA has seen the drift of the veteran population over time. While still limited, the idea has merit. Veterans are migrating south as they age and the military population, until the recent reserve and guard deployments over the past three Presidential administrations, constitutes the primary source of veterans. Military installations with sizeable populations are predominantly located in the South and Southwest.

.

Why the lack emphasis on personal, face-to-face contact in general? Beyond the issue of budget constraints, it is also philosophical.

In October 2001, Vice Admiral Cooper's (currently the Undersecretary for the VBA) 2001 VA Claims Processing Task Force presented a final report to the DVA which concluded "… as a result of basic flaws in organization and communication, [the] 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"[9]. He added on November 8, 2001, "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."[10]

In its FY 2002 VA Performance and Accountability Report:[11]

> We began implementing the recommendations of the VA Claims Processing Task Force, which included changes to management and workforce, training, and quality. One of the key initiatives is a team approach that introduces specialization to the claims process and reduces the variety of tasks each claims representative is required to perform daily. This structured workload management approach uses a triage team to process certain types of claims on the same day and immediately and accurately determine the next step in the process for incoming claims that need further action. This reduces the amount of time claims wait in a queue for further processing. Other teams are dedicated to completing other steps in the claims process, such as predetermination and rating, allowing employees to concentrate their specific skills on accurately gathering evidence to finalize the claim, and ensuring that the decision can be finalized without further turnaround.

Due to the apparent general lack of emphasis on front-end service, LVMAC conducted a limited survey this year to determine the effect of providing this "face-to-face" service in the claims processing system. The results indicate that those states that emphasize their veteran affairs systems – through ensuring the quality of their service officers and by providing sufficient numbers of them – generally do better. See Part 4. Note in Table 11 the ratio of veterans to service officers is significantly better in these states than in Pennsylvania. Upfront personal contact seems to have a decided effect on overall system performance.

Additionally, the Department of Veterans Affairs must continue to open its channels of communications with more veterans service organizations and emphasize a team approach, something it seems to be slowly doing. It needs the help. However, the DVA also needs to re-look its current front-end service philosophy. It should source more outbased outreach efforts in the Commonwealth. The DVA may not be able to perform a *bona fide* advocacy role by the very nature of being the <u>rater</u> as well, but it is also true

---

[9] op. cit., p. 282

[10] op. cit., p. 281

[11] FY 2002 Performance and Accountability Report, DVA, from "Means and Strategies", p. 49.

that the DVA holds the keys to the system, and the quality and completeness of claims input is extremely important to the reduction of processing times and the first-time accuracy of determinations.

J. THE EFFECT OF POINTS OF SERVICE (NODES)

Closely related to manpower is physical access to the veteran service officer. Points of Service should be considered a factor. Easy access reinforces (force multiplies) available manpower.

The DVA bases some of its VBA employees in locations other than their Regional Offices. LVMAC surveyed various states to determine how many benefits service sites they had (Table 12). The information was gleaned from reading DVA facility reports on the Internet site www.va.gov and from reports and conversations from state officials (Table 12). The DVA definitely "outbases" in North Carolina, Texas, and Florida – all southern states where the military has a large presence – through either its outreach efforts or through small offices. This is in addition to their normal location at Regional Offices and frequent presence in most VAMC.

Note the number of veterans per service points (major nodes). Even with inaccuracies, Pennsylvania is deficient. Typically field offices have one, sometimes two service officers (either fulltime, part-time, or itinerant). In the case of Florida, the organization of their program is superior and it is suspected that they gain the advantage of the work of service officers in other states, since many veterans move during retirement to Florida later in their lives. Two of the DVA outbases in the state have more than one or two person offices. West Palm Beach and Orlando are "service mini-centers." The same could be said of North Carolina, but to a lesser degree, and Texas, to a greater degree. This also reveals another fact. The DVA tends to concentrate or cluster its manpower around major metropolitan areas. The exception is major military installations and, as a stationing concept, is relatively new. Personal service to the outlying areas consequently suffers. Where they outbase, as in the three states mentioned, improvements in compensation and pension levels can be expected to occur.

Referring back to the Pennsylvania county-level Chart 18, the presence of a VAMC or state home in a county seems to lead to an increased use of the system. Since service officers are often at these locations (fulltime, part-time, or on an itinerant schedule), the inference is again that convenient access increases the compensation and pension claims work.

More points of reliable and convenient service seem to make a difference. Available manpower is intertwined. As Part 4 discusses, certain states monitor the locations for workload and redistribute assets accordingly. The presence of state field offices to augment counties or replace them seems to have a most decided impact, next to the DVA outbasing issue. Which is more important? Both are equally important, but the DVA overall handles more business (about 60% of it).

PART 4: DISCUSSION – WHAT OTHER STATES DO

See Appendix D for synopsis on several of the states surveyed and Tables 11 and 12.

Based on the data, both total expenditures per veteran and the participation (utilization) by veterans in their compensation and pension entitlements, West Virginia, Texas and North Carolina have the strongest programs since they exceed the national averages. Florida did very well in most aspects. While West Virginia is a relatively small state and its economic situation cannot be excluded as a major factor, it has a good system worth examining. North Carolina probably has the most thorough training system. Texas' veterans' affairs system is known to be a model for other states. Certain themes for a successful compensation and pension services program emerged.

A. THEMES FOR SUCCESS

Organization:

The state separates its veterans affairs organization from its military department to gain focus.

The state assumes administrative responsibility for the training, supervision and coordination of county-level service officers.

The state has an active, large, visible state-employed veterans' service officer presence in field locations in addition to a group at the Regional Office, which also acts as an appeals division. These field locations are assigned county service offices for which they are responsible.

DVA Interaction:

The state actively engages DVA and participates in pilot projects for expediting claims processing.

The state actively uses DVA facilities when feasible and accessible to reduce its cost of operations.

The DVA outbases in VHA facilities, military installations, and service mini-centers to increase front-end service. [No matter how well run the state program is, the DVA will always be the predominate partner because it has vaster resources at its disposal.]

Training:

There are formal training requirements for county and state employees. The training is ongoing, modularized, monitored, and reimbursed.

Accreditation is a requirement for state-level service officers and, increasingly, required for county-level officers.

The state does not totally depend upon the veterans organizations to provide accreditation training of veterans service officers.

Management and Reports:

The state takes on the role of chief advocate for the veterans of its state.

The state adopts a performance measurement system and performance reports are published for review. Together with a computer information management system, this allows better deployment of limited assets to meet the needs of the veterans. [The state-level workforce would be positioned and moved according to formal methods of management analysis. As an example: The workload in an area changes according to aging and migration of the veteran population.]

The state institutes a claims processing and tracking system. This requires a sound management information system (computers are only the hardware) and full integration into the DVA Benefits Delivery Network (BDN) at the point of service for the veteran. This is in line with DVA thinking in recognition of its front-end manpower shortages. The DVA has an ongoing initiative to out base access to the system for the purpose of streamlining submissions and encouraging veterans service organizations to take a larger role in bringing cases to "ready to rate" status (the step prior to adjudication). It also allows for reviews of affected claims when laws change.

Dual accreditation agreements with veterans organizations are formally sought to ensure open channels of communication with the DVA and veterans organizations on the behalf of the veteran, no matter where

the source of inquiry. The intention is not to "claim jump," but to keep the veteran informed while maintaining DVA confidentiality requirements, to prevent duplication of effort, to assist veteran organizations when practicable, and to track progress.

State-developed claims are pipelined through state channels. The best of the sampled states seem to have moved or are moving in this direction. This expedites the process and enhances communication. The reasoning is related to the dual accreditation issue. It also enhances morale, professionalism and the proper recognition of the service officer at point of service. [It is not uncommon where a county agency develops a claim and forwards it to a veteran organization for power of attorney purposes; and then finds itself locked out of the loop by both veterans organizations and the DVA, although it is still working on the veteran's behalf.]

The state maintains good relations with veterans organizations and their veterans service officers. The DVA and states alone cannot totally fill the void in personal service. Furthermore, veterans organizations are a vital ally and an important lobbying agent for change.

The state ensures that pay for accredited officers is competitive to promote retention. Experience is everything in this line of work. Furthermore, accredited officers are a shortage skill in the veterans' benefits services area. The competition is not so much from the veteran organizations who frequently do not pay well, except at the high end of the national level, but from the DVA itself.

Awareness: The state promotes awareness through county organizations, web sites, media, and memoranda of understanding with other agencies and organizations that are responsible for veterans' other benefits.

Other: No conclusions were drawn.

B. WHAT PENNSYLVANIA DOES

The Commonwealth of Pennsylvania's situation follows.

Organization:

Veterans issues are the responsibility of the Department of Military and Veterans Affairs, with a deputy assigned to handle veterans programs through the Bureau of Veterans Affairs (DMVA-VA).

The state county code requires Directors of Veterans Affairs in every county and assigns to them the responsibility for veterans benefits services/counseling, among other duties.

The Commonwealth is not in administrative or supervisory control of county service officers.

County service officers are not required to be accredited or certified.

Few state-level resources are devoted to benefits services and compensation and pension claims processing. About 11 personnel are authorized for veterans benefits services, including clerks (Programs and Benefits divisions). Of these, the Commonwealth fields up to four accredited, state-employed veteran service officers of which one each is assigned to the Philadelphia and Pittsburgh VBA Regional Offices.

The vast majority of manpower of the Bureau, 1818 of 1839 personnel, is directly assigned to the six veterans homes and Scotland School for Veterans' Children.

The Governor's Veterans Outreach and Assistance Center (GVOAC) personnel expand the state's reach. However, this Department of Labor and Industry Program does not coordinate its activities with the Bureau. Additionally, GVOAC personnel are contract employees under grant (Wagner-Peyser, as amended) and can not be accredited per 38 CFR 14.629 – further limiting their use. Their original role was counseling, rehabilitation and job placement. Mission creep has occurred, with good intentions, and partly as a result of Bureau manpower shortfalls.

DVA Interaction:

DVA Transition Assistance Program (TAP) is in place. However, the more expansive Separation Examination Program and Benefits Delivery at Discharge Site (BDDS) are not, probably because the Commonwealth has no major military installations.

The DVA fields about five veterans' benefits counselors in Pennsylvania on a traveling circuit scheme. Their origin is in an older system of benefits services delivery.

No outbasing is known of except at the VAMCs and perhaps two clinics. None of these locations are fulltime.

Training:

The Commonwealth conducts training of paid, county veteran service officers once a year. The intention is to bring them to level of passing a test and then being sponsored by the Commonwealth for accreditation. The number currently accredited can only be estimated, since management by county officials does not emphasize the importance of this voluntary requirement. Currency training is not mandatory.

Otherwise, the state depends upon veteran organizations to train and accredit county service officers. This complicates the uniformity and standardization of training to professional levels currently. Some veterans' organizations, like the Disabled American Veterans, have outstanding programs.

State employees are trained and accredited.

Management and Reports:

The Commonwealth's bureau lacks the necessary authority by statute to perform its role in compensation and pension services.

The Commonwealth is inadequately staffed to pursue an active advocacy role in the area of compensation and pensions.

The Bureau publishes no performance reports on an annual basis, although some reporting does occur monthly to the Pennsylvania Veterans Commission though the exact content of it is not known. Lehigh and Northampton counties produce no annual veterans affairs reports. It is suspected that this is the general situation and those reports produced are generally meaningless number counts that add nothing to the management of claims.

No state-wide claims processing and tracking system exists. County service officers have the choice on who they will file the claims through (the Power of Attorney issue) and they exercise that right.

Benefits Delivery Network (BDN) computerization at county level lags. This is related to the problems of accreditation and TRIP training which are prerequisites.

Awareness:

The GVOAC situation was discussed above.

Web site, www.dmva.doa.vets/vets/va.htm, is average. It is not listed on the DVA general information site, www.va.gov/vso.

Other: Responsible for state veterans homes and Scotland School for Veterans' Children.

PART 5: DISCUSSION – WHERE WE COULD BE

Where should Lehigh and Northampton counties be among its peers in the area of compensation and pensions? Where should Pennsylvania be, since what the Commonwealth does affects the counties? As a minimum, both should be at the national average.

Lehigh County is below Northampton County in disability compensation participation when statistically it should be ahead of it. Northampton County, though steady, is also below the national average. The numbers themselves are not as significant as the fact that the Commonwealth's and Lehigh Valley's programs have not been keeping up with the rate of increased expenditures in compensation and pensions nationally over the last five years. More money is being spent by the DVA, though one could argue not enough, but Pennsylvania and our two counties are falling further behind.

The age and period of service profiles of Lehigh and Northampton counties should be pushing benefits higher. Their median household incomes should be pushing benefits lower, however, that can be overcome with increased claims processing. These two factors would only be relevant if the goal of this study were to raise the benefits level to those of the best states, which it is not.

If all disabled veterans in the United States were properly rated (13.8% of veterans nationally from the 2001 NSV), the estimate would be that 11.9% of them would be compensated (compare with the 9.3% FY 2002 national average, 7.4% for PA, 6.2% for Northampton, 5.8% for Lehigh). Considering the proportionality of pensions, DIC, and other death benefits, the return to the Lehigh Valley would double from about $31,000,000 to $65,000,000 in compensation and pension dollars (FY 2002 dollars). If statistics hold forth, the total expenditures -- which includes compensation and pension, medical services, insurance and educational services – for the Lehigh Valley veterans would more than double to $125,000,000. [See Appendix E for more details.]

Can increased effort be expected to produce results? The other states certainly believe that. Chart 38 demonstrated it. Chart 40 and Supplemental Chart 46 show that more claims mean an increased total return to the veterans and on the investment.

How much would this cost? No one can truly come up with a figure without knowing what public officials are willing to invest in improving the system. Furthermore, the DVA itself can not say "x" amount of dollars will produce certain results. The Texas Veterans Commission estimates for every dollar it spends, $227 is returned to the veteran.[12]

PART 6: SYNOPSIS – ANECDOTAL EVIDENCE IS CONFIRMED

---

[12] Strategic Plan, 2003-2007, Texas Veterans Commission, 1 Jun 02, p. 8

Both Lehigh and Northampton counties and the Commonwealth of Pennsylvania are below average -- even well below average -- in using one of the Department of Veterans Affairs' most important programs, its compensation and pension program. Although it was not the objective of this study, the counties are also well below average in using the healthcare system, a system that is already inundated.

In total expenditures per veteran, the Lehigh Valley falls about $1000 per year below the national average (53% lower) and is at the very bottom of the counties and the country. [Part 2.A; Charts 2 & 3]

The Commonwealth falls about $400 below the national average and ranks in the lower third of states in service-connected disability compensation for its <u>veteran</u> <u>recipients</u>. No county data was available. However, since disability compensation has a direct and correlated effect on total expenditures per veteran, one could expect the Lehigh Valley to be even worse off. This contention is supported by the compensation and pension dollars spread over the <u>veteran</u> <u>population</u>. The Lehigh Valley, at $545, is well below the national average of $993 (45% lower) and near the bottom of Pennsylvania's counties. [Part 2.A; Chart 5, Table 2]

Lehigh and Northampton counties combined are about $2,000 below the national average (39% lower) in medical expenditures per <u>patient</u> in a state that is within the lower fourth of states. This is the most dramatic budget statistic illuminating the existence of a problem. [Part 2.A; Charts 7 & 8]

From a utilization perspective, the situation is even more revealing. The Lehigh Valley falls 38% below the national average of 10.6% in compensation and pension cases per veteran population and is near the bottom of the Commonwealth which itself is near the bottom of the country. [Part 2.B, Charts 13 & 14]

Since compensation and pension cases have a direct effect on medical utilization, the medical picture in terms of patients treated per veteran population per annum would be expected to be at least equally bad. Lehigh and Northampton counties combined are about 45% below the national average of 17.8% and at the bottom of the counties in Pennsylvania, though Pennsylvania fairs slightly better -- yet is still below the national average. [Part 2.B., Charts 15 & 16]

The utilization data shows that Lehigh and Northampton counties' veteran population (aggregated) are not receiving their full entitlements. [Part 2.C; Charts 17 & 18]

The size of the state and counties with respect to their peers (the denominator effect) does not explain the discrepancy. As examples, the states of New York and Texas and Pennsylvania's Berks and Luzerne counties all perform better. Berks County is very close to the Lehigh Valley's performance. Considering its similarities in most measures this is not unexpected. [Part 3.A; Charts 19 & 20]

If age and period of service were reasons, Lehigh and Northampton counties and the Commonwealth of Pennsylvania should be performing much better and perhaps close to the top of the list. Texas' population is younger and it performs much better. The "business" – those most susceptible to needing and using the DVA – is there and will continue to be for the foreseeable future despite the talk of World War II veterans dying off. [Part 3.B and C; Charts 21, 22, 25, & 26]

Lehigh and Northampton counties' service-connected disability profile is insignificantly different from the state's average and lies in the middle third of the group, as do Berks and Luzerne. The Lehigh Valley's veterans are not less healthy or more healthy than most. It is a minor factor, if one, at county level. However, while the range of differences for most states is low, Pennsylvania, with an older veteran population, should be expected to do better, and there is a parallel effect on the Lehigh Valley. The quality of the claims work in documenting or substantiating cases may also be involved. [Part 3.D; Chart 27 & 28]

The financial well-being of a community's citizens (the veteran population being a subset of it and performing better relative to their peers according to the 2001 NSV) seems to have a decided effect on performance. Statistically Lehigh and Northampton counties are better off than most other state counties. However, the state is only average at best. We know from direct contact with the DVA Allentown Outpatient Clinic that its patient loads have about doubled over the past few years. Although they service a wider area than the Lehigh Valley, its performance is also reflective of it. The Bethlehem Steel "legacy" debacle has thrown many older veterans onto the system for the first time. While a factor, personal finances are not only explanation for the relative performance of Lehigh and Northampton counties. It does not explain why Massachusetts and Virginia, with a higher median household income and lower poverty rate than Pennsylvania's, perform better. And since the system's disability compensation awards are not based upon economic need and access to medical service does not fully depend on it, other factors must be in play. It does confirm anecdotal information that veterans do not first look to the DVA for assistance if their finances, to include health benefits, can afford otherwise. We also know that private sector health benefits are decreasing. The decline of private sector health care benefits could explain why the DVA medical system has become more saturated. [Part 3.E; Charts 29 thru 34]

Claims processing times, a management indicator of the performance and efficiency of the Regional Offices, provide no direct explanation of the poor performance of the Lehigh Valley and Pennsylvania. In claims processing times, Pennsylvania as a whole appears to be average. The Philadelphia Regional Office has particularly long turnaround times and is one of the worst. However, it is no worse than New York's Regional Offices, and New York performs better. This all seems illogical. Nevertheless, the statistical correlation is slight. This statistic might also hint at quality control problems. [Part 3.F; Charts 35 thru 37]

In claims processed per year, Pennsylvania is near the bottom. Considering the size of its veteran population, one of the five largest in the country, the state has significantly less disability compensation claims processing in proportion to its veterans population (claims per veteran population per annum) than the majority of states. Lehigh and Northampton counties are subsequently affected. It is processing about 32% less cases in proportion to its veteran population than the national average. A defined relationship between the number of claims processed in a year and the number of claims in the veteran population appears to exist. Note that relationship would extend onto <u>all</u> compensation and pension cases since a proportional relationship exists. Unfortunately the data could not be more refined to show a stronger correspondence, and it is not the only factor in involved (one other key one being personal finances). [Part 3.G; Charts 38 & 39]

According to the 2001 NSV, most veterans (at least two-thirds) tend to go directly to the DVA when seeking their benefits. But over 40% self-screen themselves out of inquiring into service-connected disability benefits and another 13% are not even aware of the program. About 49% did not thoroughly understand their benefits. The system is too complex for a layman and this figure may be even higher than reported. The majority (55%) do not believe the system it is an easy system in which to obtain disability benefits. While the extent of difference between other states is not known, the lack of benefits awareness is a nationally recognized problem. Since the Lehigh Valley is doing so poorly and anecdotes indicated that many veterans do not know their benefit entitlements, the lack of awareness of veterans' benefits must be a factor. [Part 3.H; Tables 7 thru 10]

In the 2003 budget submission, the DVA rated its disability and pension claims processing system and its care for the disabled and low-income veteran as both ineffective. [Part 3.I]

The DVA does not emphasize "front-end" personal service in compensation and pensions in general and assuredly in Pennsylvania. The emphasis is on special in-house teams, process, technology and a telephone number. There are exceptions to this rule where the DVA outbases personnel. That seems to be occurring in the larger southern and southwestern states, where they see the migration of the aging

veteran population and the concentration of younger military retirees. Front-end service has a definite impact and pays dividends. However, manpower without sufficient and properly placed points of service is useless. Locations must match up with veteran concentrations, to minimize manpower waste. However, the DVA tends to center on major metropolitan areas. Where they outbase performance of the system improves. Where states augment or replace counties with their own employees and offices, the total system improves. The DVA and the states are the major determinants to a successful system. [Parts 3.I & J; Tables 11 & 12]

The other states sampled, with the exception of Ohio, have more aggressive programs. Texas followed by North Carolina have the best programs and could serve as models based upon their overall performance. An advocacy mindset seems to drive the New York and Texas organization. An augmentation mindset seems to drive the North Carolina initiatives, although advocacy is on their agenda. All the states sampled have chosen to separate their veterans affairs "bureaus" from their military "bureaus" to ensure focus. Those states that augment or replace the county service officers do better. Most states do not require county level officers, although all have them, except West Virginia. All have experienced at some time problems with county level officers and their quality. All, except West Virginia, conduct county level training. Claims tracking and accountability reports appear to stimulate professionalism, effectiveness, efficiency, and proper workload redistribution. The states that track and follow their customer base show adaptability to the currently changing veteran picture, especially as areas urbanize. These states also make up for the deficit the DVA leaves in emphasizing procedure (sometimes taking on an adversarial flavor) over personal contact and concentrating the vast majority of its workforce in major metropolitan areas. The better states have tended over the course of time to route the flow of paperwork through their own people in the DVA Regional Offices, unless the veteran desires it otherwise (the POA issue). This improves quality and turnaround times. Those who work closely with the DVA generally decrease their own costs. Competitive pay for quality personnel and personnel retention is a factor as the system is very complicated. Those who promote awareness also show improved results, especially where there is interagency involvement. Computerization receives heavy emphasis in the southern states where the streamlining the flow of claims seems to be the most successful. [Part 4]

How could the Lehigh Valley improve its services to veterans? A concerted effort is needed, but the payoff is huge. In just trying to achieve national standards, not Texas' or North Carolinas', the Lehigh Valley could double its returns in compensation and pension dollars and participation in the system. This also has a follow-on effect on medical services utilization and total expenditures in the Valley. Lehigh and Northampton counties and the Commonwealth of Pennsylvania are lagging behind most other states, to include gaining access to the recent increases in the DVA budget. [Part 5]

PART 7: CONCLUSION

By one count, nearly one in seven adults in the Lehigh Valley is a veteran.[13] In a major statistical area of with a population of nearly 500,000 adults, that is a significant part of the population. Nor does that comparison consider the veterans' dependents, which are subsequently affected. Veterans' access to their benefits and entitlements is an important issue for the Lehigh Valley.

And in the Lehigh Valley, a problem does exist in veterans' benefits services, if the yardstick is the compensation and pension program. Since the current Department of Veterans Affairs – the major administrator of veteran benefits – is concentrating on disability and indigent care, the compensation and pension program takes on added significance, for it most frequently is the gateway to the most important benefits. The Lehigh Valley veterans' participation in the healthcare system provides a poignant example of its importance.

[13] U.S. Census 2000, found at www.va.gov/vetdata/Census2000/index.htm

The factors of age, period of service, disability, personal finances, and DVA regional office efficiency, individually or in combination, do not explain away the deficiency.

However, the Lehigh Valley's situation cannot be considered in isolation of Pennsylvania's. The Commonwealth's dependence upon a loosely organized system of county veterans directors (offices) to perform a core duty of claims processing – without state oversight, without uniform and required standards of training and certification, and largely without the next level of support – has had unintended consequences. The DVA does not have the capacity to compensate and has become increasingly dependent on state and veteran organization resources for front-end service and claims development. Nor can the veterans organizations entirely pick up the slack. While they are now a vital resource for claims processing and a necessary advocate, they do not have the qualified manpower or budget to accomplish the task of providing a complete system with adequate front-end service. The proof is in the history of our and other states.

The Commonwealth and, consequently, the Lehigh Valley fall short in comparison with most other states in helping their veterans secure their deserved benefits. Again, the key shortfall is the lack of an organized and properly staffed system that can be effectively and efficiently managed – that can deliver. Other states have encountered this problem, and have taken steps to overcome it. Now is the time for Pennsylvania to do likewise. The issue will not die away with the World War II veteran, and already 12% of the returning soldiers from the recent conflicts are seeking VA healthcare. For various reasons, the number of cases is not decreasing. Service-connected disability compensation is expected to rise to 2.6 million nationally in 2005, from 2.3 million in 2001.[14]

Some will argue that the Commonwealth and the nation cannot afford such a proactive position. This is not true and really beside the point, if we are to keep our promise to "take care for him who has borne the battle, and for his widow, and his orphan."[15] A measure of honor is involved. Still, our veterans are not greedy. They ask for no more than their fair due if they aware of their entitlements. Less than 15% of their compatriots will ever benefit from the compensation and pension program in a perfect system, which it is not. Furthermore, our investment in them has been well rewarded in productive lives and returns to the community.

The following recommendations are made in an effort to propose a solution to what the Lehigh Valley Military Affairs Council views as a county and state problem.

PART 8: RECOMMENDATIONS – SEEKING SOLUTIONS

Use Texas, North Carolina, and West Virginia systems as the models for new ways of doing business in the Commonwealth of Pennsylvania.

By statute, create a State Department of Veterans Affairs (hereafter called the SDVA) to subsume the current bureau and expand its advocacy and support mission in the area of veterans benefits counseling and claims processing.

By statute, turn over the administrative control of the county veterans service officers to the SDVA to improve their training, credentialing and professionalism. Require counties to have accredited veterans service officers. Augment these counties with state veterans service officers formed into districts with areas of responsibility.

---

[14] Delivered Remarks on VA Budget Roll-Out [FY 2005], Sec. of VA Anthony J. Principi, before the National Press Club, 2 Feb '04.

[15] A phrase often quoted by the DVA from Abraham Lincoln's second inaugural address, 1865.

Require accreditation for all state and county veterans' service officers and district supervisors as a condition of continued employment. Require currency training. Include claims processing performance measures in their job descriptions. This will mean making service officer pay competitive once accreditation is achieved to ensure retention and fend off DVA and other organizations' head hunting, as accredited veterans' service officers are in demand.

By statute, require that all state and county veterans' service officers' claims be forwarded through the state veterans' service office at the Philadelphia VARIOC or Pittsburgh VARO, unless the veteran assigns Power of Attorney (POA) to another organization. The follow-on to this is that the state assumes responsibility for advocacy and represents the veteran during the appeals process, when POA is assigned. Enter into agreements with veterans' organizations for dual accreditation of state and county service officers for access to the Benefits Delivery Network (see Glossary) and veteran organizations' National Service Officers. This will allow point-of-service follow-up for management and the veteran.

Require at state and county levels compensation and pension program management measures of performance, performance tracking; and at least annual Performance and Accountability Reports.

Implement the DVA Benefits Delivery Network (BDN) system statewide and down to county level to expedite and streamline claims processing. This will require additional training of county and state "accredited" personnel.

Require the DVA to electronically publish county and state "budgets," utilization and other pertinent data for state and county use in assessing system performance.

Increase DVA field personnel presence in the Commonwealth via outbasing and outreach initiatives.

Increase awareness of veterans benefits and service locations for <u>all</u> organizations (federal, state, county, city, veteran, and physicians' organizations) involved with veterans benefits on one central, linking web site managed at state level, through broadcast and print media, physicians' conferences, and through inter-agency and inter-organization Memorandums of Agreement.

Create an inter-agency Veterans Service Center as a pilot project in the Lehigh Valley. Major requirements are:

- DVA staffing with VSR and VRE personnel
- SDVA veterans' service officer staffing
- State Department of Labor and Industry (DLI) veterans' employment representative staffing
- County veterans service officers
- Veteran organization representatives
- Social workers (example: Homeless Veterans assistance, Women Veterans assistance)
- Other agencies involved with veterans benefits
- A fully computerized and integrated claims operation approved by SDVA and DVA.
- Convenient access (handicapped), free parking, near a bus route, and adjacent to the U.S. Route 22 artery that connects the Lehigh Valley's major urban areas
- Memorandums of Agreement and Reimbursement

Richard J. Hudzinski
Chairman, Veterans Affairs Committee
LVMAC

Colonel William T. Harris III, US Army-Ret.
President
LVMAC

Revisions:

12 July 2004: grammatical error corrections
30 Sep 2004: page number correction, no content changes

TABLE OF CONTENTS

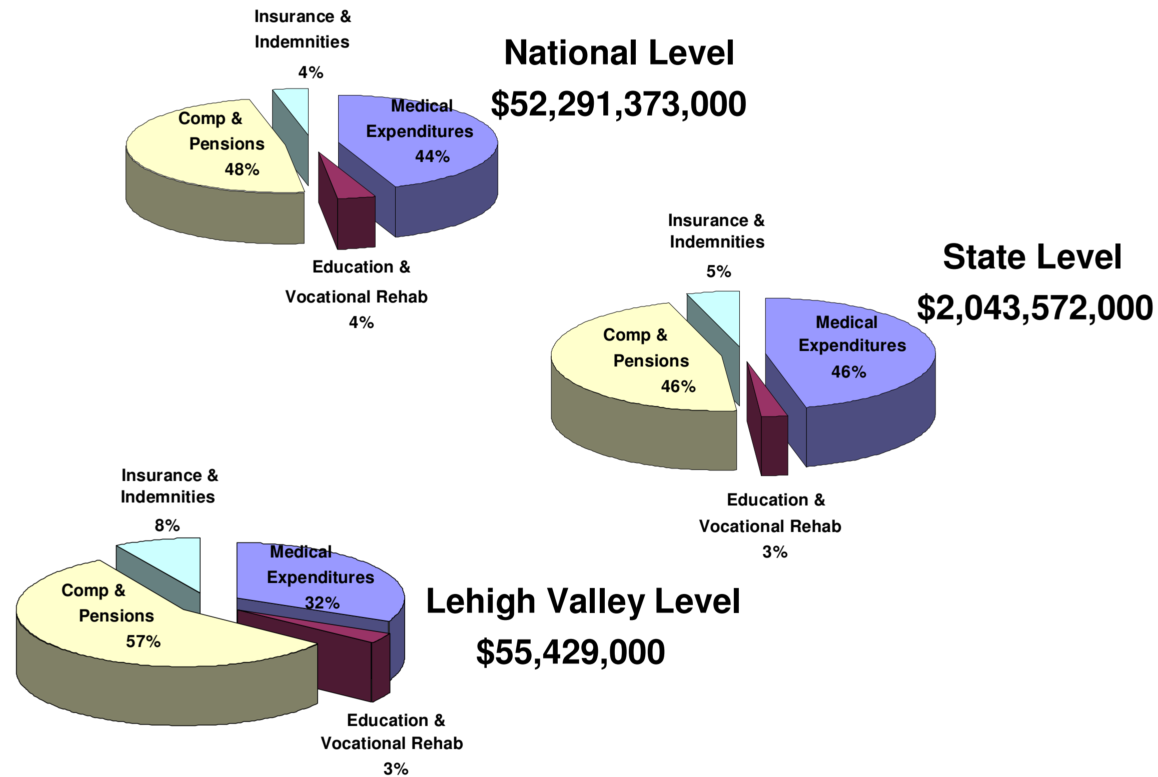
Chart 1: Major VA Program Categories 3
Chart 2: VA "Budget" by County 4
Chart 3: VA "Budget" by State 5
Chart 4: The Correlation between Disability Claims and Death Benefits 6
Chart 5: Disability Compensation by State, FY 2003 Projection 7
Chart 6: Disability Pensions by State, FY 2003 Projection 8
Chart 7: Medical Cost per Treated Patient by State, FY 2002 9
Chart 8: Medical Cost per Treated Patient by County, FY 2002 10
Chart 9: Service-Connected Disability Comp Percentages by State, FY02 11
Chart 10: Service-Connected Disability Comp Percentages by County, FY02 12
Chart 11: Disability Pension Cases/Population by State, FY 2002 13
Chart 12: Disability Pension Cases/Population by County, FY 2002 14
Chart 13: Disability C&P Cases by State, FY 2002 15
Chart 14: Disability C&P Cases by County, ca FY 2002 16
Chart 15: Medical Utilization by State, FY 2002 17
Chart 16: Medical Utilization by County, FY 2002 18
Chart 17: Utilization of Key Benefits by State, FY 2002 19
Chart 18: Utilization of Key Benefits by County, FY 2002 20
Chart 19: State Veteran Population and Denominator 21
Chart 20: County Veteran Population and Denominator 22
Chart 21: Age Profile by the States 23
Chart 22: Age Profile by County 24
Chart 23: Disability Compensation Profile by Period of Service 25
Chart 24: Disability Pension Profile by Period of Service 26
Chart 25: Period of Service Profile by State 27
Chart 26: Period of Service Profile by County 28
Chart 27: State Disability Profile 29
Chart 28: County Disability Profile 30

Chart 29: Household Income by State ... 31
Chart 30: Household Income by County ... 32
Chart 31: Looking for a Relationship between Income and C&P Cases ... 33
Chart 32: Poverty Level by State ... 34
Chart 33: Poverty Level by County ... 35
Chart 34: Looking for a Relationship between Poverty and C&P Cases ... 36
Chart 35: Claims Processing Exceeding 180 Days for December 2002 ... 37
Chart 36: Claims Processing Exceeding 180 Days, 3 Point Average ... 38
Chart 37: Looking for a Relationship between Claims Time and Disability Cases ... 39
Chart 38: Compensation Cases Completed per Annum, FY 2002 ... 40
Chart 39: Looking for a Relationship between Claims Rate and Disability Cases ... 41
Chart 40: Looking for a Relationship between Expenditures and C&P ... 42

Supplemental Charts

Chart 41: Correlation between Disability and Total Compensation and Pension Cases ... 43
Chart 42: Correlation between Median Household Income and Disability Compensation and Pension Cases ... 44
Chart 43: Correlation between Poverty and Disability Compensation and Pension Cases ... 45
Chart 44: Correlation between Claims Processing Time and Disability Compensation and Pension Cases ... 46
Chart 45: Correlation between Disability Compensation Claims per Year and Disability Compensation Cases ... 47
Chart 46: Correlation between Total Compensation and Pension Cases and Total “Direct” Expenditures ... 48

FY 2002 Total "Direct" Expenditures



Notes:
1. Excludes general operating expenses and construction expenses.
2. Includes Direct Appropriations. Excludes revolving fund programs, such as mortgage guaranties.
3. Source: FY 2002 DVA "GDX" Report found at www.va.gov/vetdata.

This study conducted by the Lehigh Valley Military Affairs Council, a non-profit 501c3 organization dedicated to help veterans, military and their families.

Chart 1: Major VA Program Categories

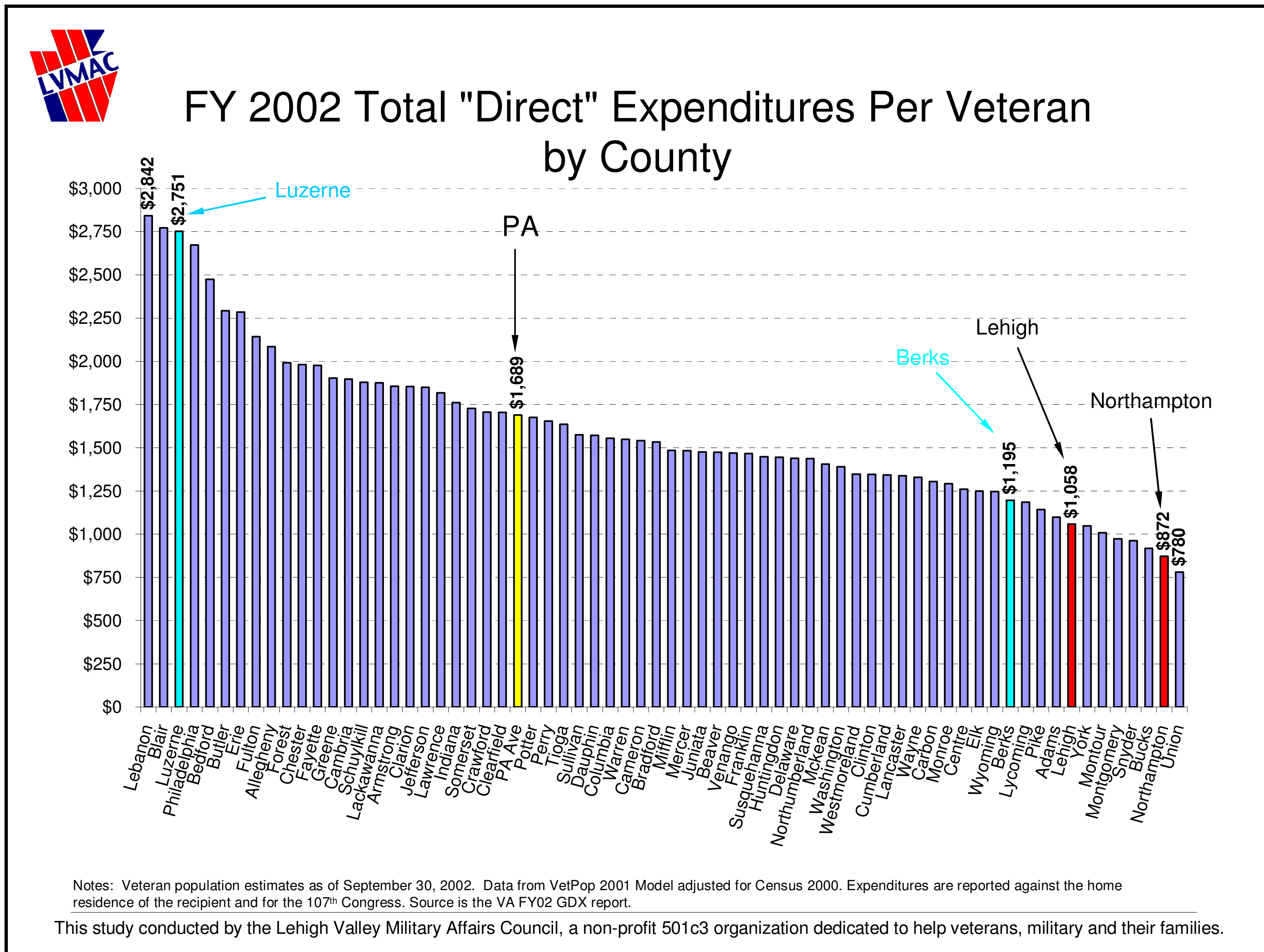


Chart 2: VA "Budget" by County

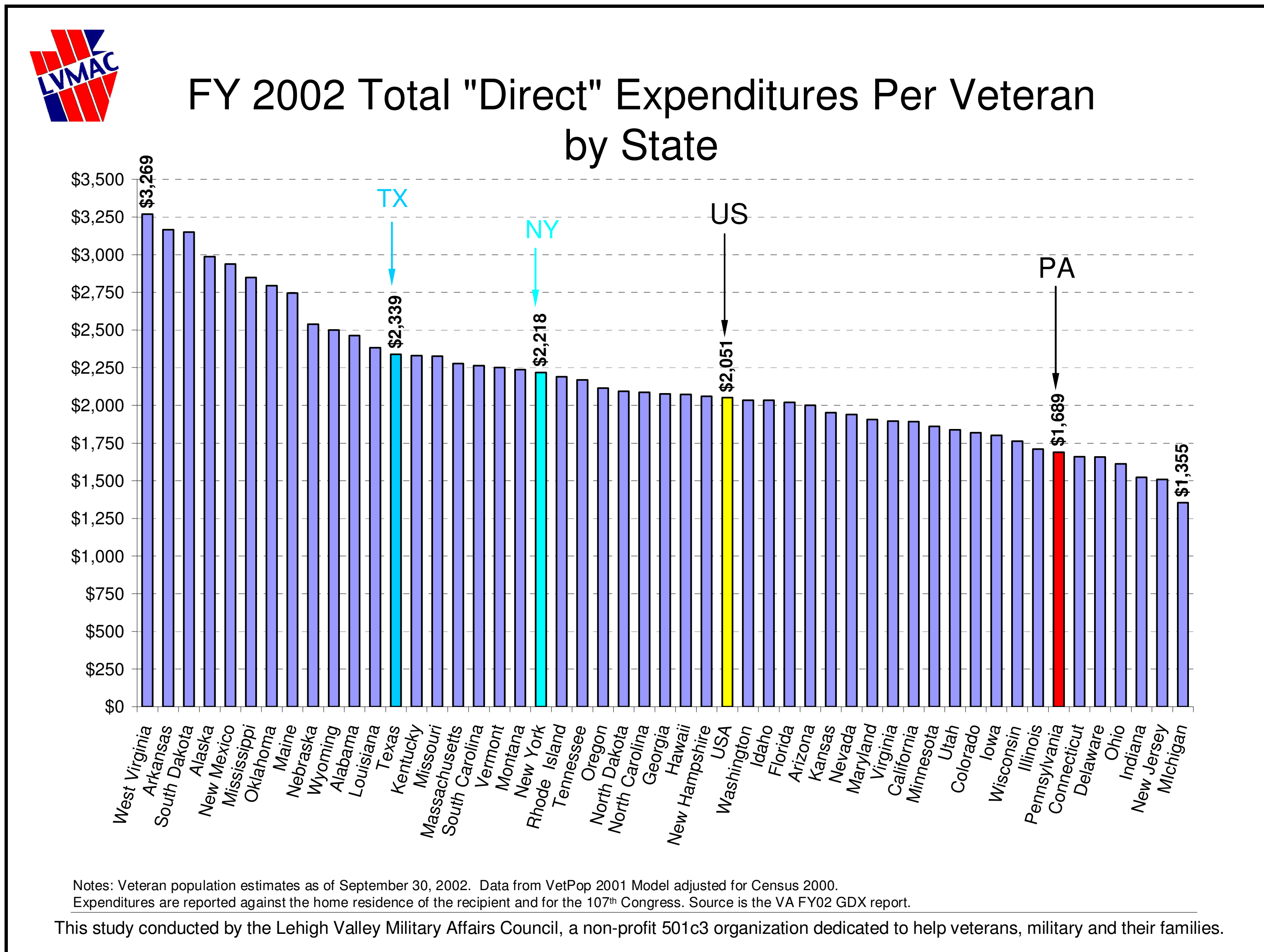


Chart 3: VA "Budget" by State

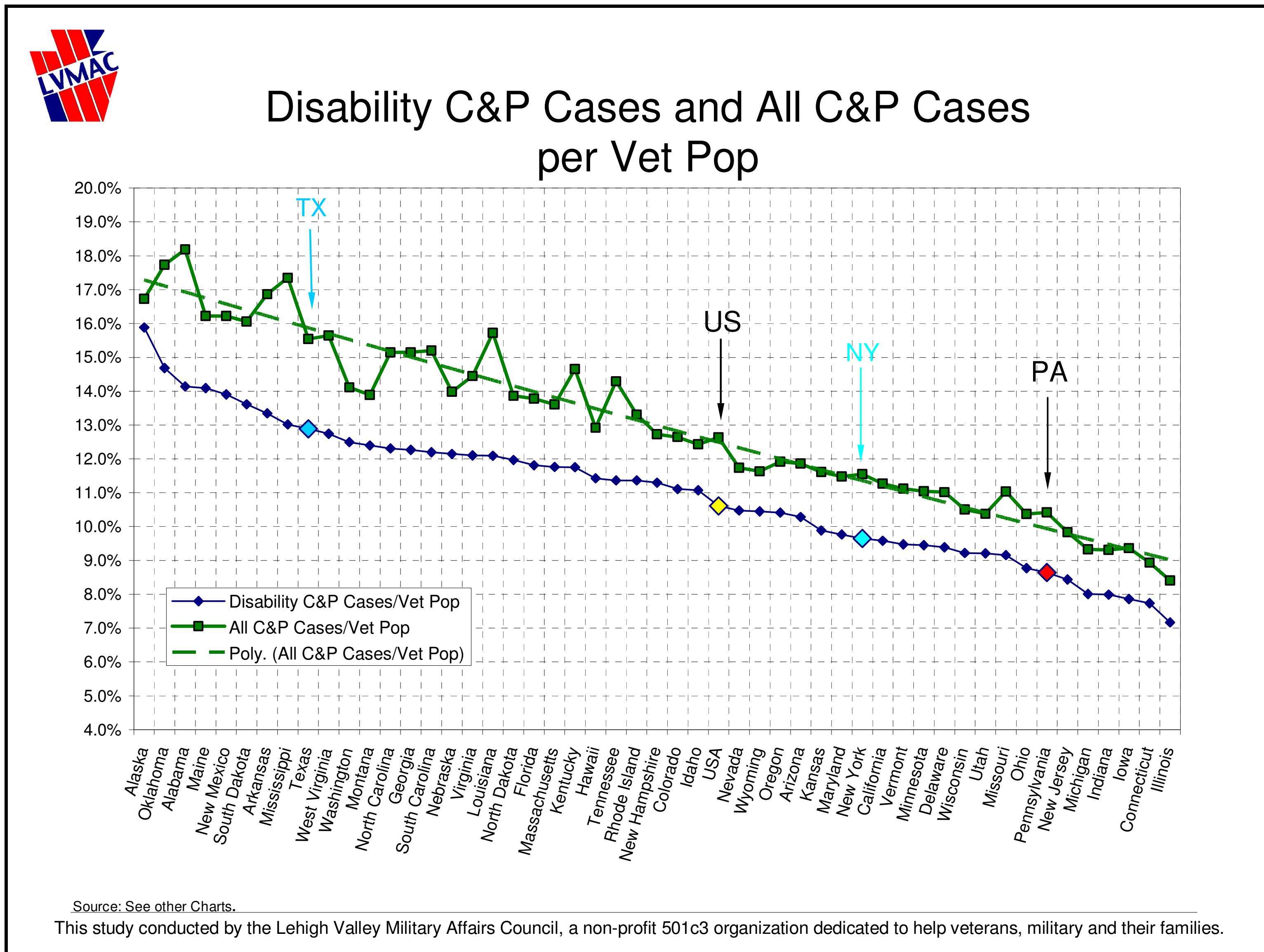


Chart 4: The Correlation between Disability Claims and Death Benefits

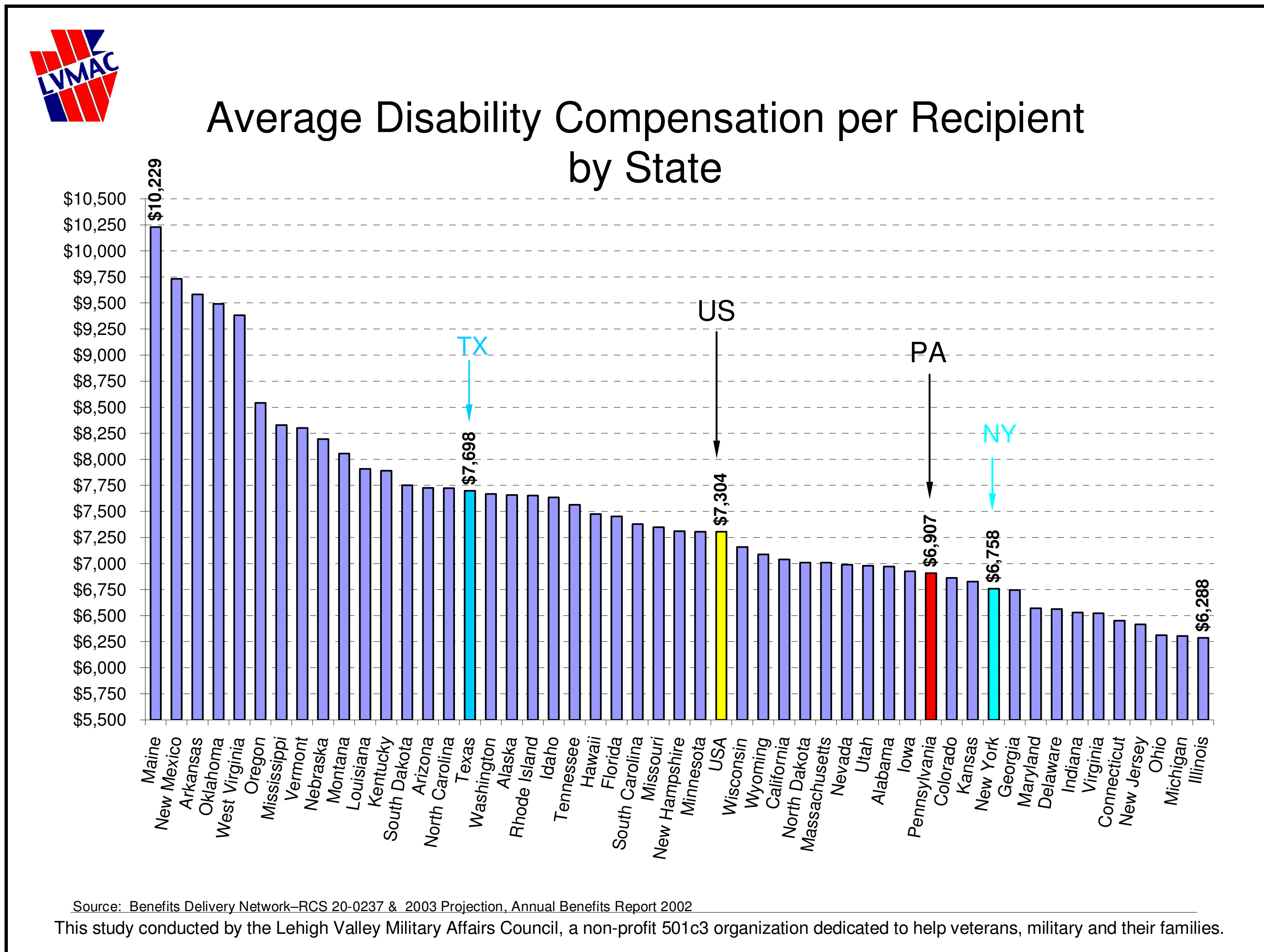


Chart 5: Disability Compensation by State, FY 2003 Projection

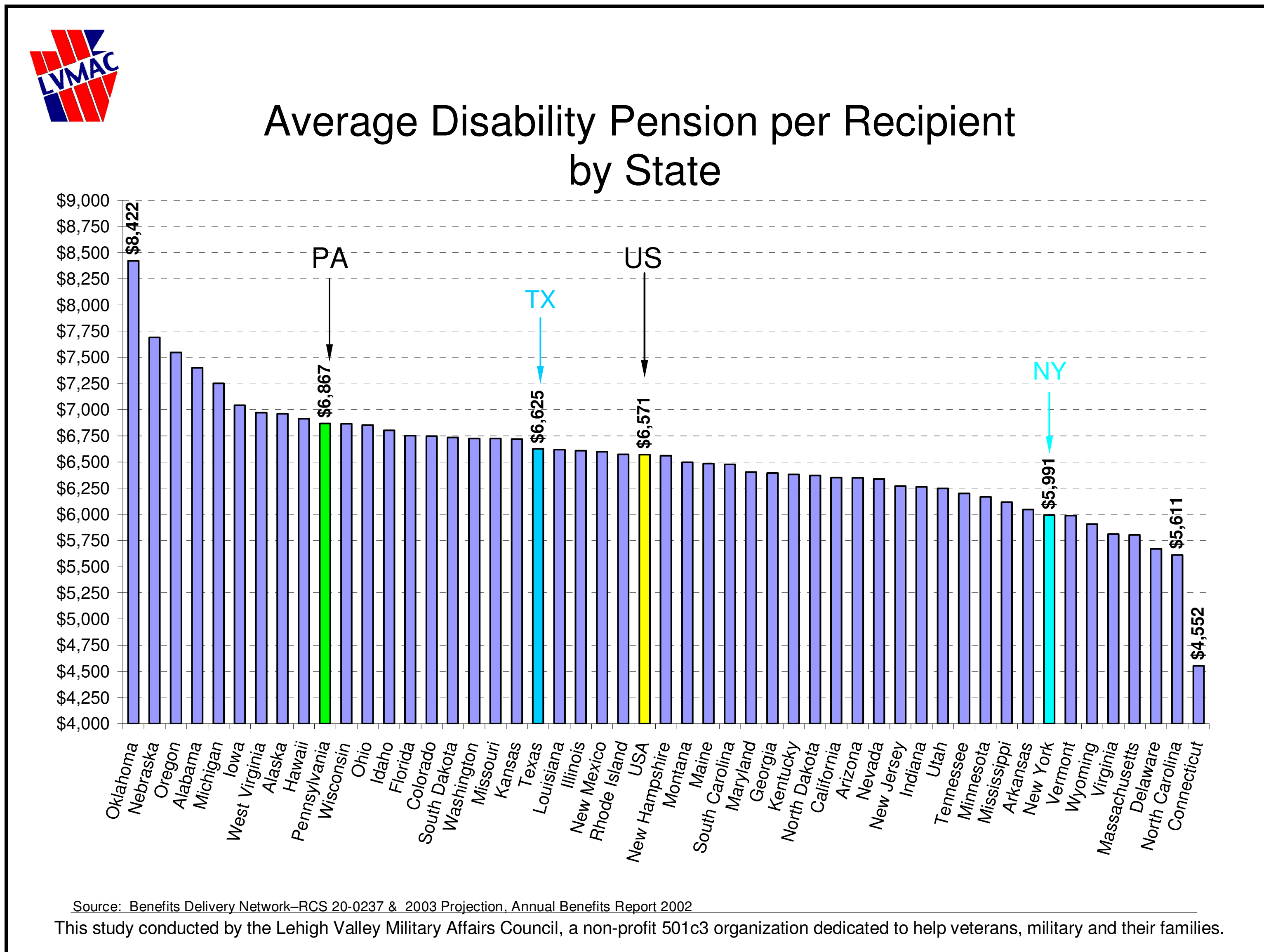


Chart 6: Disability Pensions by State, FY 2003 Projection

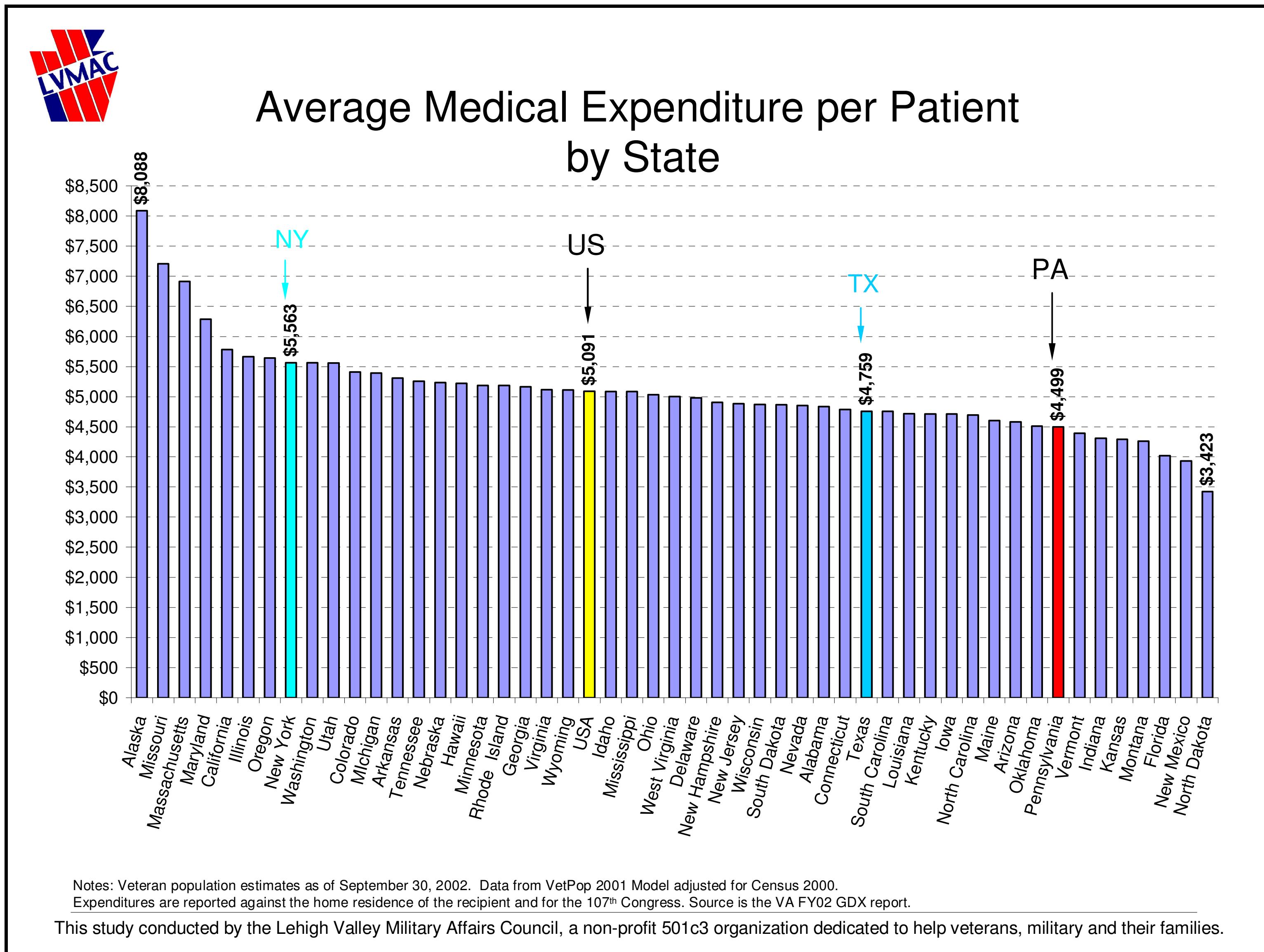


Chart 7: Medical Cost per Treated Patient by State, FY 2002

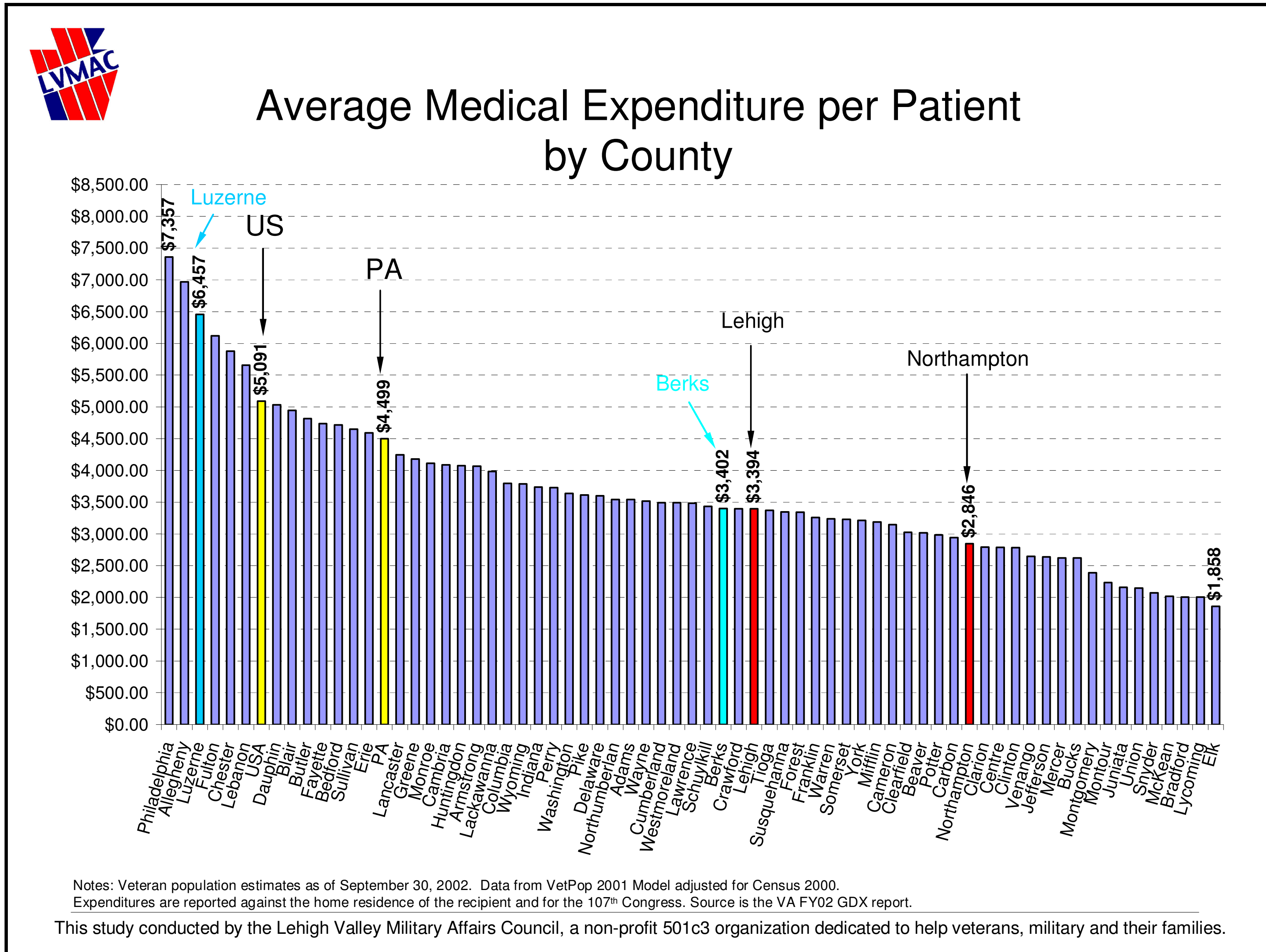


Chart 8: Medical Cost per Treated Patient by County, FY 2002

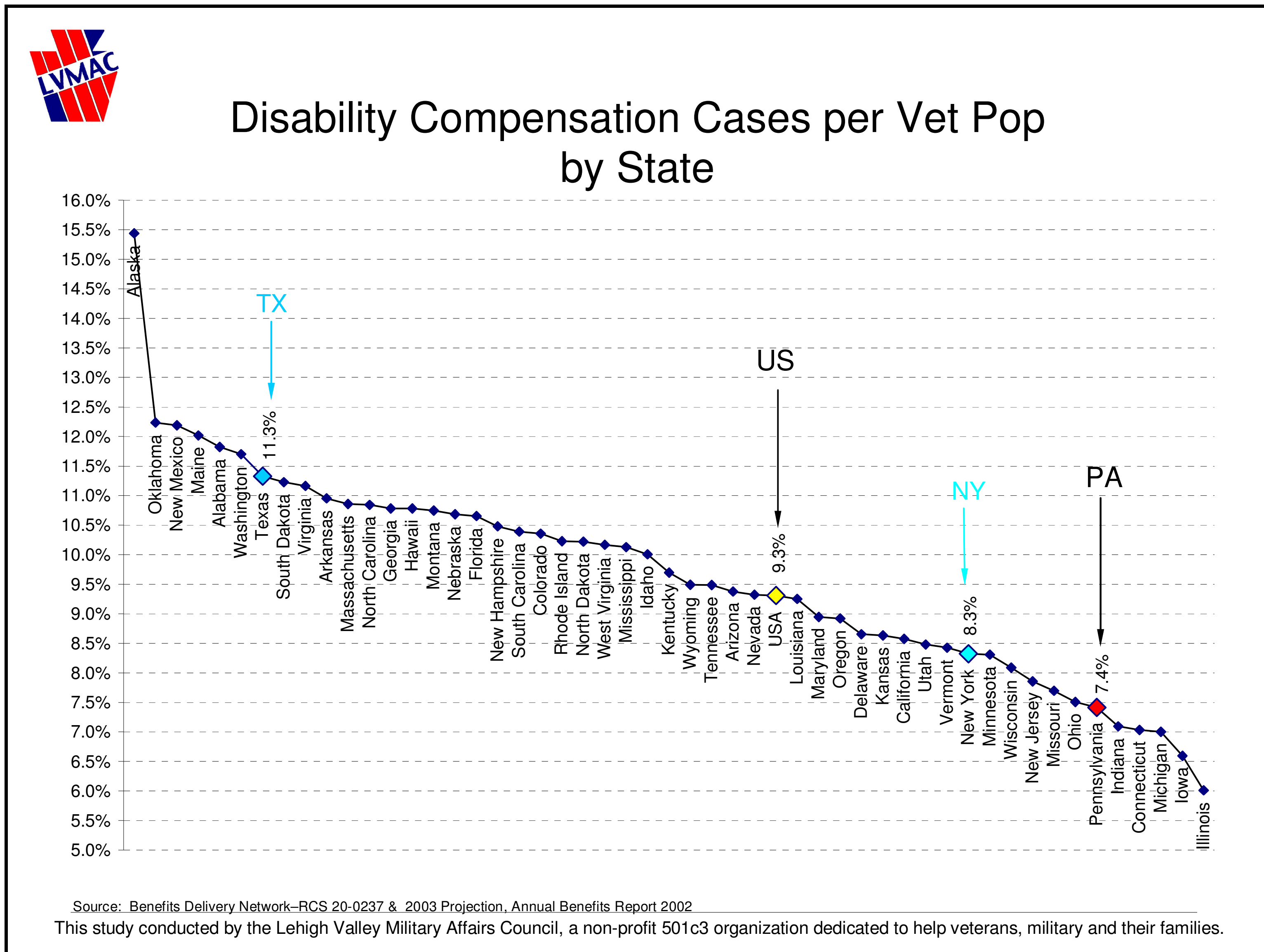


Chart 9: Service-Connected Disability Comp Percentages by State, FY02

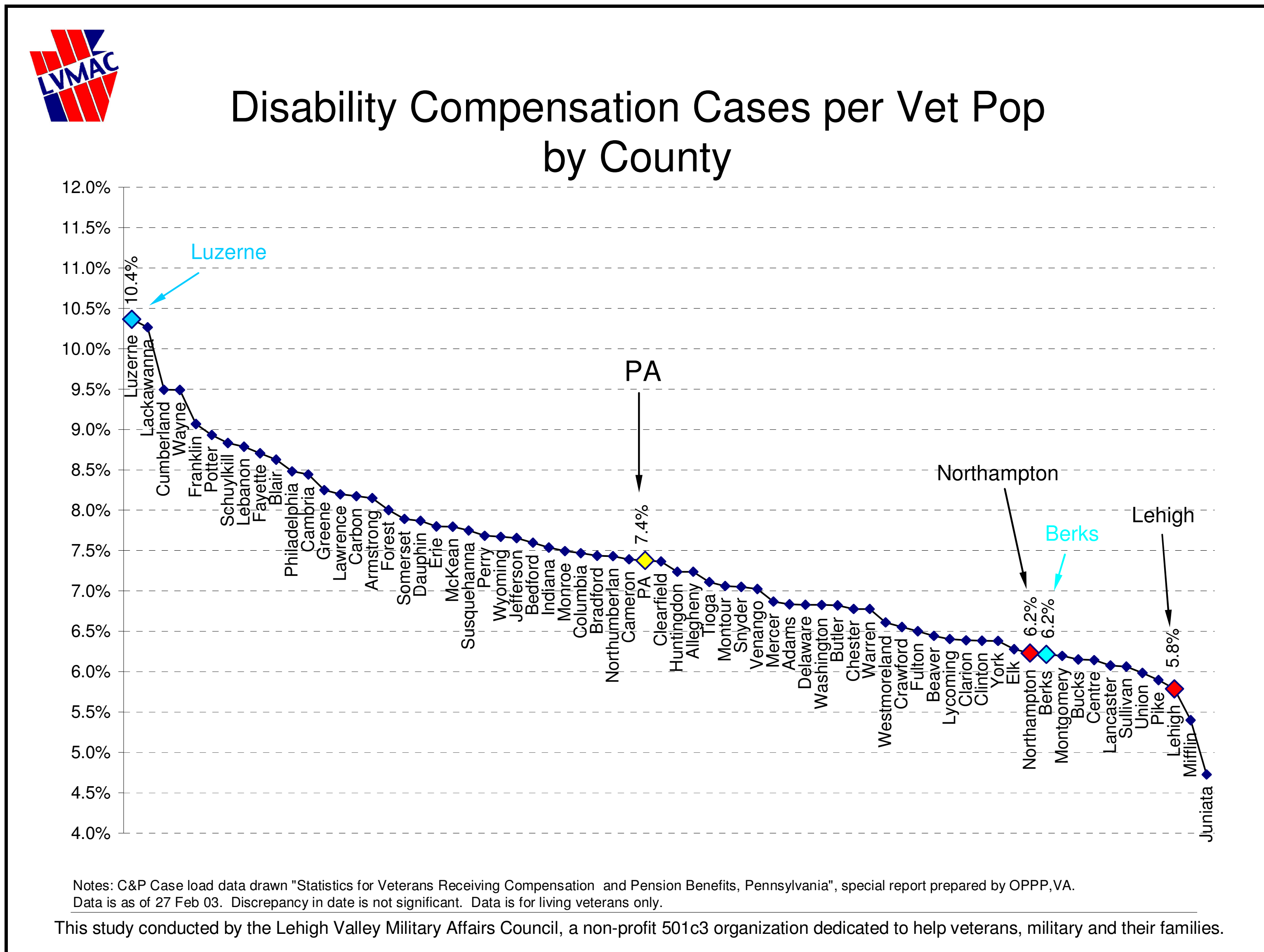


Chart 10: Service-Connected Disability Comp Percentages by County, FY02

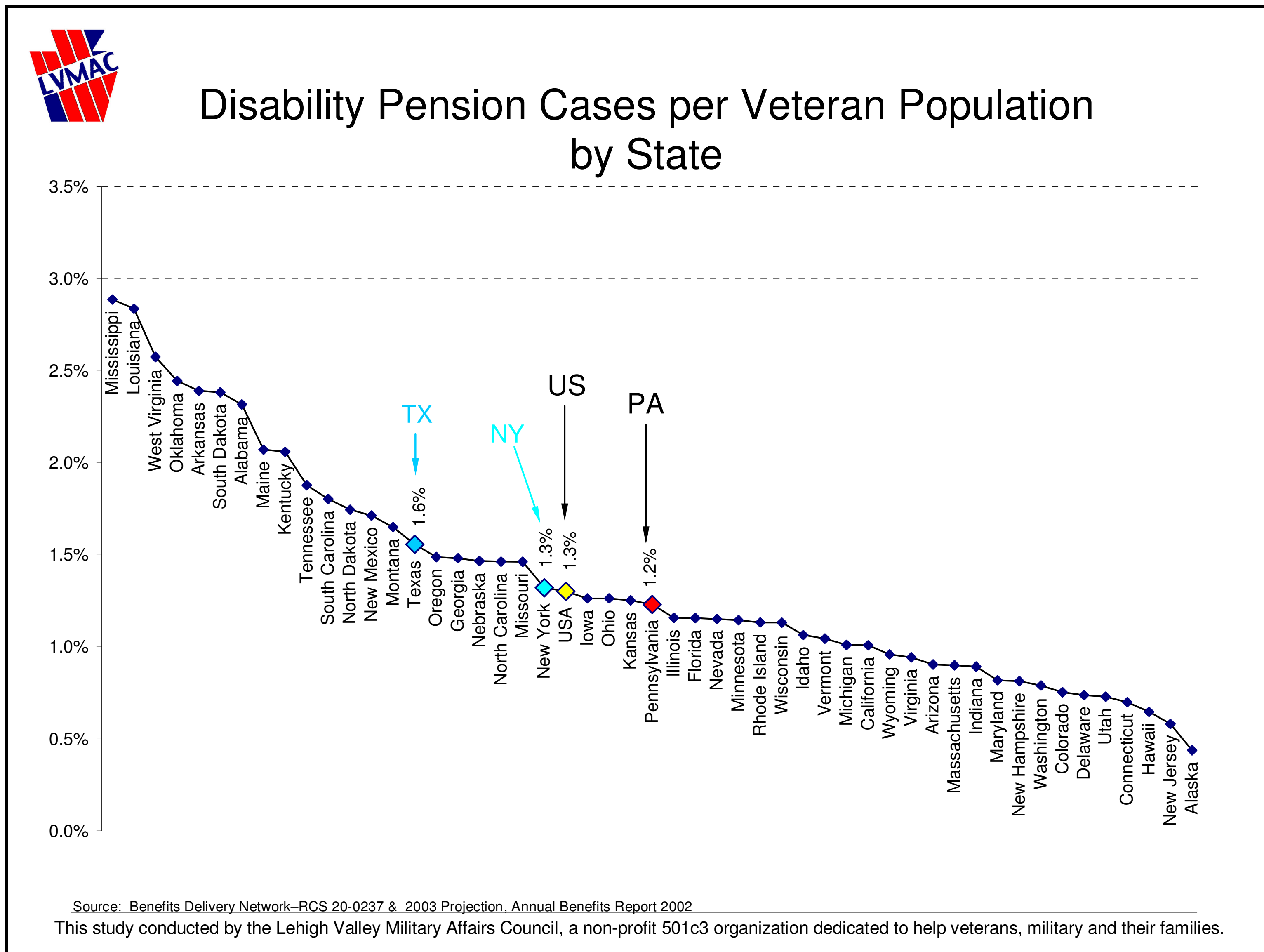


Chart 11: Disability Pension Cases/Population by State, FY 2002

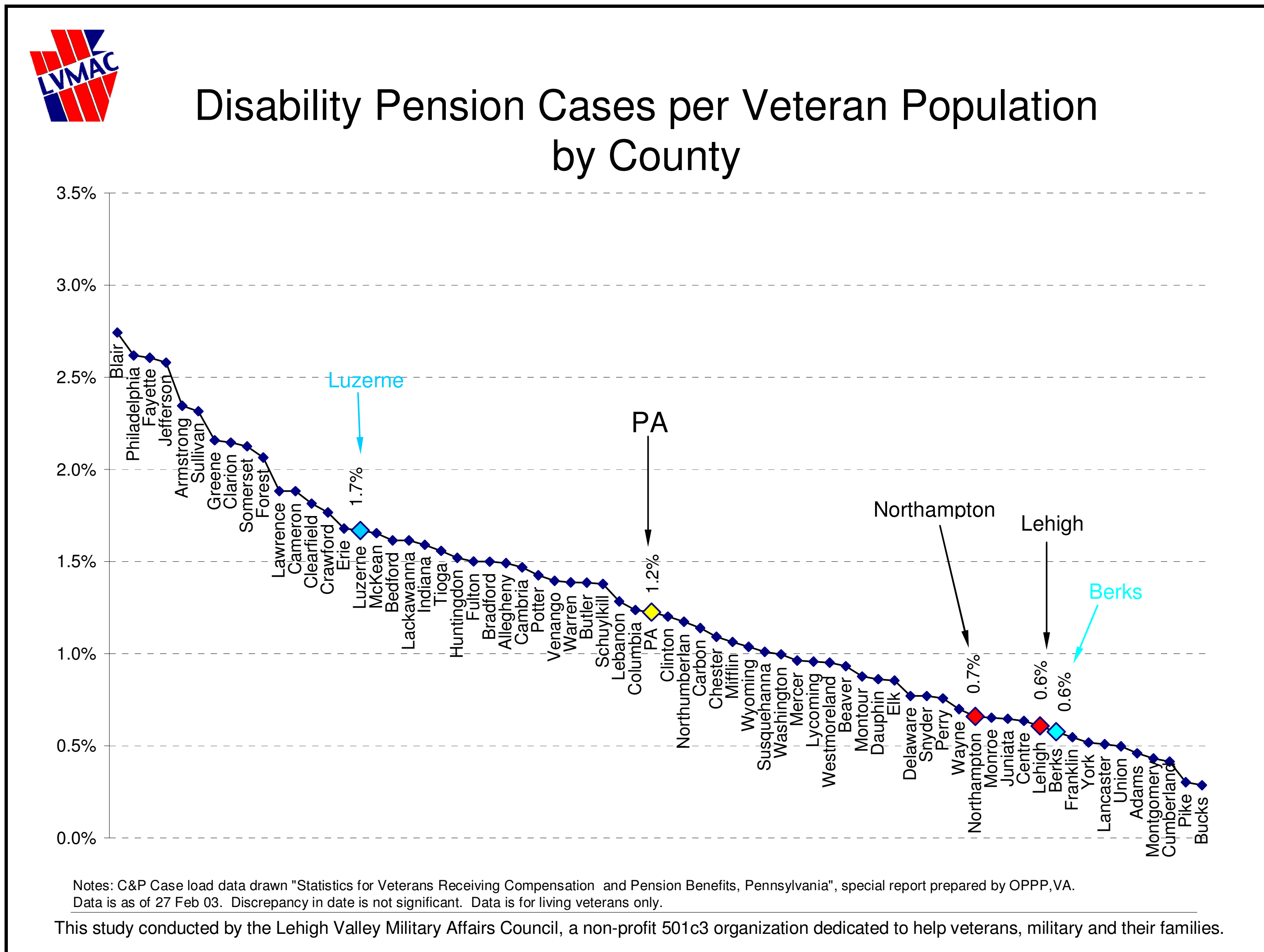


Chart 12: Disability Pension Cases/Population by County, FY 2002

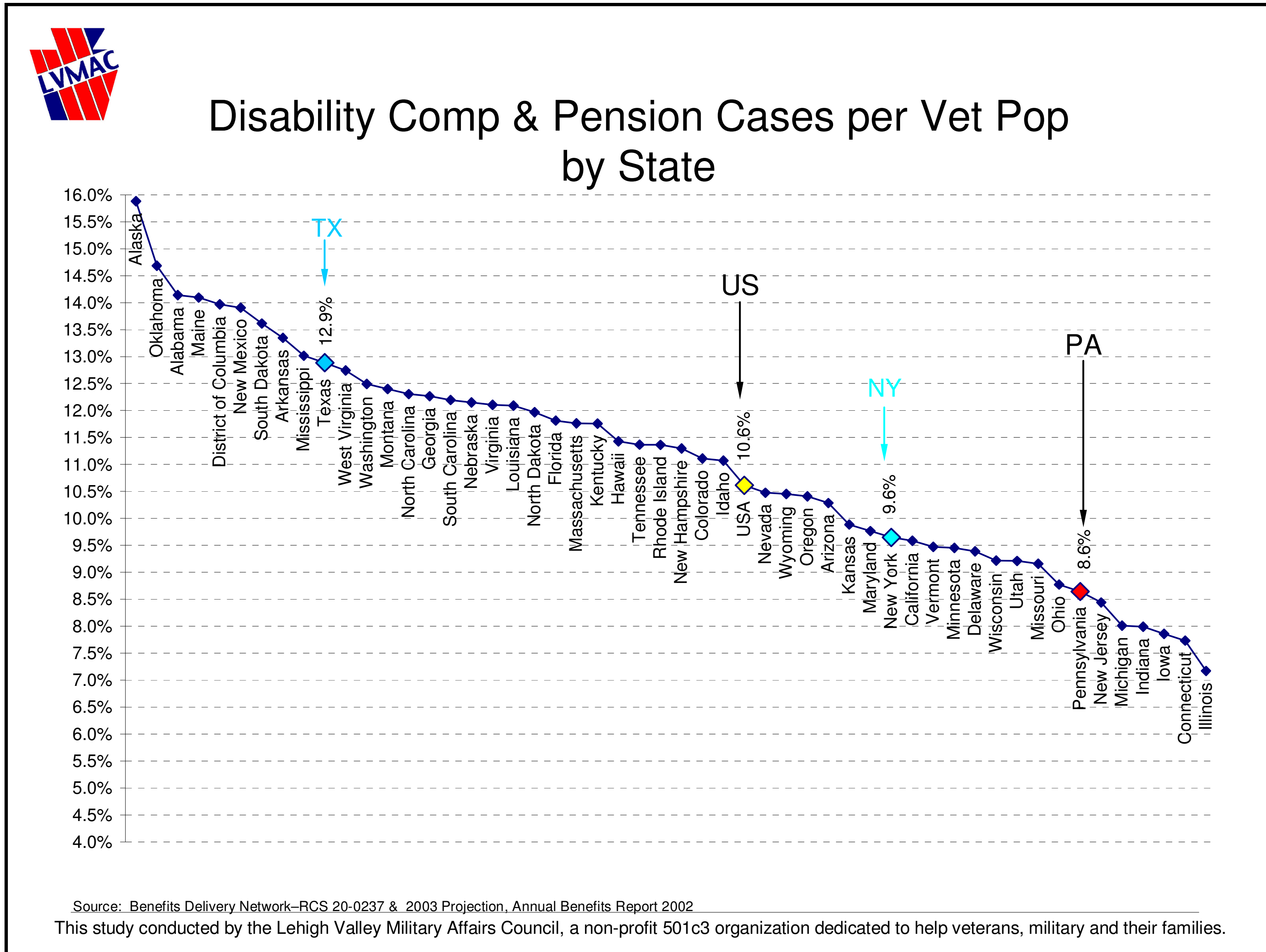


Chart 13: Disability C&P Cases by State, FY 2002

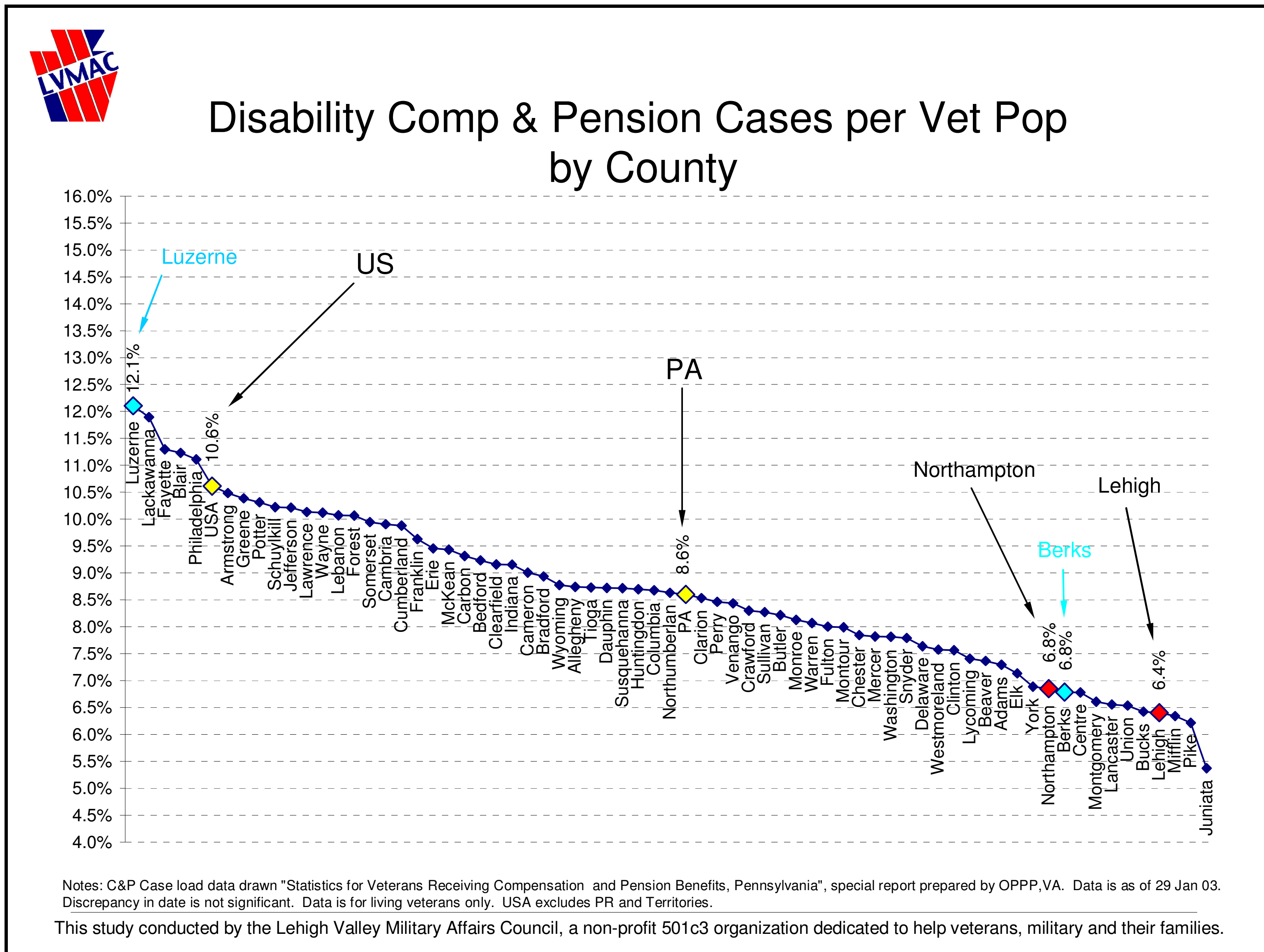


Chart 14: Disability C&P Cases by County, ca FY 2002

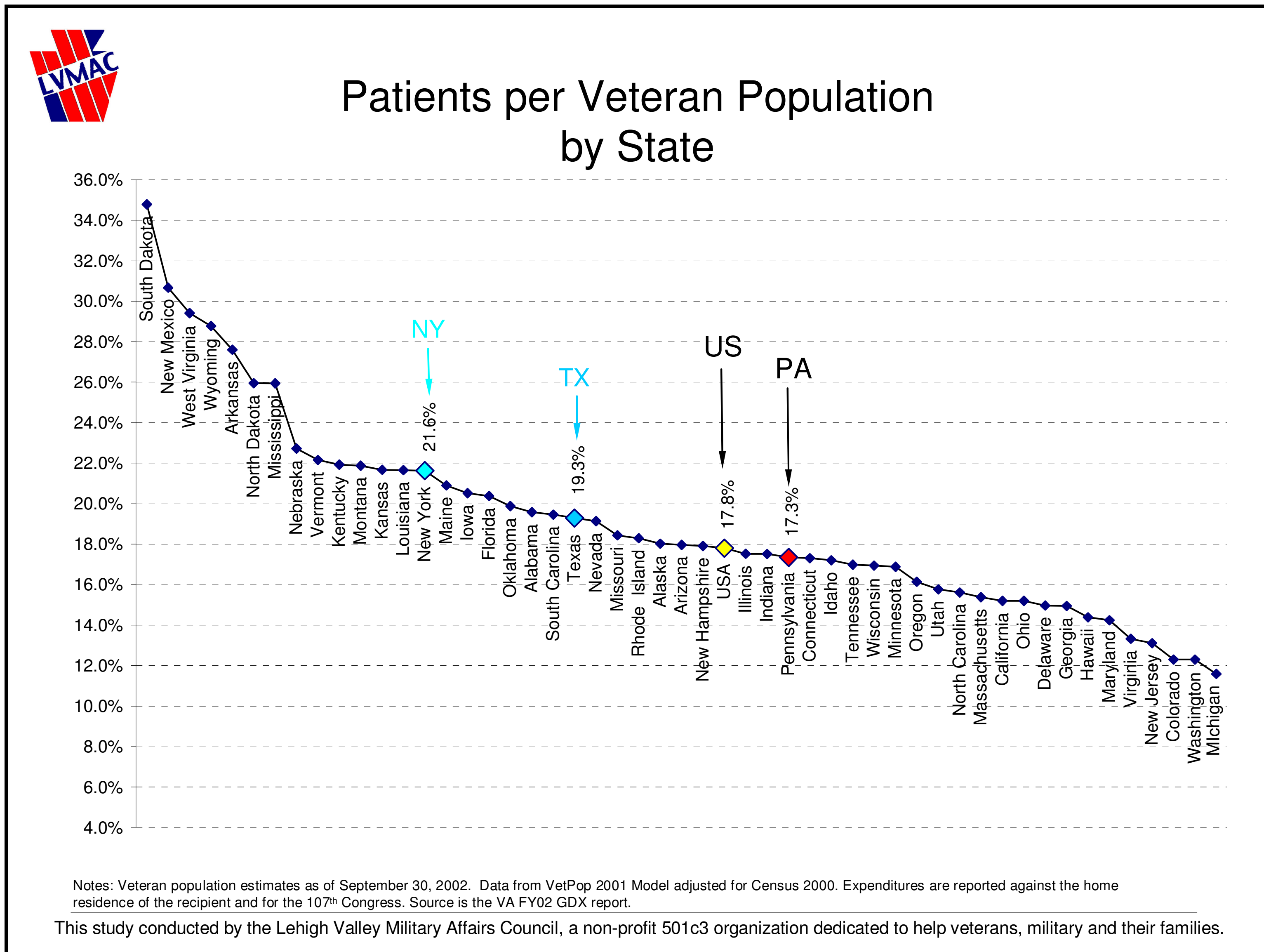


Chart 15: Medical Utilization by State, FY 2002

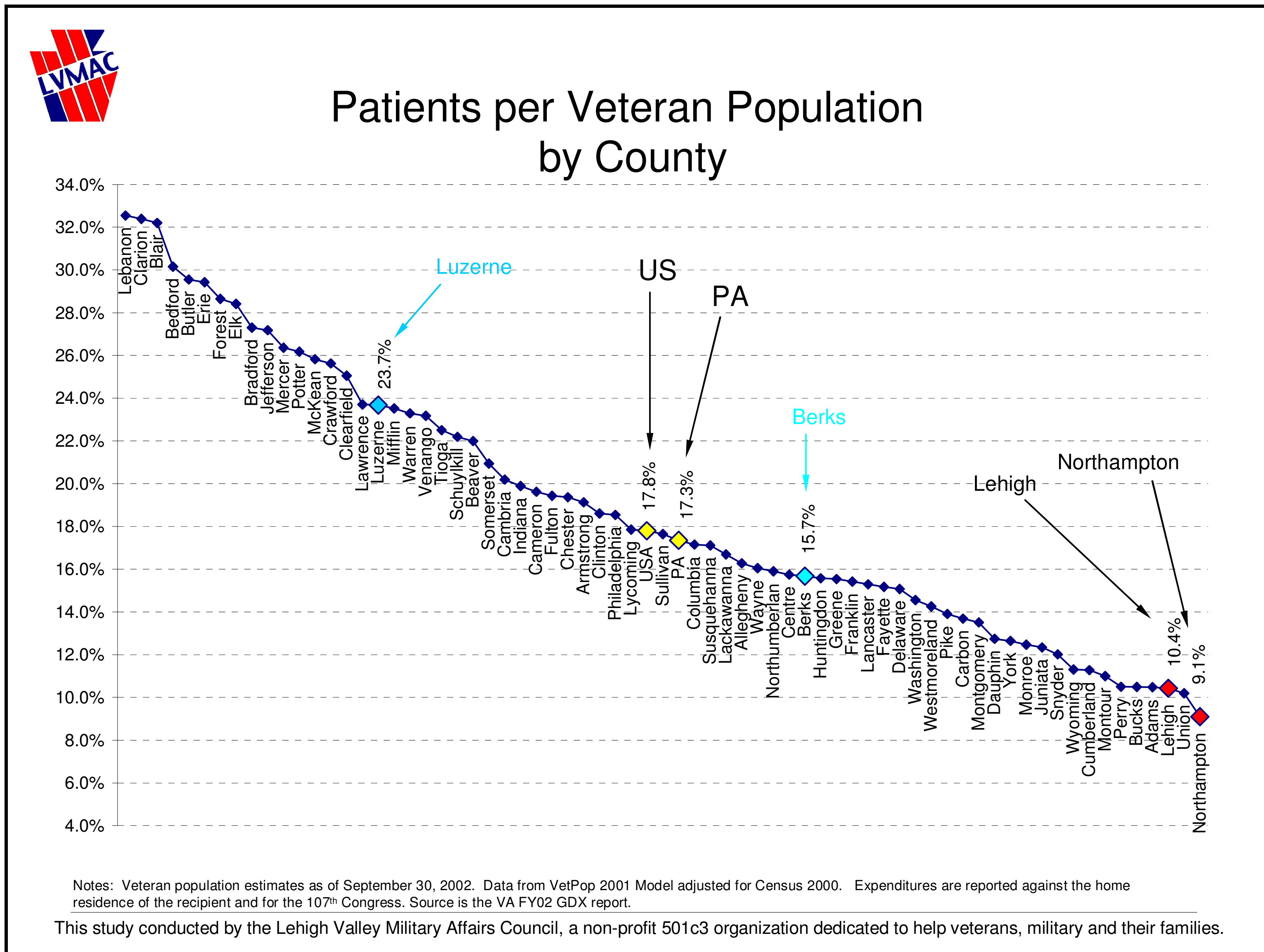


Chart 16: Medical Utilization by County, FY 2002

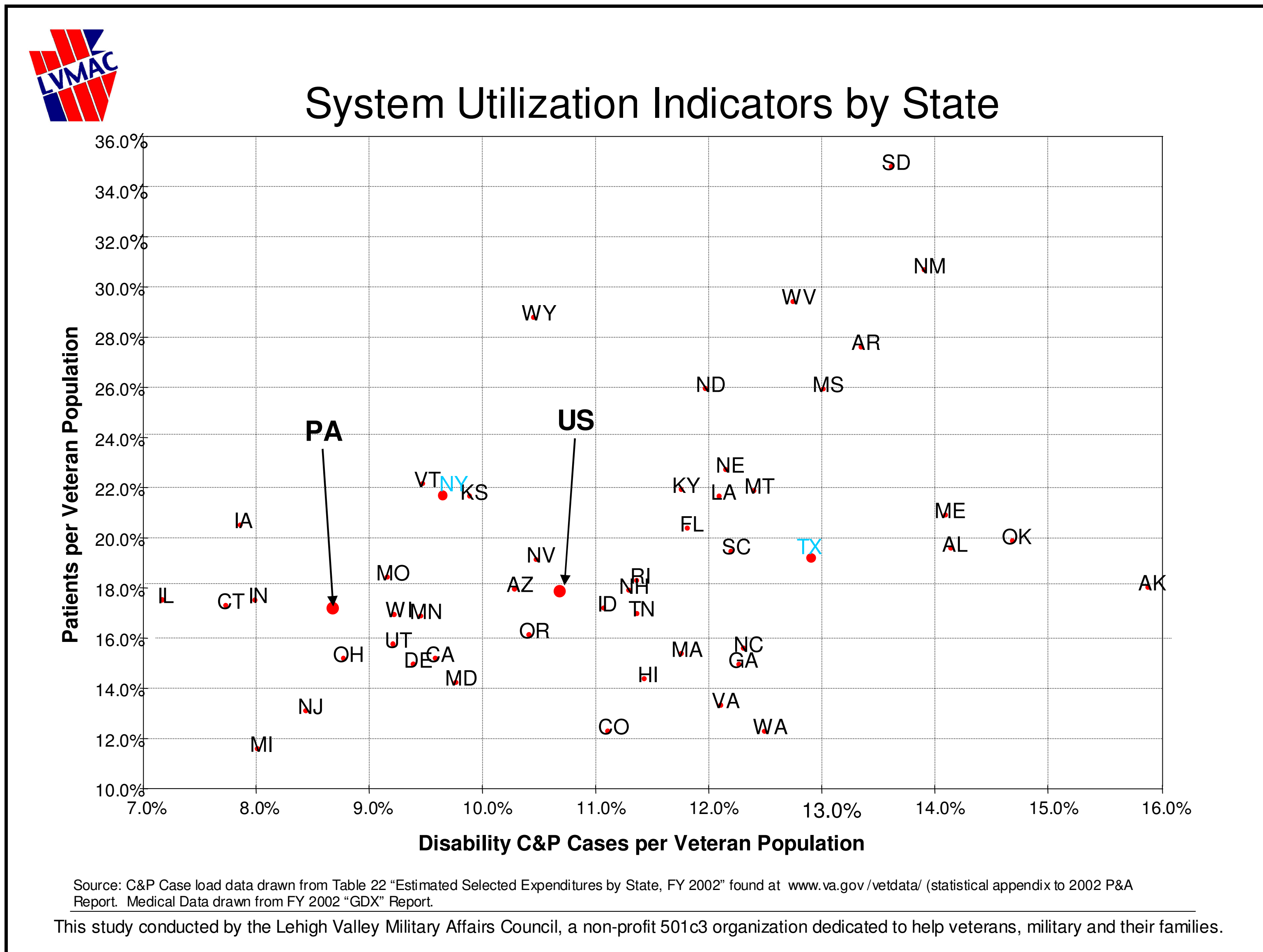


Chart 17: Utilization of Key Benefits by State, FY 2002

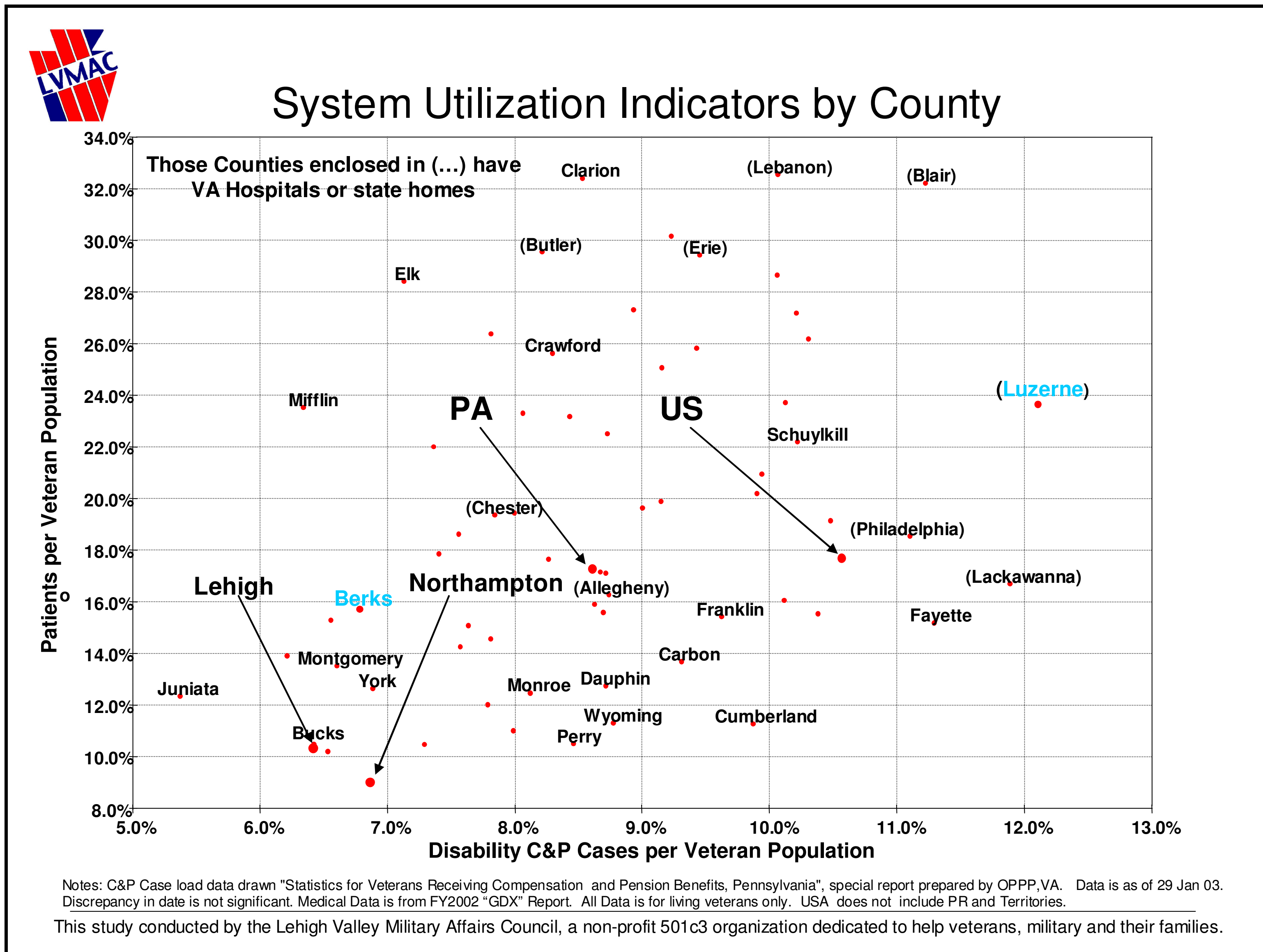


Chart 18: Utilization of Key Benefits by County, FY 2002

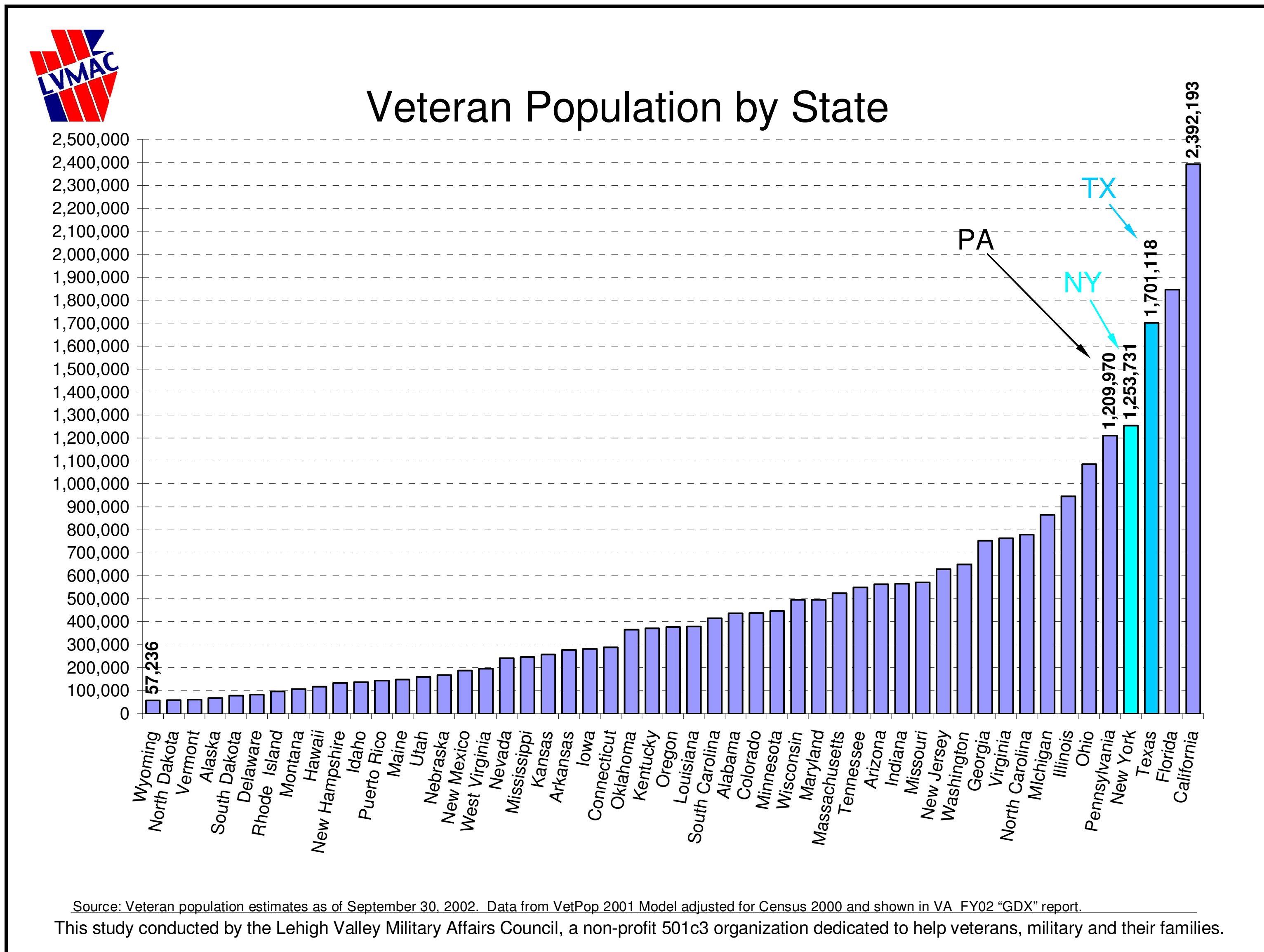


Chart 19: State Veteran Population and Denominator

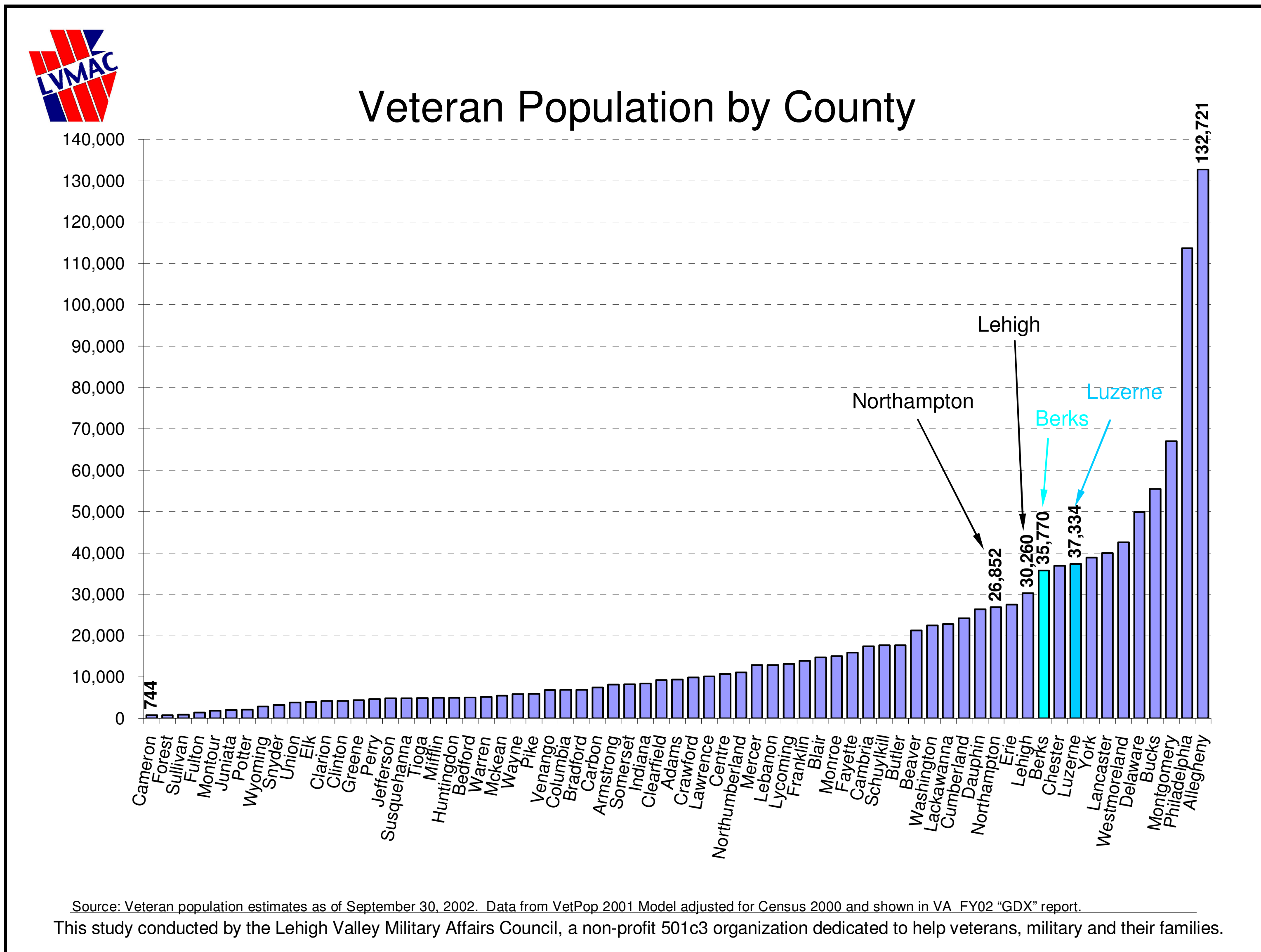


Chart 20: County Veteran Population and Denominator

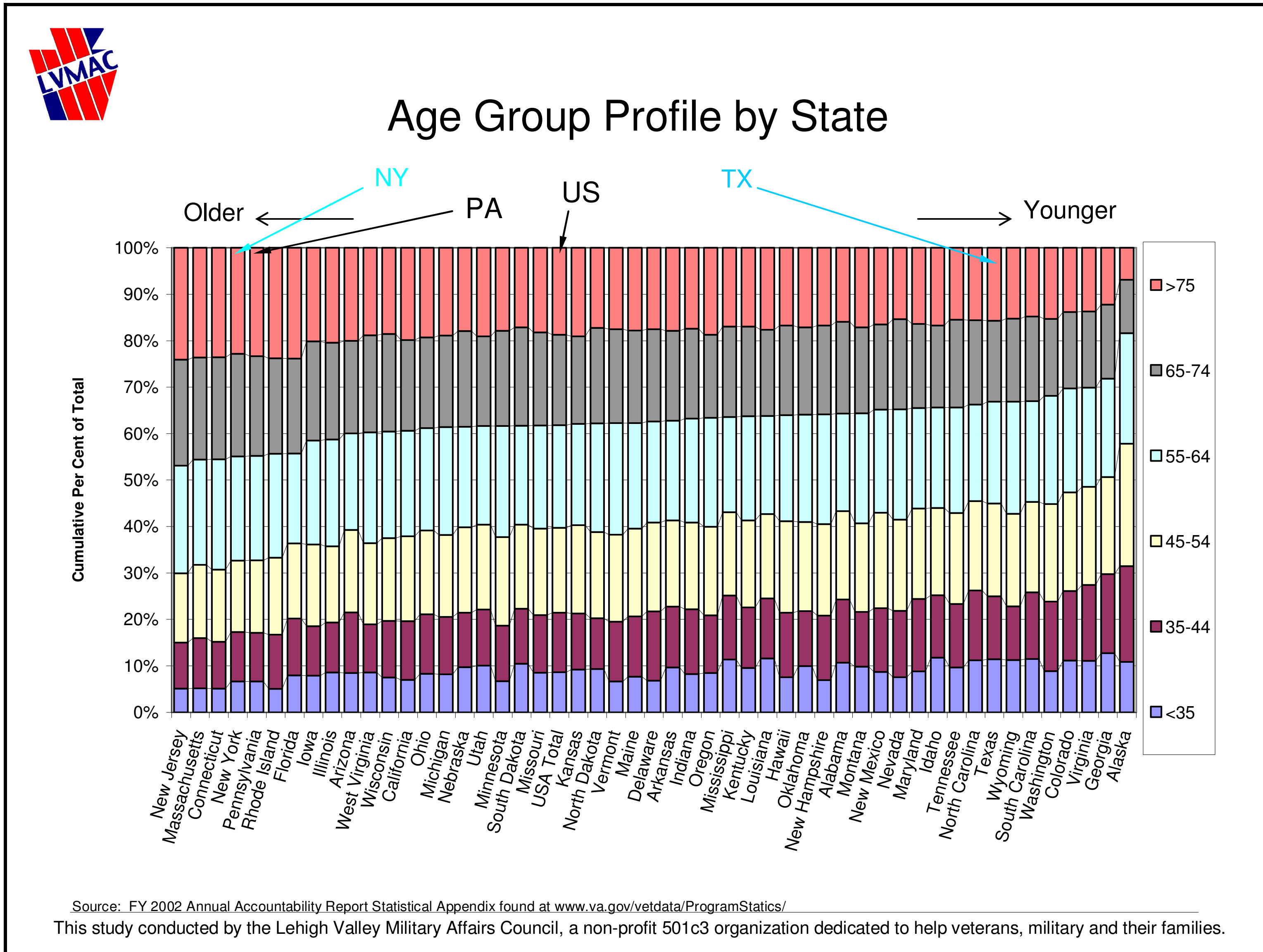


Chart 21: Age Profile by the States
[Data is sorted on >=65 years of age]

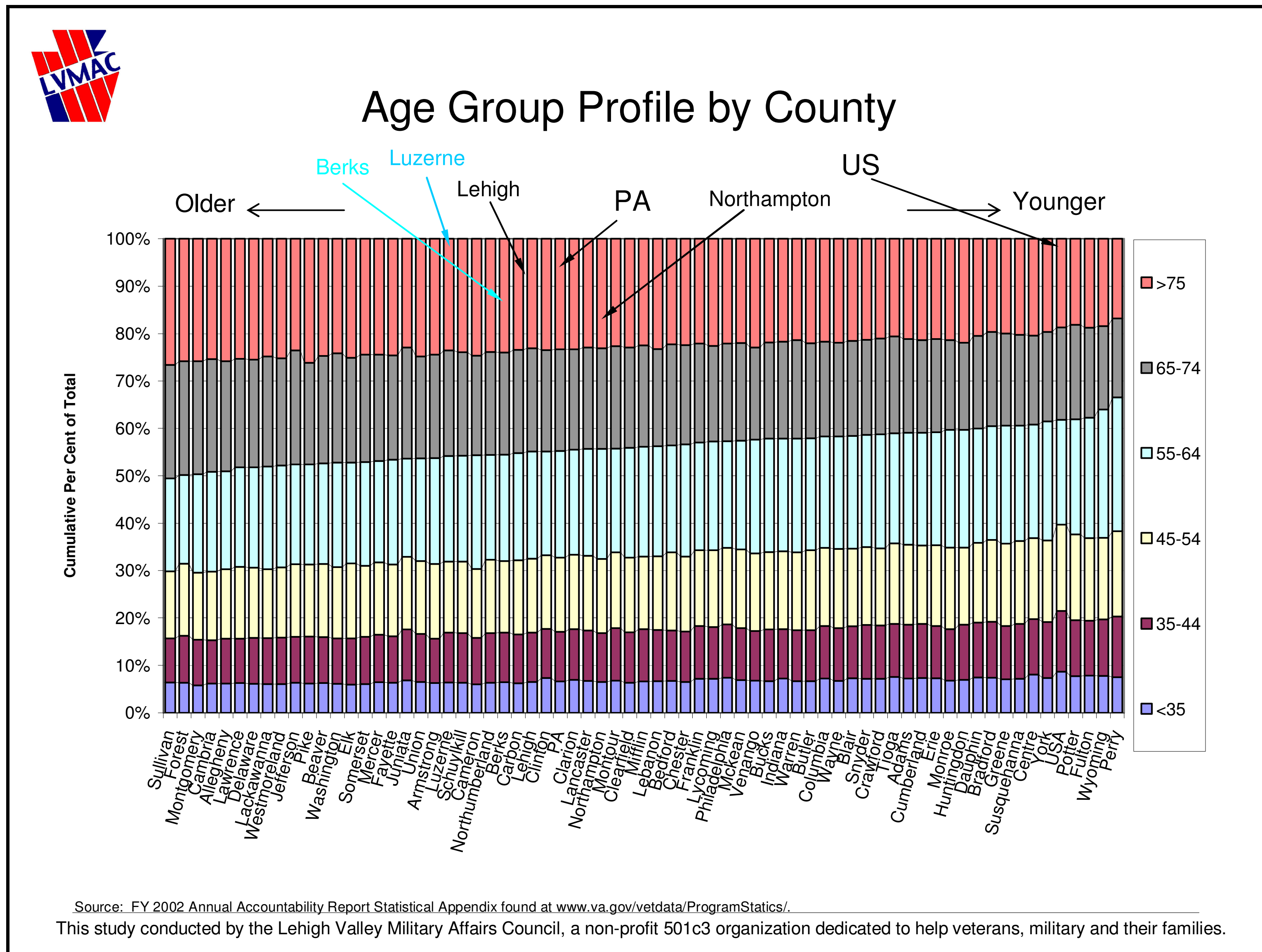


Chart 22: Age Profile by County
[Data is sorted on >=65 years of age]

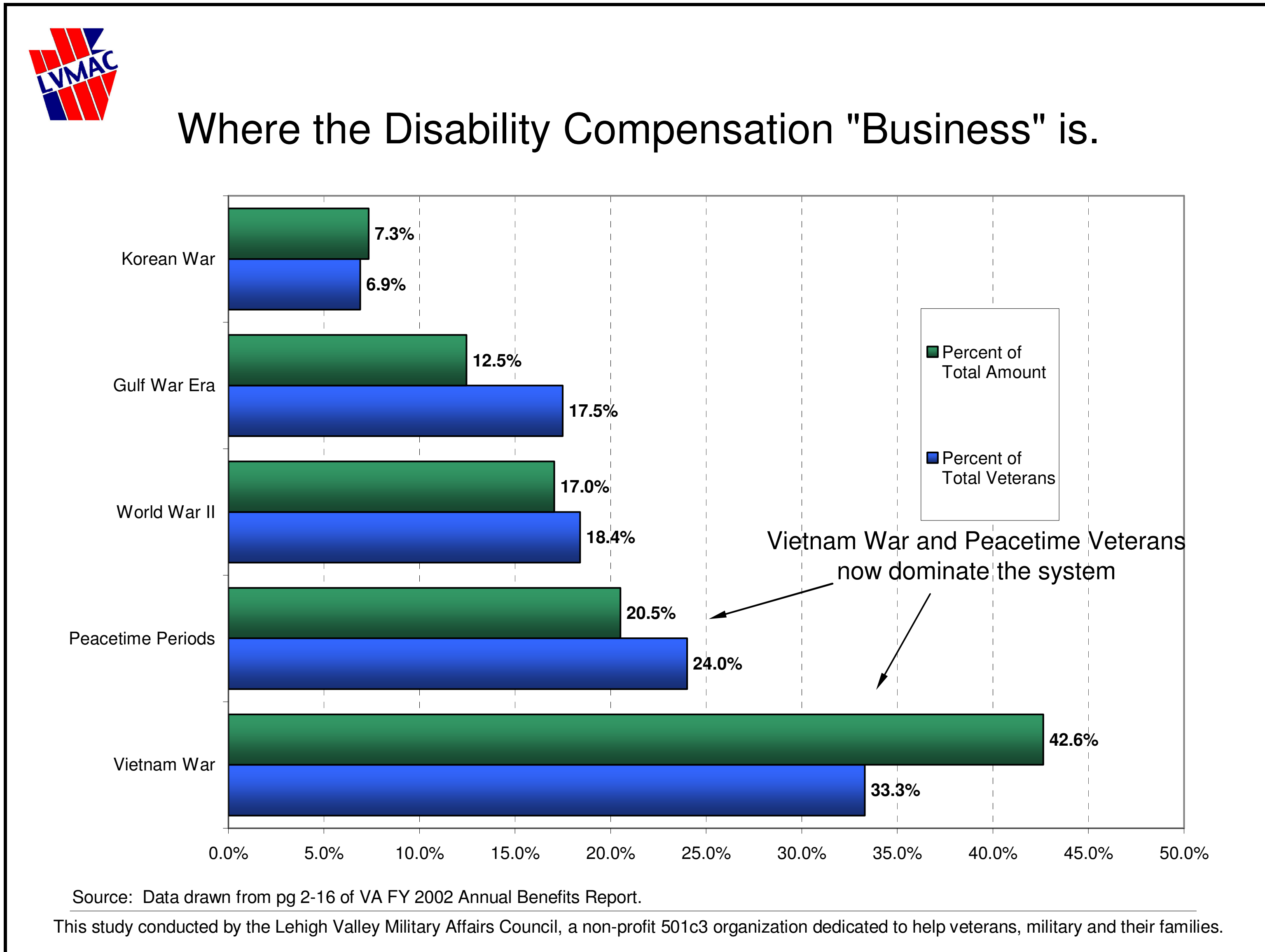


Chart 23: Disability Compensation Profile by Period of Service

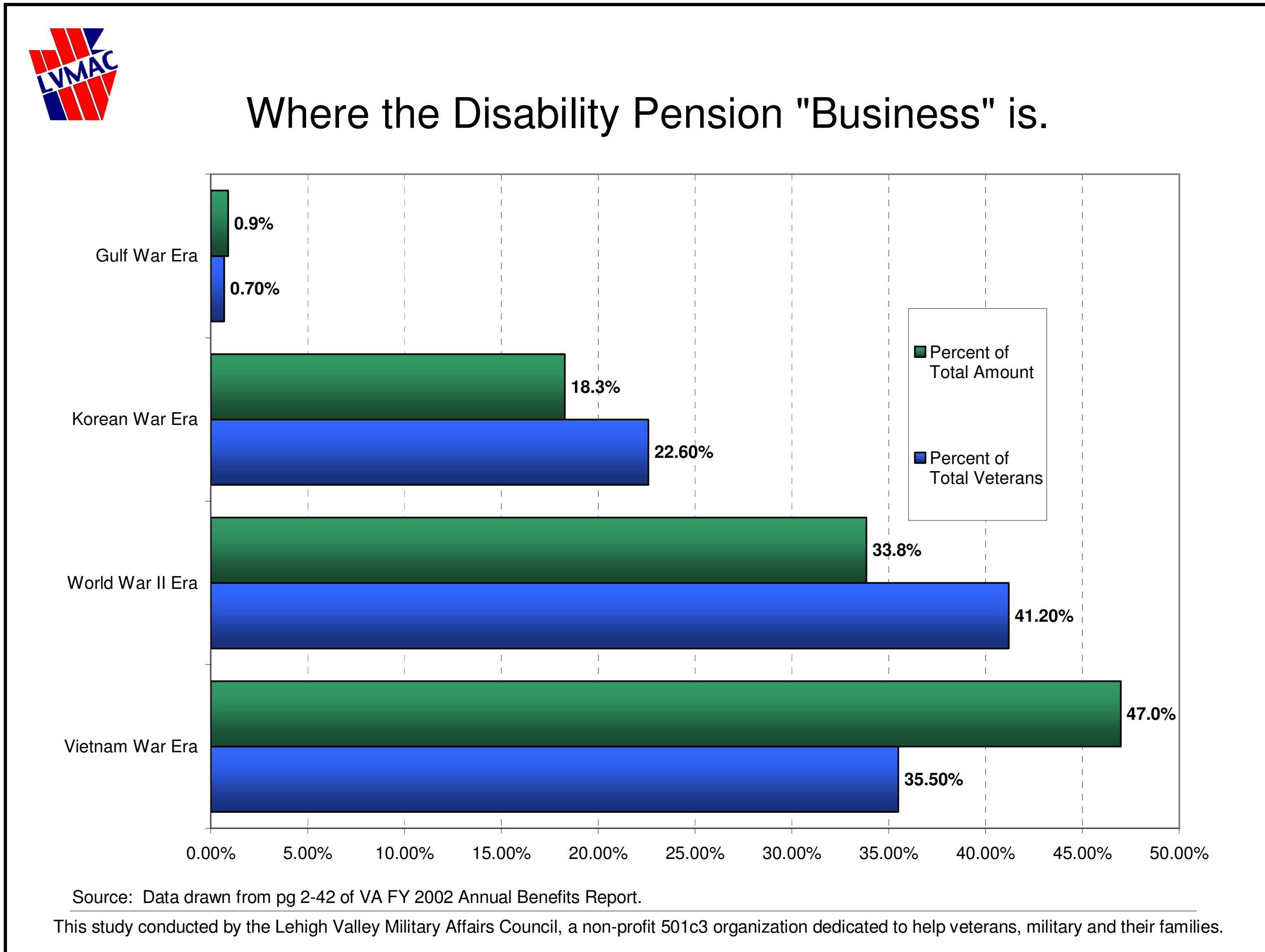


Chart 24: Disability Pension Profile by Period of Service

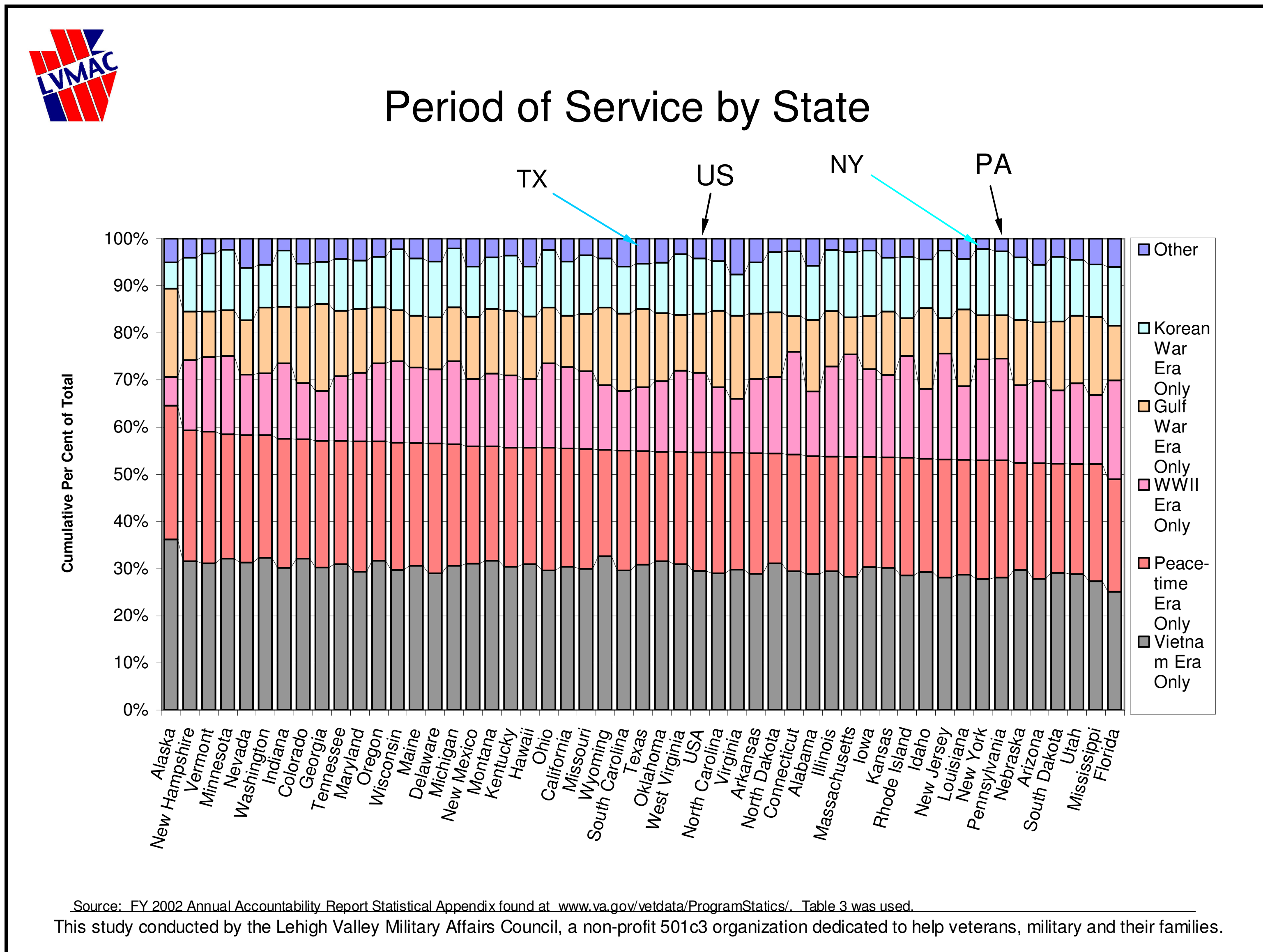


Chart 25: Period of Service Profile by State

[Data is sorted on Vietnam and peacetime era figures combined.]

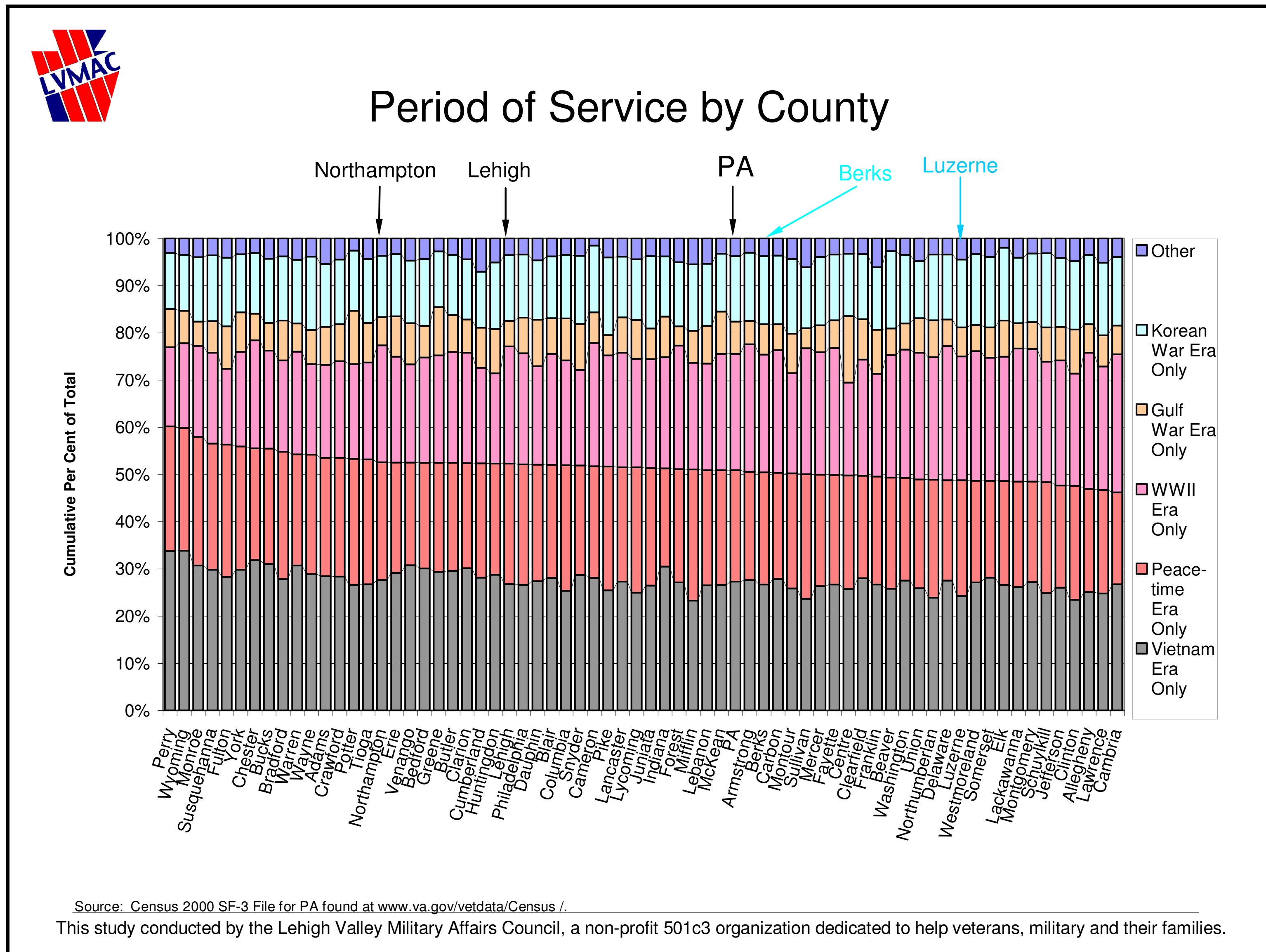


Chart 26: Period of Service Profile by County

[Data is sorted on Vietnam and peacetime era figures combined.]

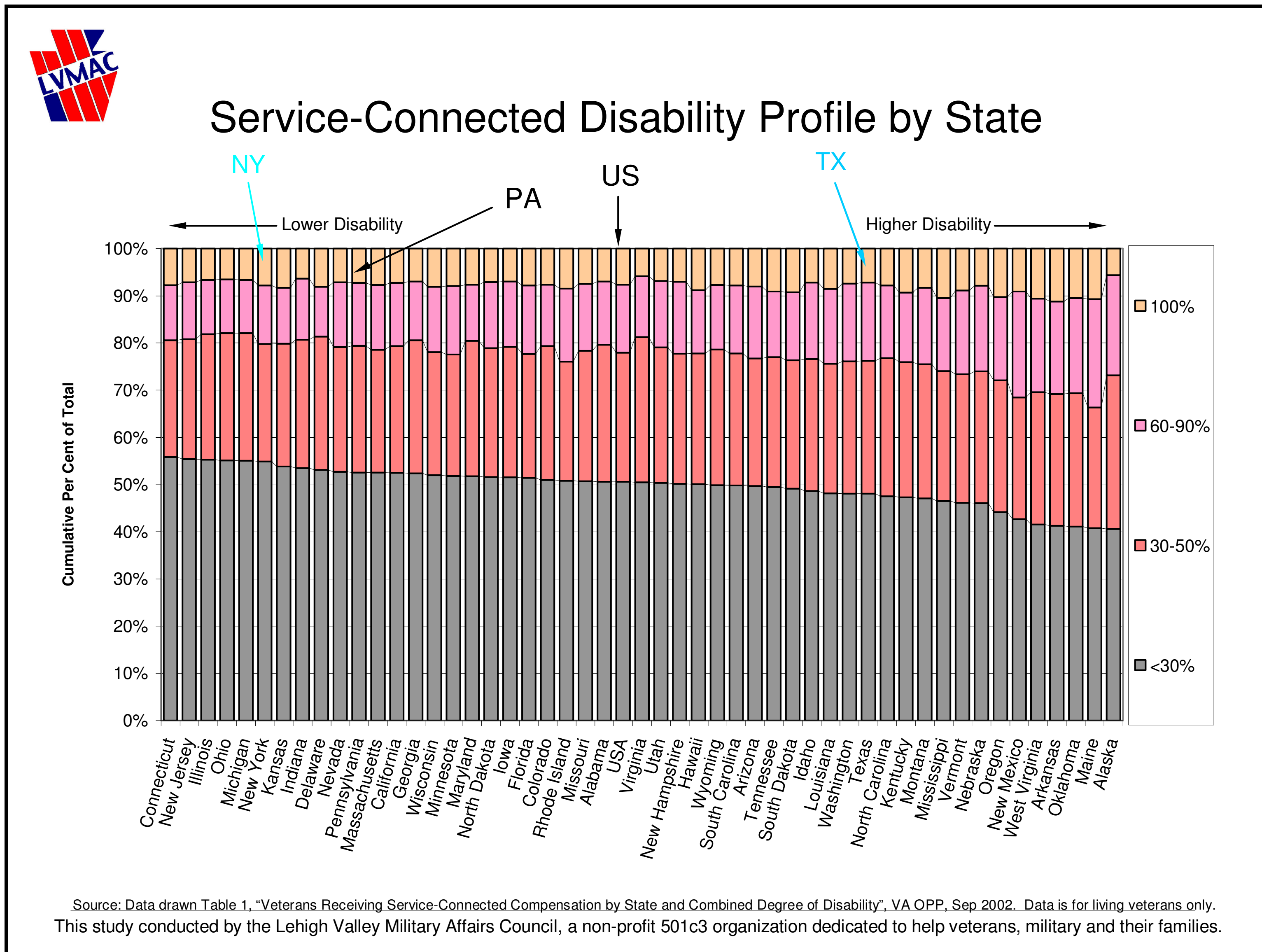


Chart 27: State Disability Profile

[Sort is on less than 30% disability.]

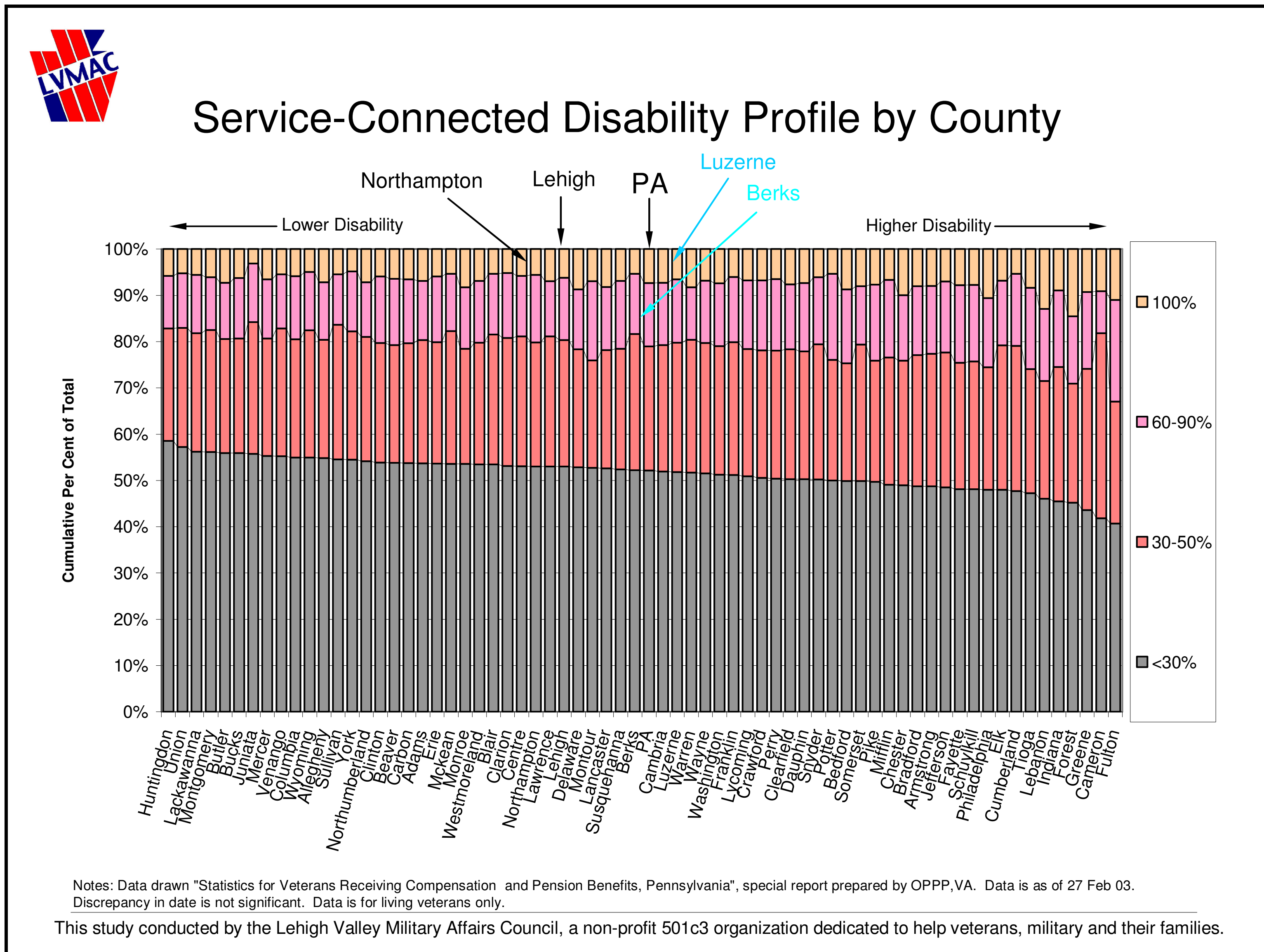


Chart 28: County Disability Profile
[Sort is on less than 30% disability.]

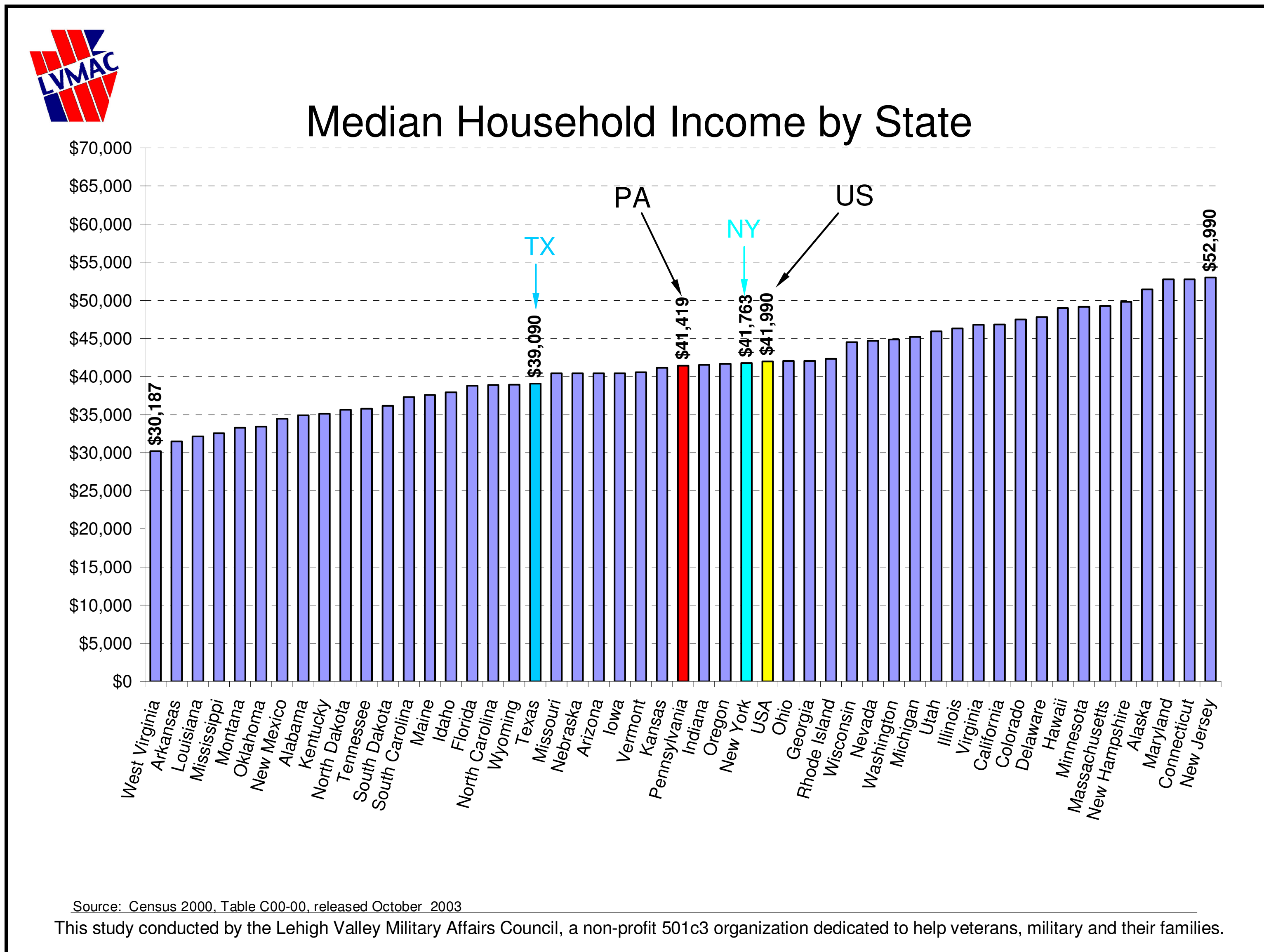


Chart 29: Household Income by State

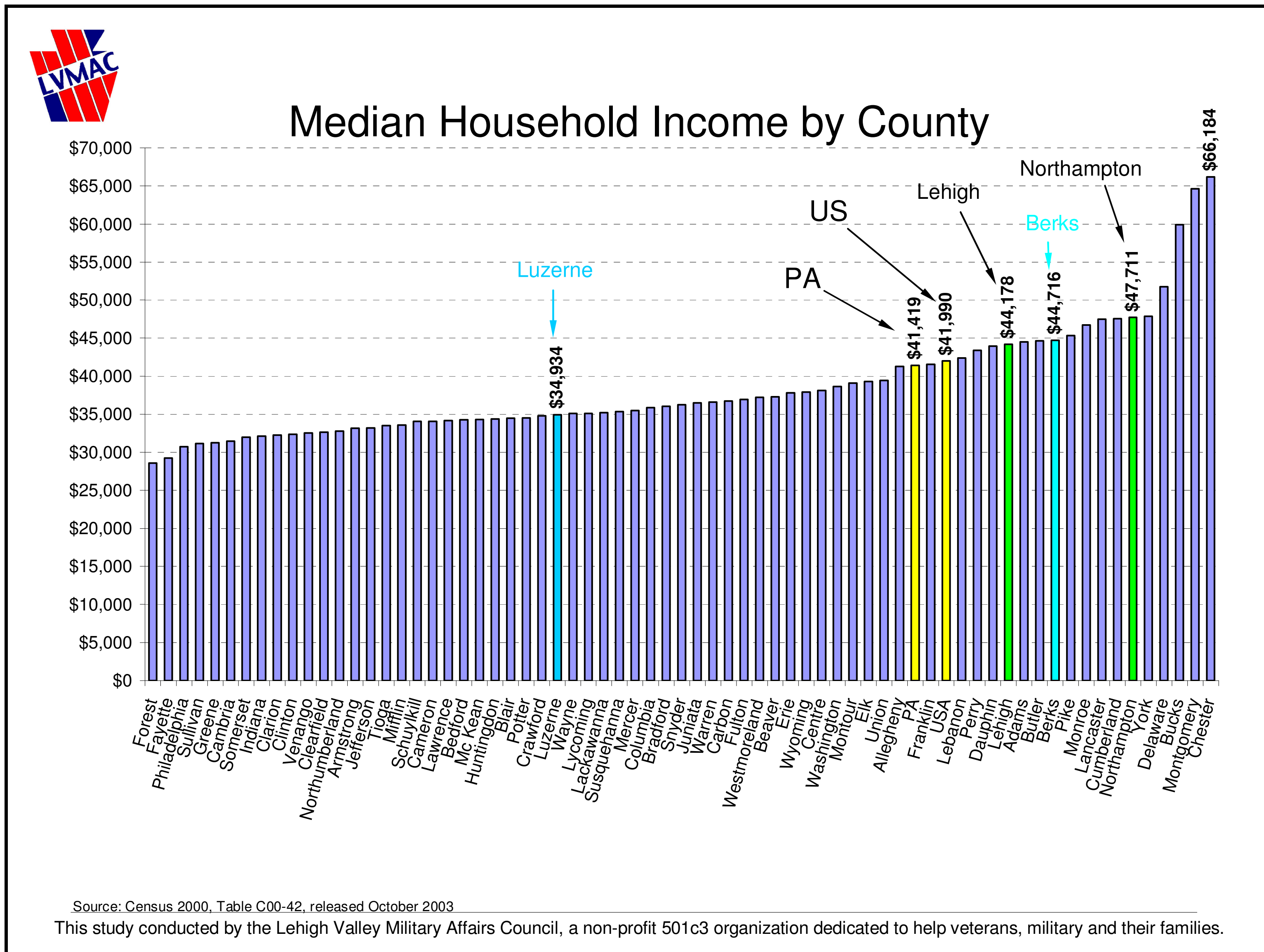


Chart 30: Household Income by County

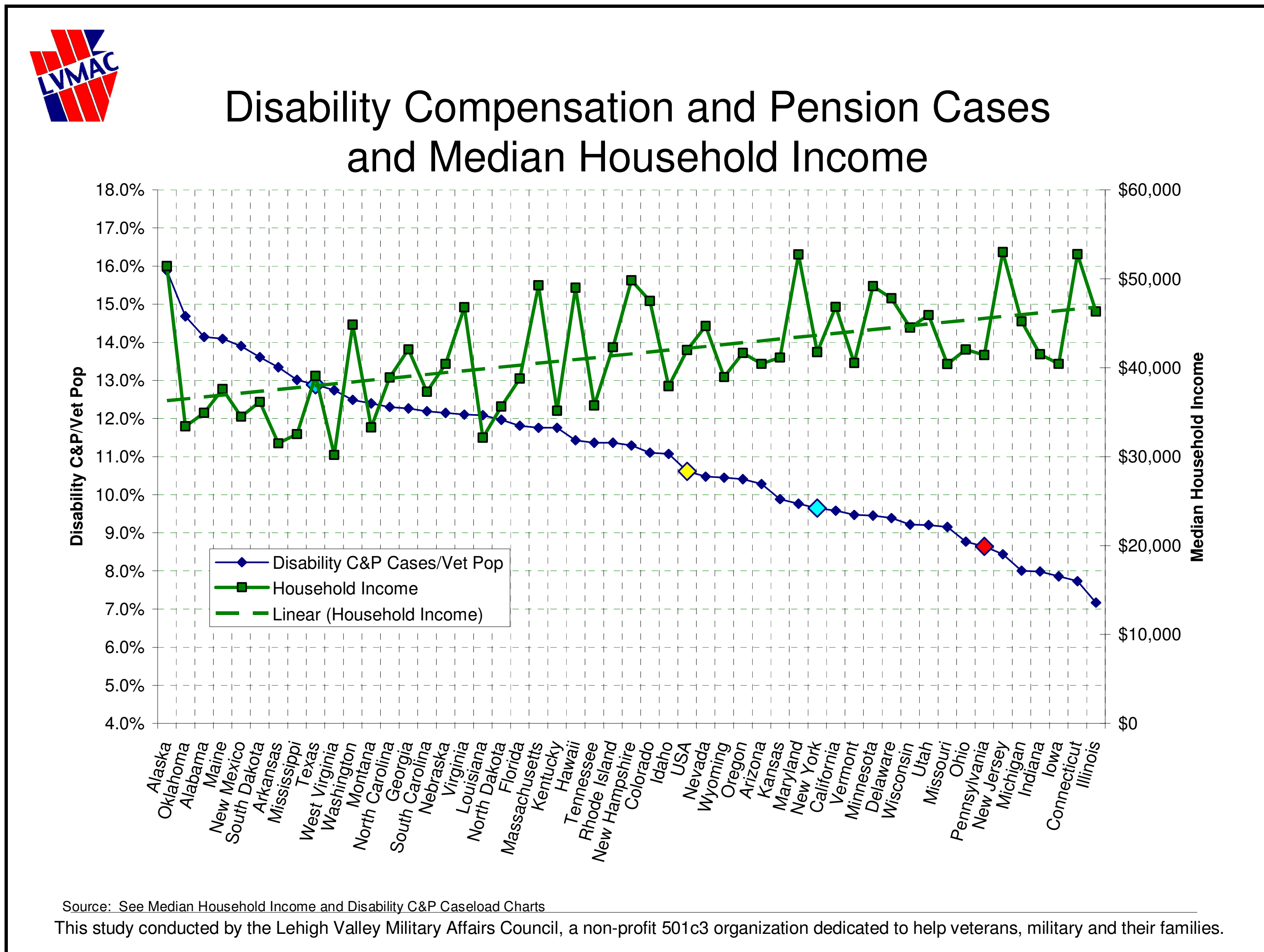


Chart 31: Looking for a Relationship between Income and C&P Cases

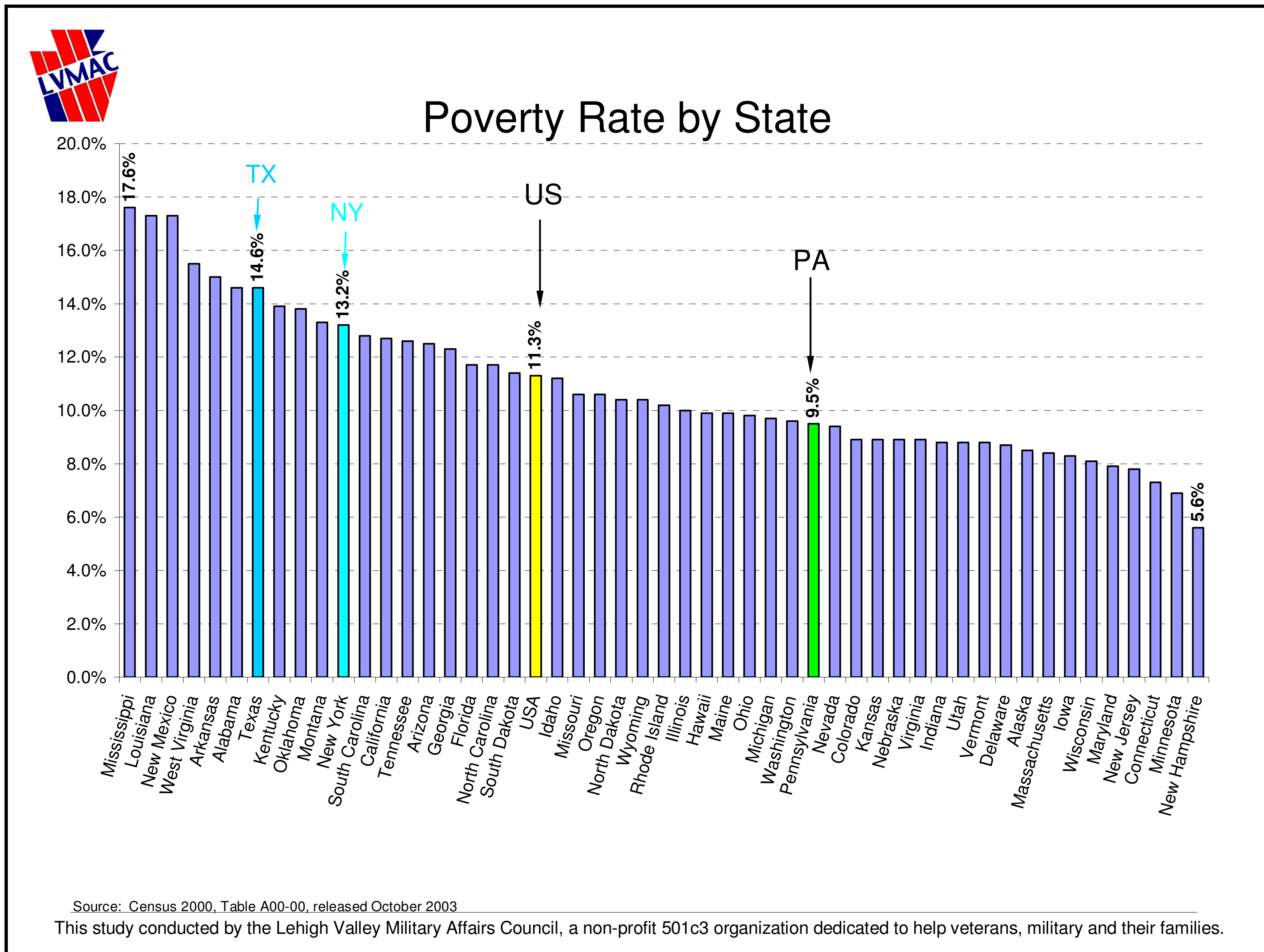


Chart 32: Poverty Level by State

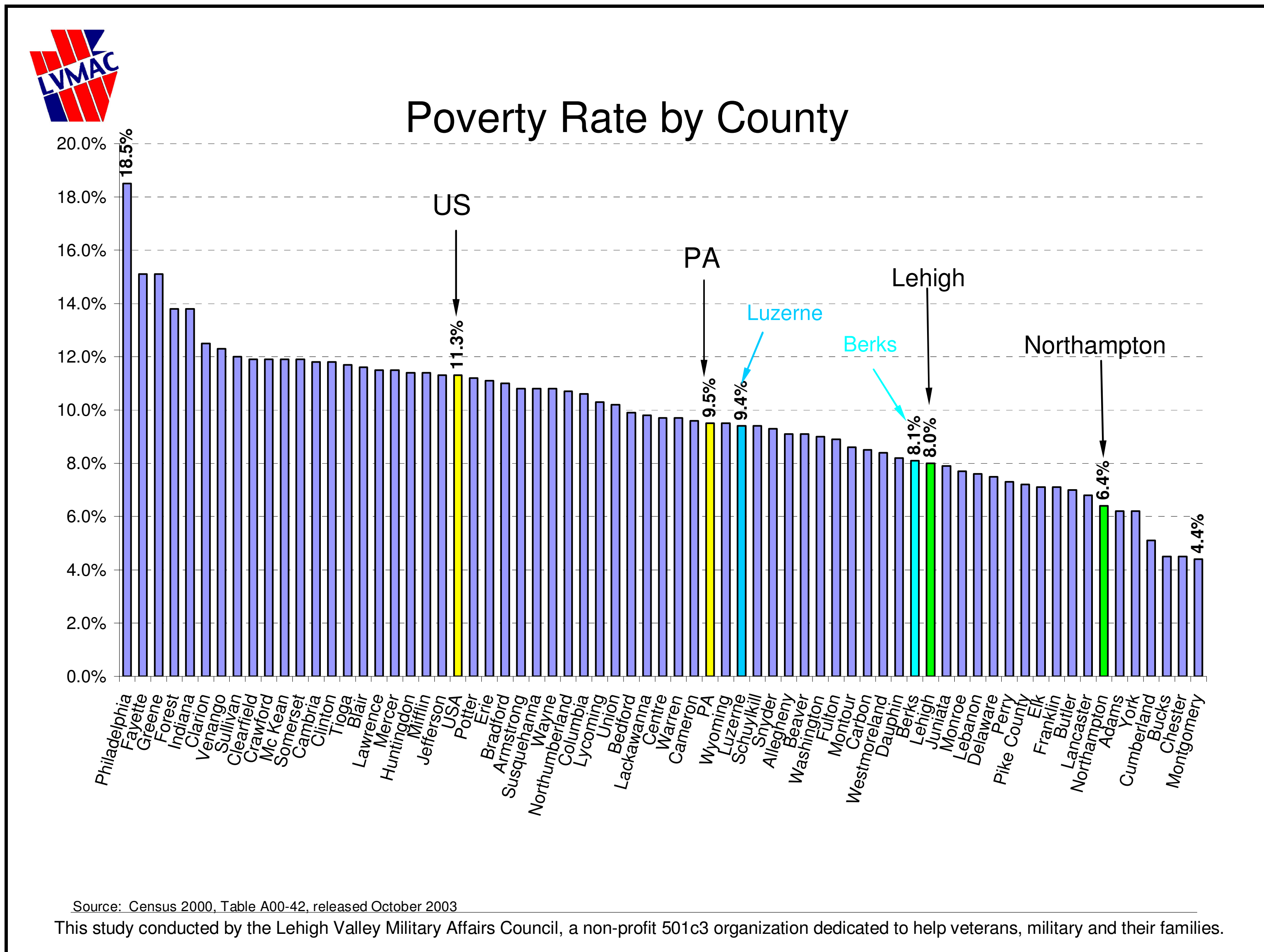


Chart 33: Poverty Level by County

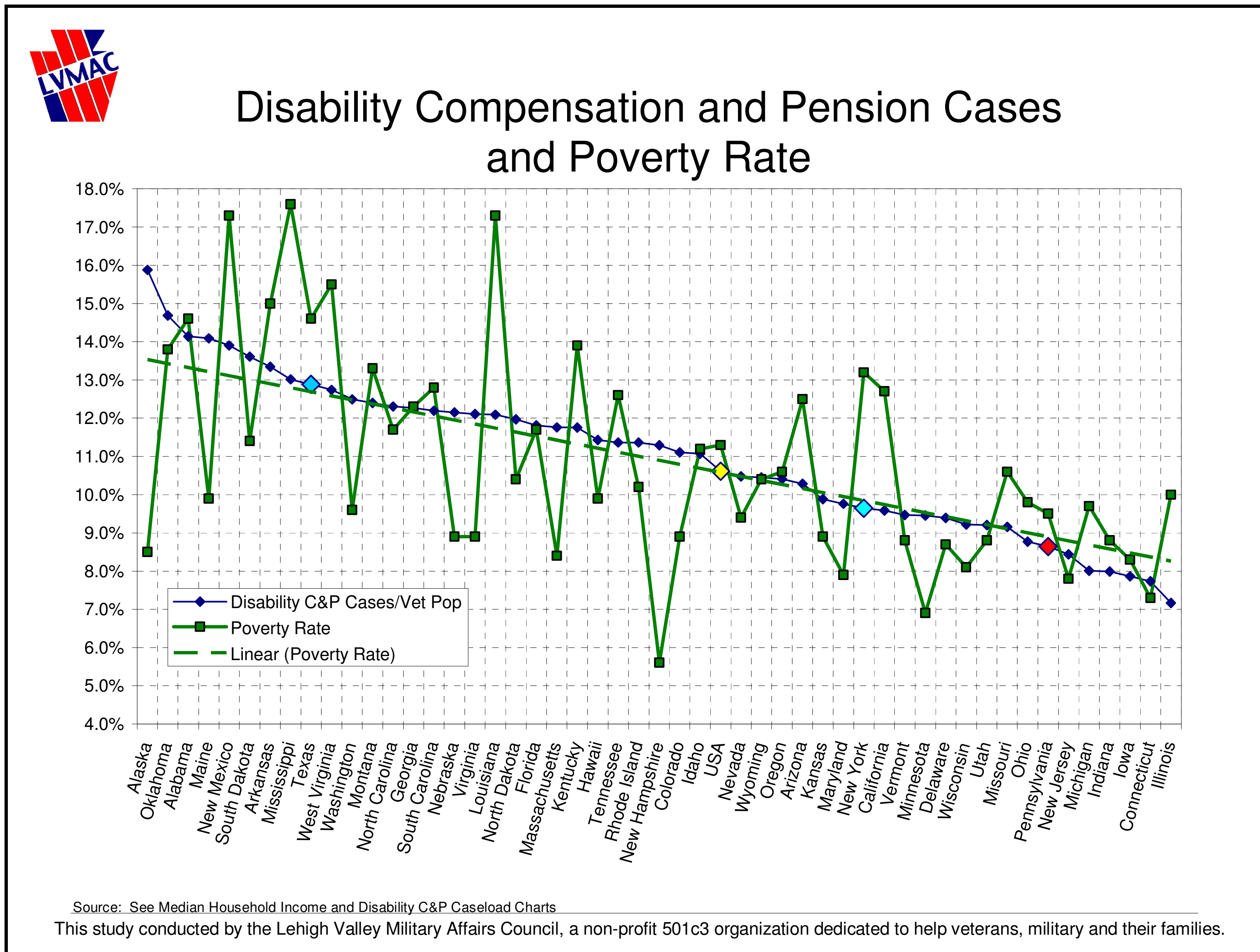


Chart 34: Looking for a Relationship between Poverty and C&P Cases

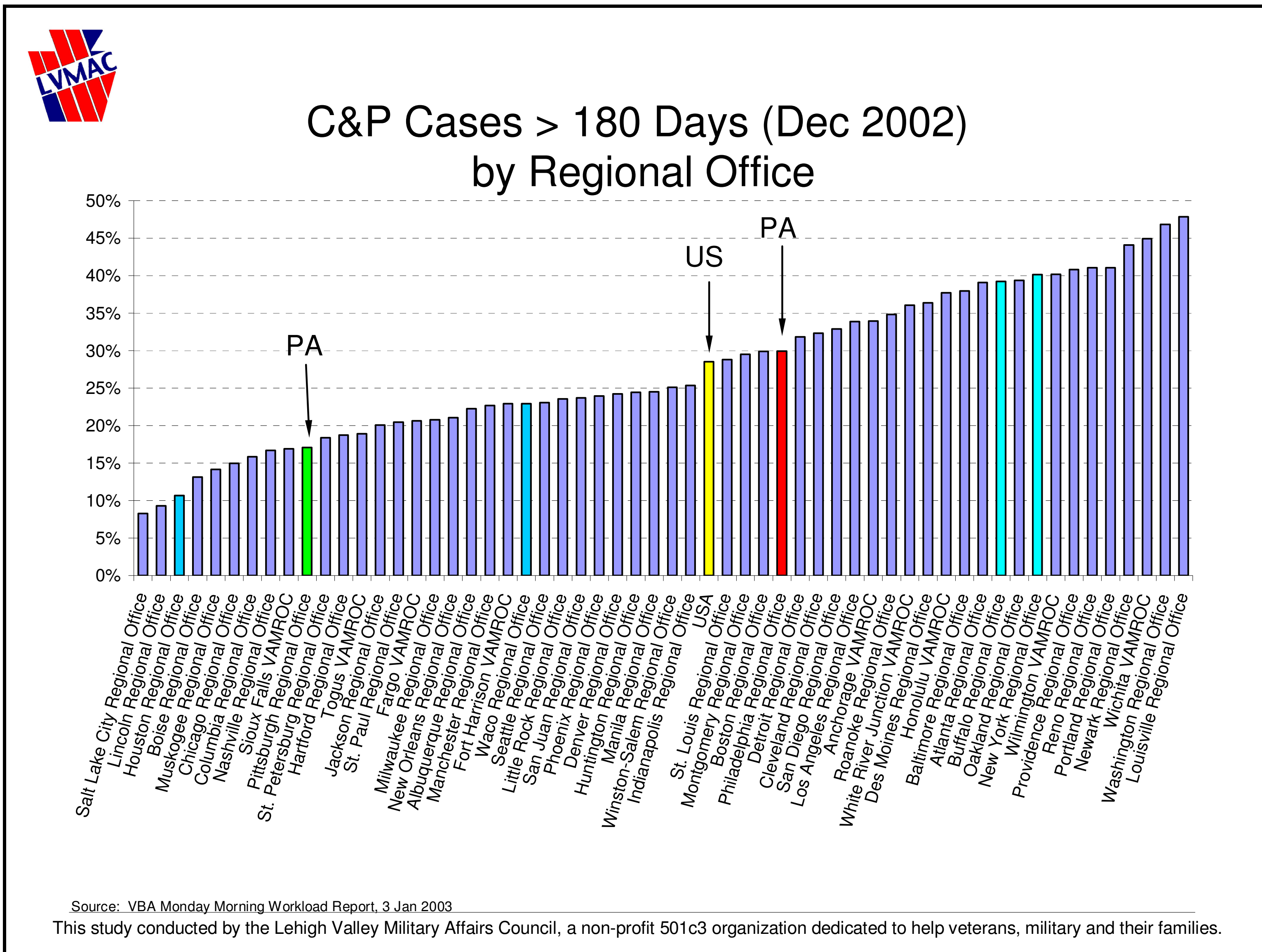


Chart 35: Claims Processing Exceeding 180 Days for December 2002

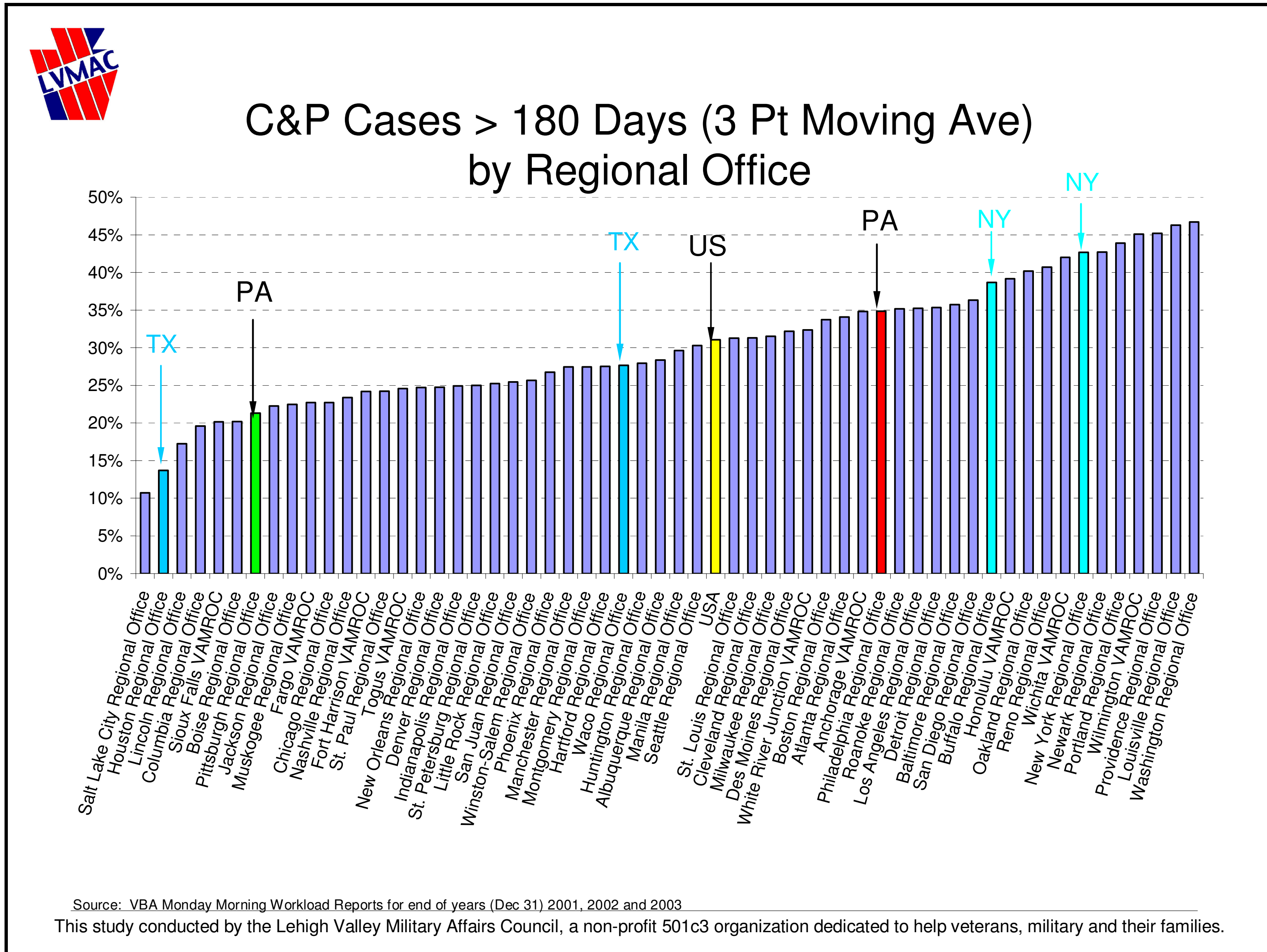


Chart 36: Claims Processing Exceeding 180 Days, 3 Point Average

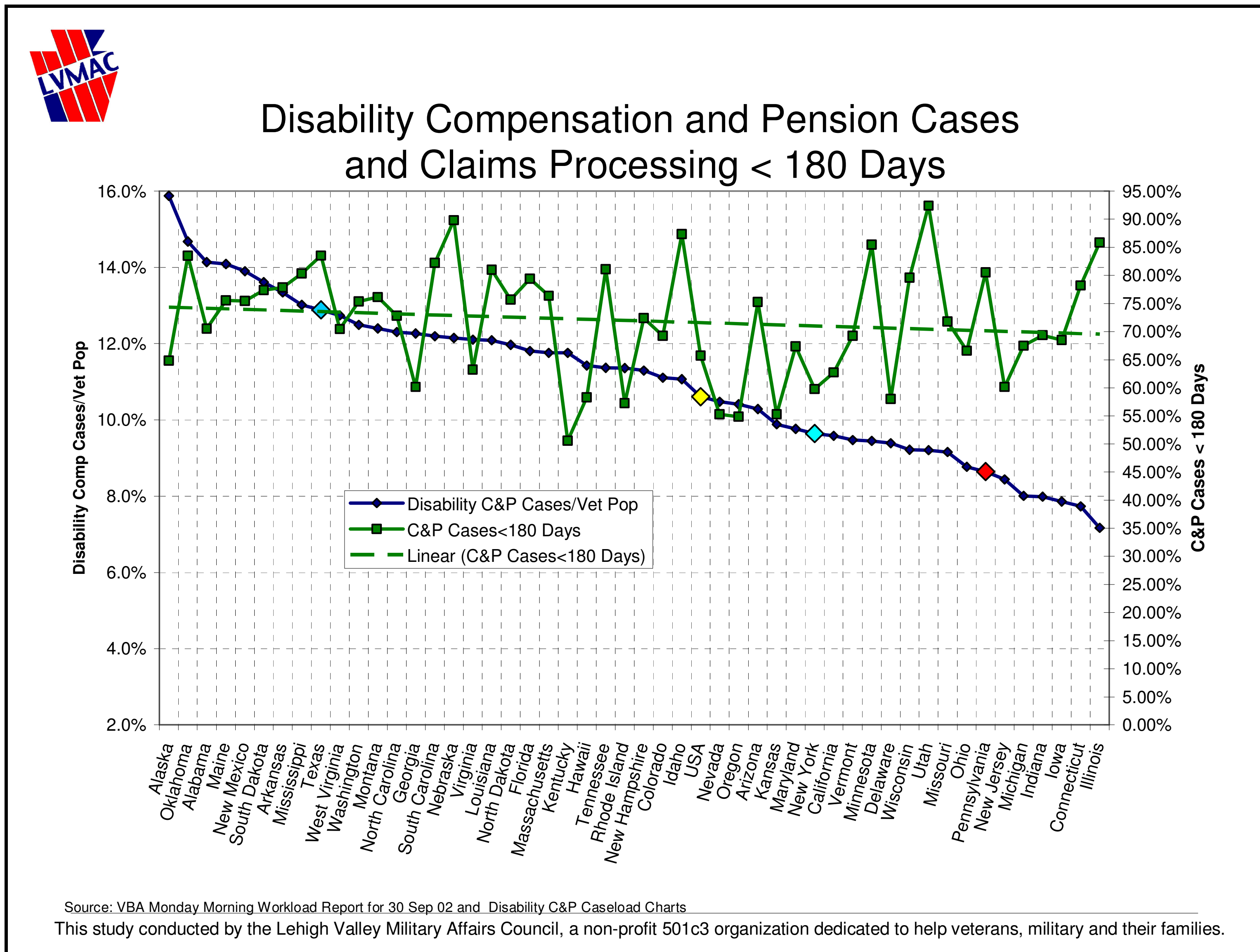


Chart 37: Looking for a Relationship between Claims Time and Disability Cases

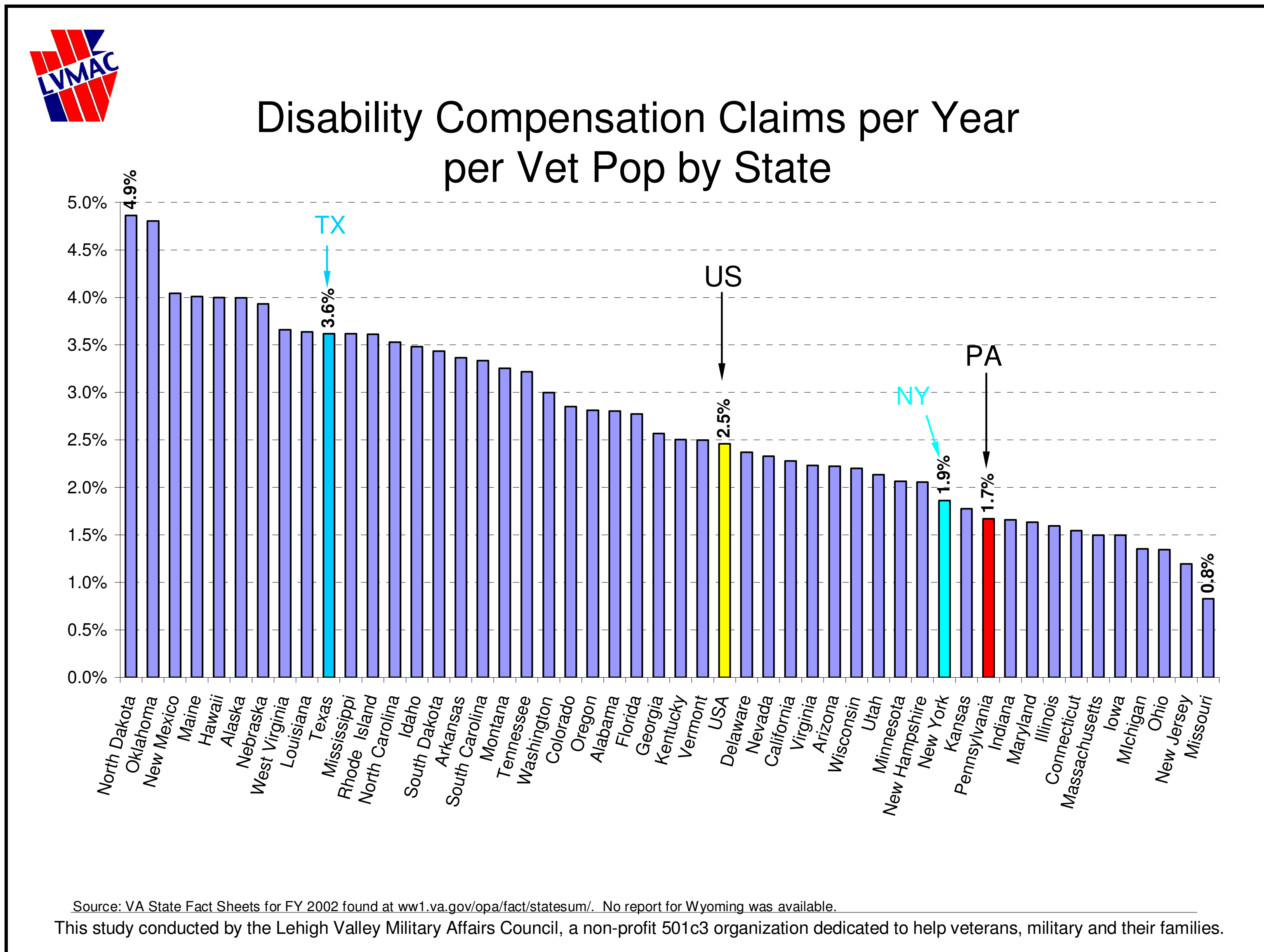


Chart 38: Compensation Cases Completed per Annum, FY 2002

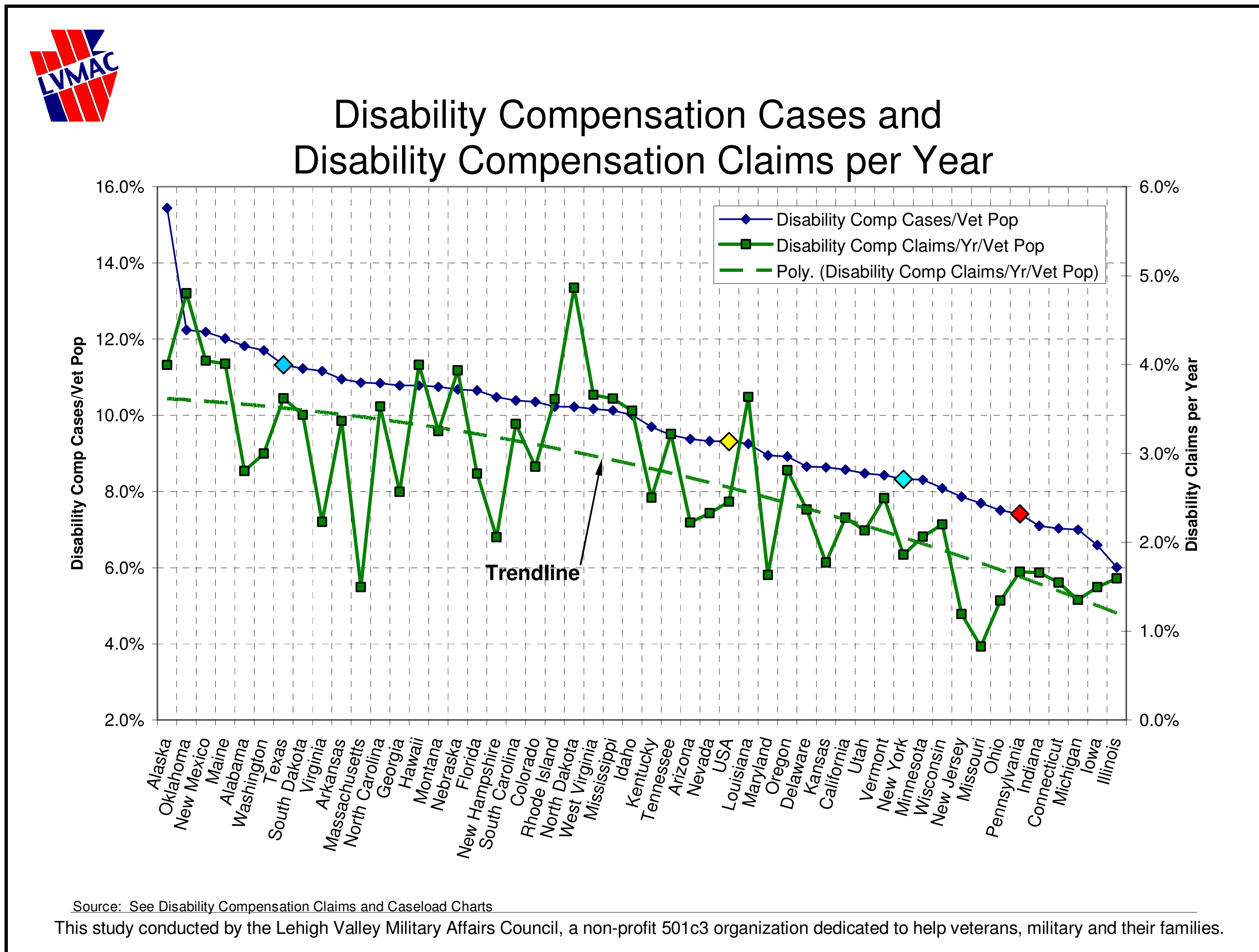


Chart 39: Looking for a Relationship between Claims Rate and Disability Cases

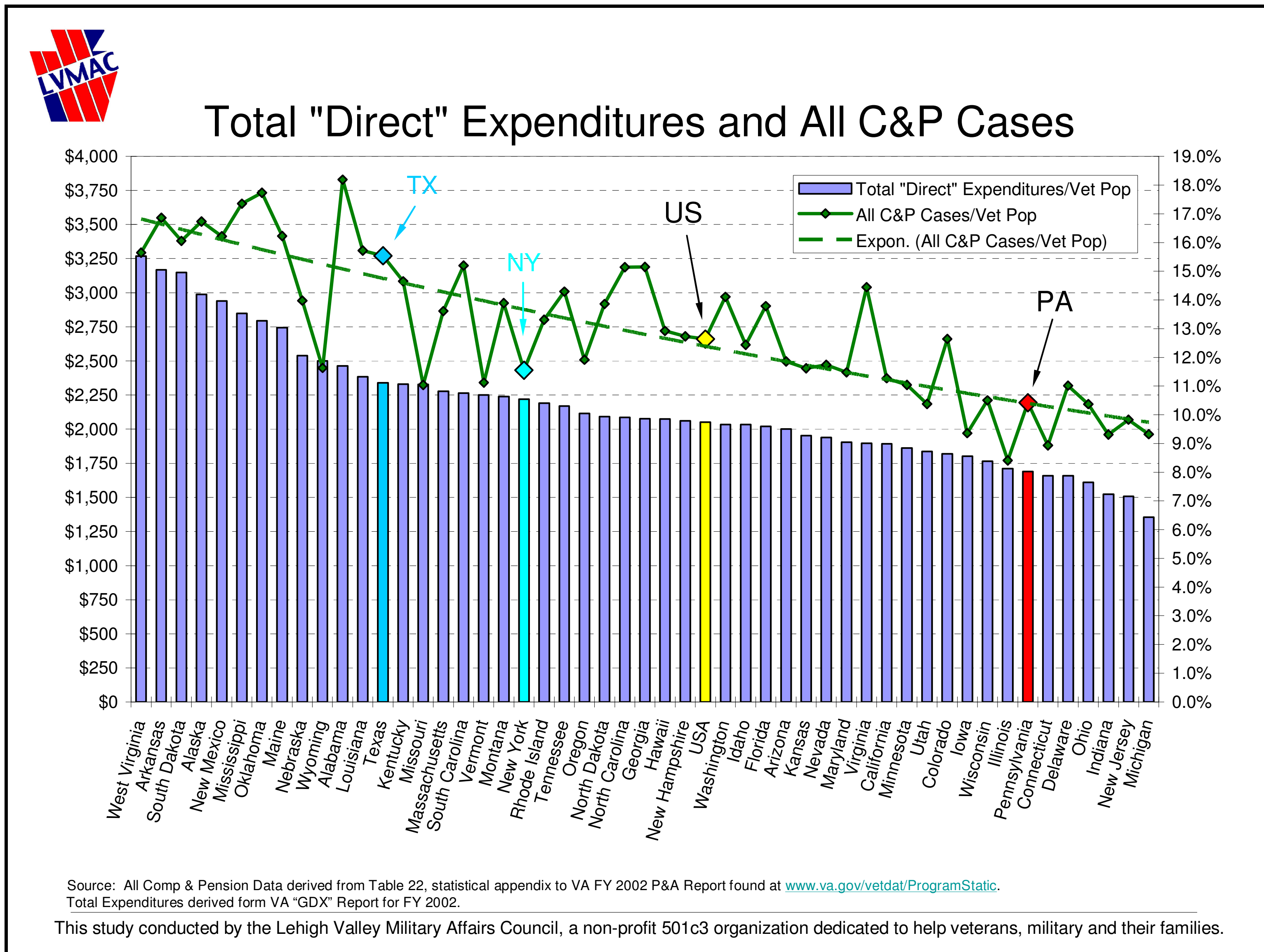


Chart 40: Looking for a Relationship between Expenditures and C&P

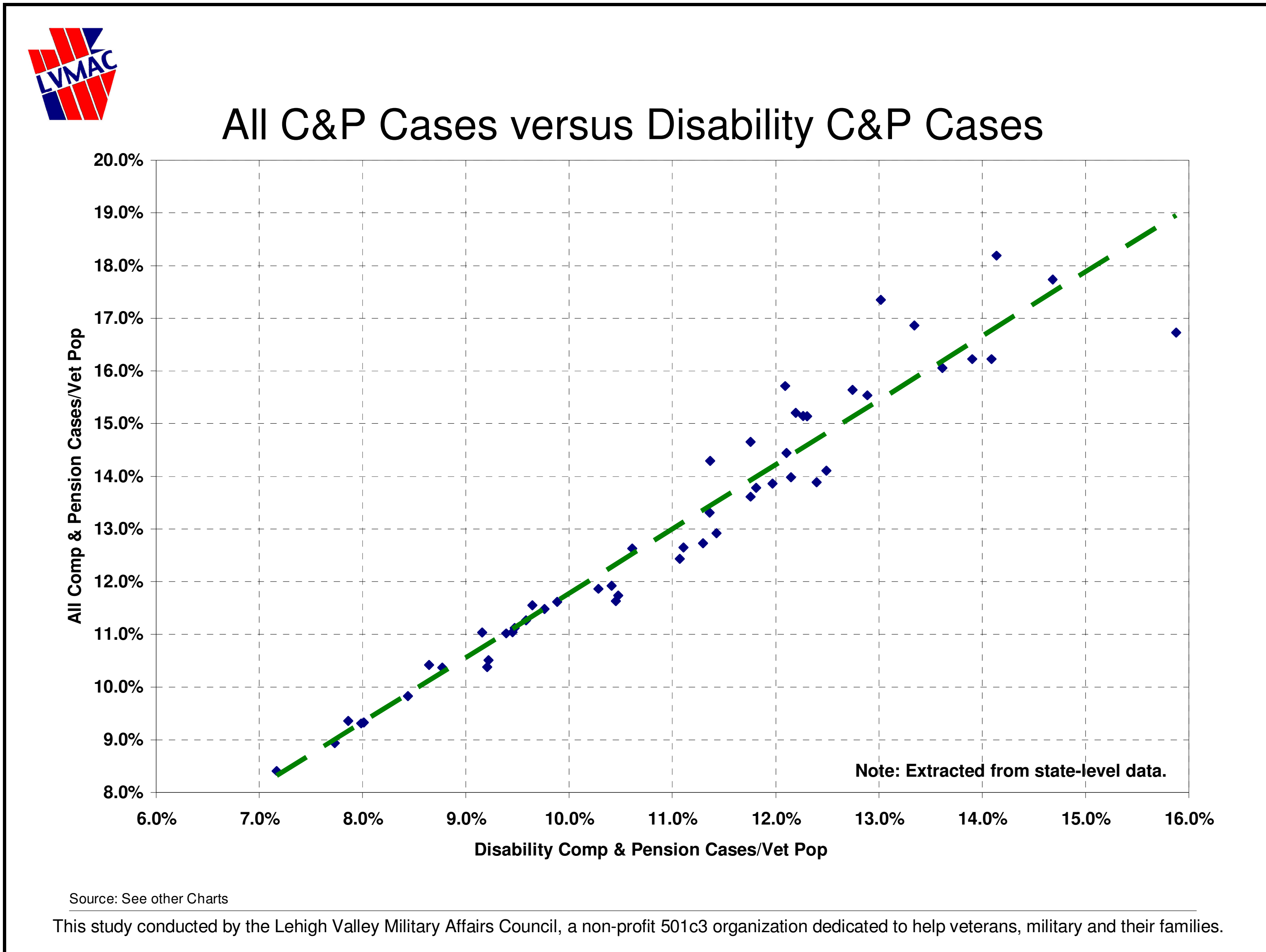
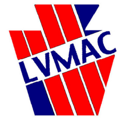


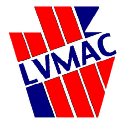
Chart 41: Correlation between Disability and Total Compensation and Pension Cases

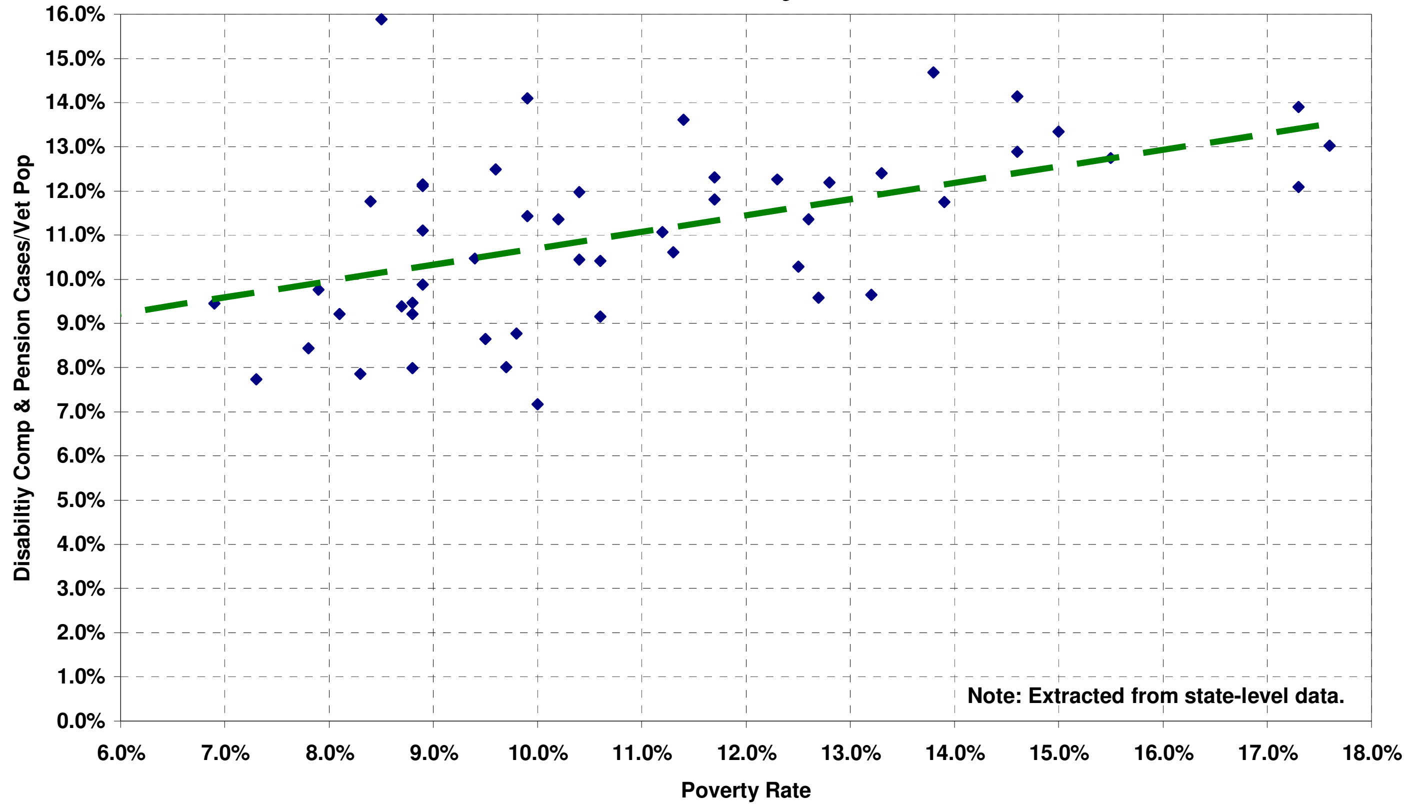


Source: See Median Household Income and Disability C&P Caseload Charts

This study conducted by the Lehigh Valley Military Affairs Council, a non-profit 501c3 organization dedicated to help veterans, military and their families.

Chart 42: Correlation between Median Household Income and Disability Compensation and Pension Cases





Source: See Median Household Income and Disability C&P Caseload Charts

This study conducted by the Lehigh Valley Military Affairs Council, a non-profit 501c3 organization dedicated to help veterans, military and their families.

Chart 43: Correlation between Poverty and Disability Compensation and Pension Cases

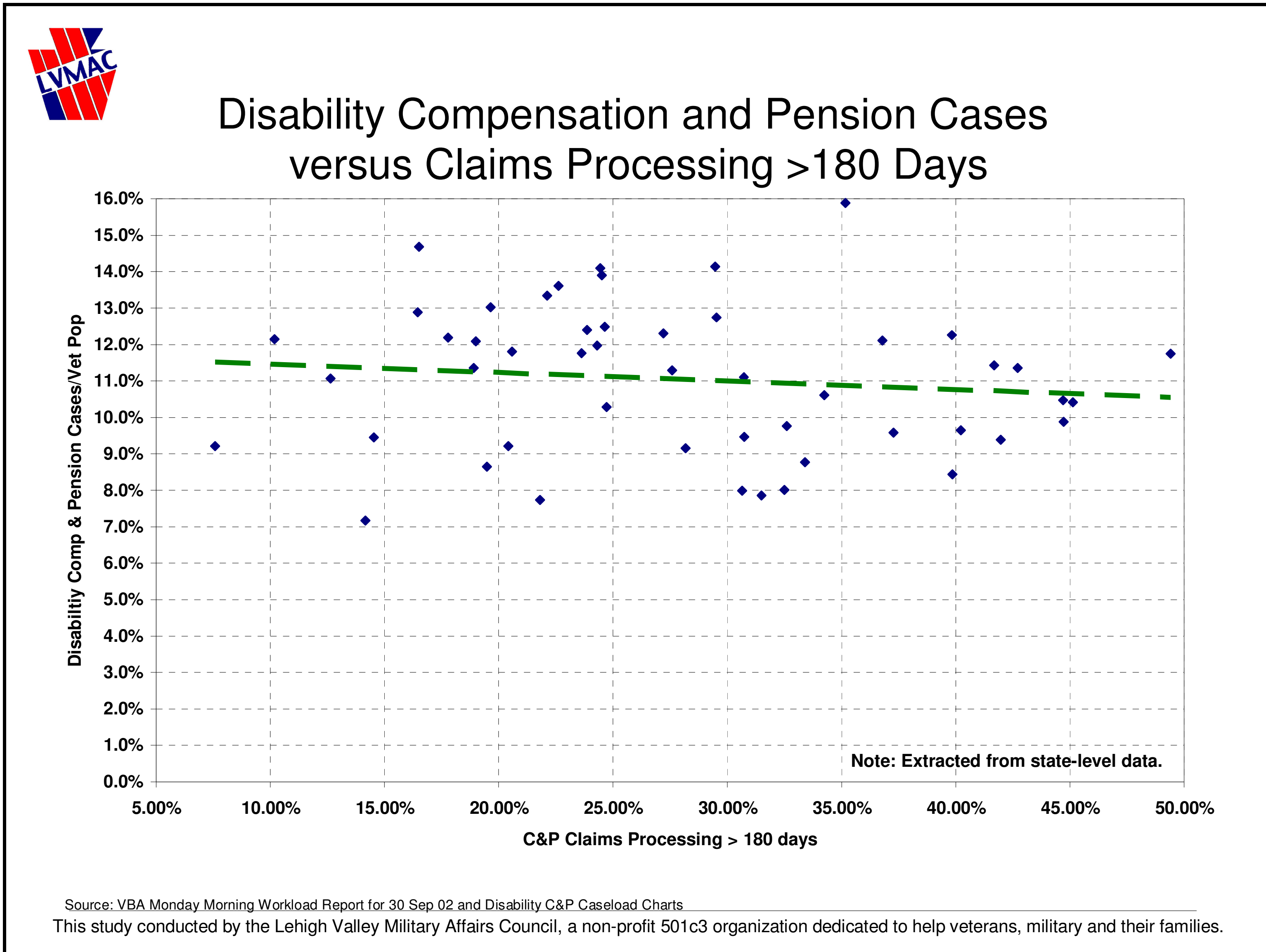


Chart 44: Correlation between Claims Processing Time and Disability Compensation and Pension Cases

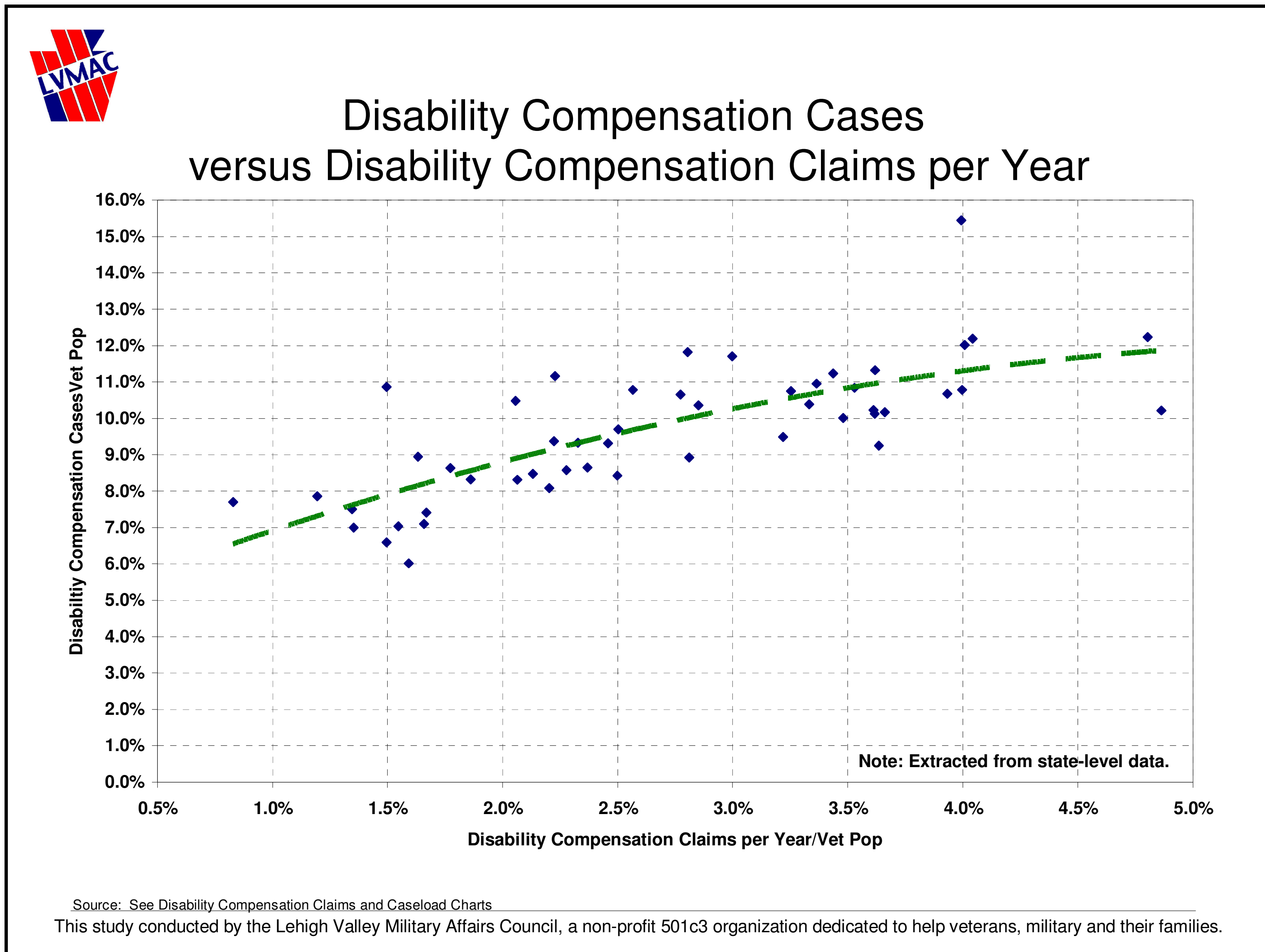


Chart 45: Correlation between Disability Compensation Claims per Year and Disability Compensation Cases

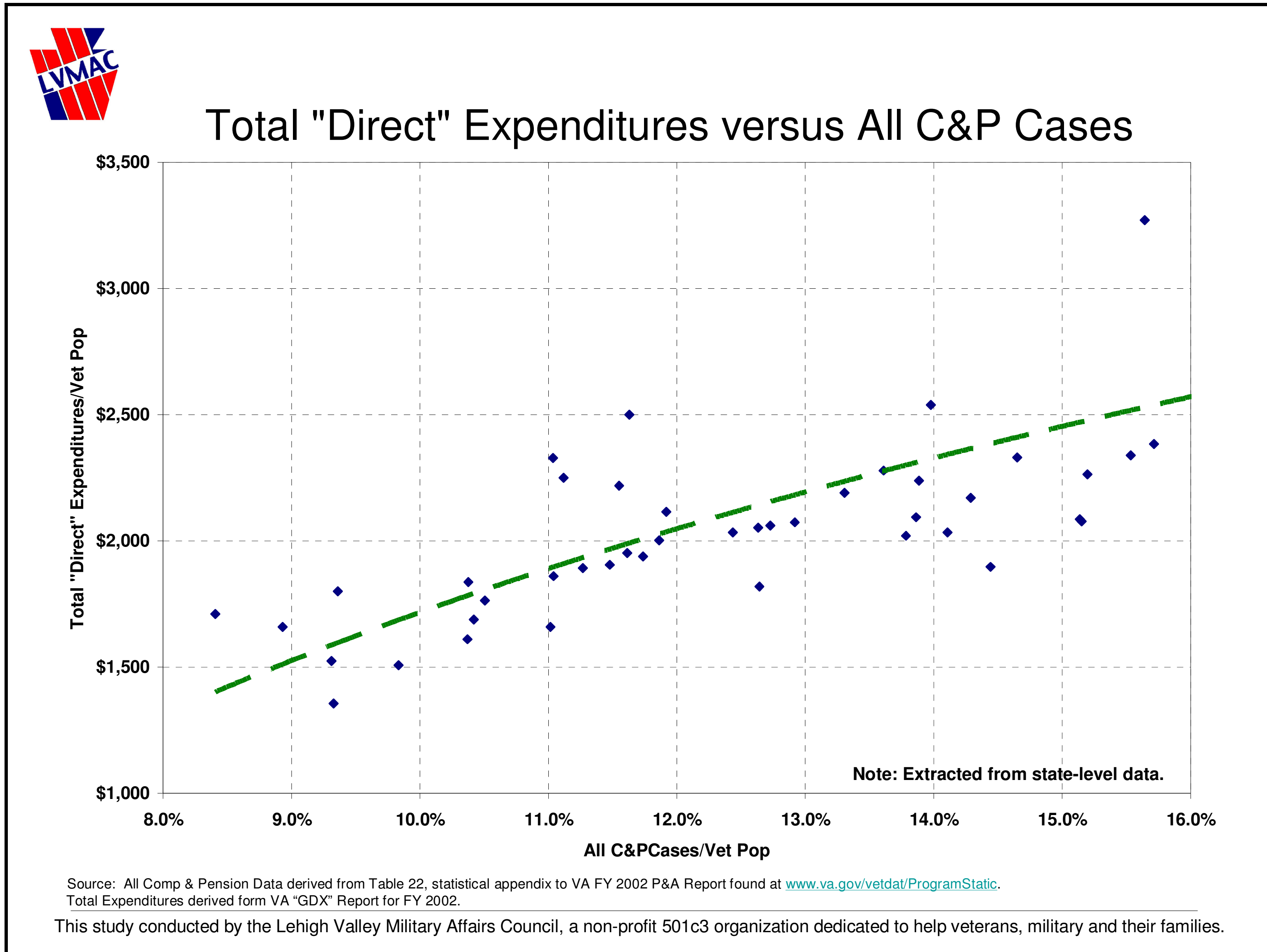


Chart 46: Correlation between Total Compensation and Pension Cases and Total "Direct" Expenditures

TABLE OF CONTENTS

Table 1: The Importance of Claims Processing 2

Table 2: Breakdown of Total "Direct" Expenditures Distributed over the Veteran Population, Sorted on C&P, by Selected Counties........ 3

Table 3: Breakdown of Total "Direct" Expenditures Distributed over the Veteran Population, Sorted on C&P, by Selected States 3

Table 4: The Major Subcategories of Compensation and Pensions........ 4

Table 5: Frequency of Users, FY 2002 4

Table 6: Veteran Characteristics from Table 1, Census 2000 Brief: Veterans 4

Table 7: The Information Pipeline 5

Table 8: Percent Distribution of Veterans by Reasons Veterans Did Not Apply 6

Table 9: Percent Distribution of Veterans by Understanding of Disability Benefits........ 6

Table 10: Percent Distribution of Veterans by Ease of Getting VA Disability Benefits 7

Table 11: Veteran Service Officer Populations in Selected States 7

Table 12: Major Points of Service in Selected States 7

Table 1: The Importance of Claims Processing

Benefits	Claim Required	Disability Rating Required
Disability Compensation		
Service-Connected Disability Compensation	Yes	Yes
Allowances for Dependents	Yes	Yes
Aid and Attendance/Housebound	Yes	Yes
Specially Adapted Homes	Yes	Yes
Automobile Assistance	Yes	Yes
Clothing Allowance	Yes	Yes
Dependency and Indemnity Compensation (DIC)	Yes	Yes
Pensions		
Service-Connected Disability Pensions	Yes	Yes
Non-Service Connected Disability Pensions	Yes	Usually
Aid and Attendance/Housebound	Yes	Yes
Medal of Honor	No	No
Dependents' Death Pension	Yes	Usually
Education and Training		
Montgomery GI Bill	No	N/A
Veterans Educational Assistance Program (VEAP)	No	N/A
Vocational Rehabilitation and Employment	Yes	Yes
Dependents' Education	Yes	Usually
Home Loan Guaranties	No	No
Birth Defects (various)	Yes	No
Insurance		
Insurance (SGLI,FSGLI,VGLI)	No	No
Insurance (SDVI,VMLI)	Yes	Yes
Workplace Benefits	Maybe	Maybe
Homeless Veterans Program	Helps	Helps
Burial Benefits	Maybe	Maybe
Health Services		
Outpatient	Usually	Usually
Hospital	Helps	Helps
Nursing Home	Yes	Yes
Domiciliary Care	Yes	No
Home Improvement and Structural Adaptations	Usually	Usually
Services and Aids for Blind Veterans	Maybe	Yes
Prosthetic and Sensory Aid Services	Usually	Usually
Dental	Usually	Usually
CHAMPVA	Yes	Usually

Source: Federal Benefits for Veterans and Dependents Handbook, DVA, 2003 Edition; DVA Benefits Handbook; DVA Benefits Handbook, Philadelphia VARIOC, 2003.

Table 2: Breakdown of Total "Direct" Expenditures Distributed over the Veteran Population, Sorted on C&P, by Selected Counties

County	Veteran Population	Comp & Pensions	Education & Vocational Rehab	Insurance & Indemnity	Medical Expenses	Total Expenses	Unique Patients	Medical Expenses per Patient
Philadelphia	113,698	$1,138	$73	$97	$1,364	$2,672	21,080	$7,357
Luzerne	37,334	$1,106	$30	$86	$1,529	$2,751	8,840	$6,457
Lackawanna	22,797	$1,094	$28	$87	$665	$1,875	3,805	$3,986
Schuylkill	17,268	$1,017	$37	$87	$778	$1,919	3,912	$3,435
USA	25,490,093	$993	$78	$75	$906	$2,051	4,536,603	$5,091
Franklin	13,918	$856	$36	$73	$502	$1,467	2146	$3,258
Allegheny	132,721	$805	$54	$91	$1,134	$2,084	21,594	$6,969
Carbon	7,463	$795	$28	$78	$403	$1,304	1,021	$2,944
PA	1,209,970	$784	$43	$82	$780	$1,689	209,869	$4,499
Westmoreland	42,582	$735	$34	$81	$498	$1,347	6,070	$3,491
Monroe	15,039	$689	$33	$58	$512	$1,292	1,874	$4,112
Lehigh	30,260	$582	$36	$86	$354	$1,058	3,154	$3,394
Berks	35,770	$556	$27	$79	$533	$1,195	5,607	$3,402
Montgomery	67,059	$538	$29	$83	$323	$973	9,058	$2,388
Bucks	55,428	$535	$29	$78	$275	$917	5,811	$2,621
Northampton	26,852	$509	$27	$78	$259	$872	2,442	$2,846

1. Based on DVA GDX Report for FY 2002
2. Expenditures exclude General Operating Expenses and Construction Program
3. Expenditures under Medical Expenses include medical overhead. They are the sum for all individuals wherever they receive treatment
4. Mortgage guaranties and loans not included as they operate from a revolving fund, not annual appropriation.
5. Unique Patients are identified by zip code, state and SSN. This is not patient visits.

Table 3: Breakdown of Total "Direct" Expenditures Distributed over the Veteran Population, Sorted on C&P, by Selected States

County	Veteran Population	Comp & Pensions	Education & Vocational Rehab	Insurance & Indemnity	Medical Expenses	Total Expenses	Unique Patients	Medical Expenses per Patient
West Virginia	195,180	$1,429	$317	$53	$1,471	$3,269	57,395	$5,002
Texas	1,701,118	$1,262	$96	$63	$918	$2,339	328,041	$4,759
North Carolina	779,393	$1,197	$97	$59	$733	$2,086	121,616	$4,695
Virginia	763,522	$1,036	$105	$73	$682	$1,896	101,757	$5,116
Florida	1,846,327	$1,030	$76	$95	$819	$2,020	376,251	$4,021
USA	25,490,093	$993	$78	$75	$906	$2,051	4,536,603	$5,091
California	2,392,193	$853	$75	$84	$879	$1,891	363,495	$5,783
New York	1,253,731	$838	$76	$101	$1,203	$2,218	271,146	$5,563
Pennsylvania	1,209,970	$784	$43	$82	$780	$1,689	209,869	$4,499
Ohio	1,086,352	$729	$50	$66	$765	$1,610	165,018	$5,035
New Jersey	628,493	$713	$48	$106	$640	$1,507	82,366	$4,885
Illinois	945,487	$571	$62	$85	$992	$1,710	165,633	$5,665

Notes: See previous table.

Table 4: The Major Subcategories of Compensation and Pensions

Benefit Programs	Number of People	Percent of Total	Total Annual Amounts	Average Annual Amounts
Compensation–Disability	2,398,287	72.9%	$17,589,232,812	$7,334
Compensation–Death	315,731	9.6%	$3,688,272,387	$11,682
Pension–Disability	346,579	10.5%	$2,274,957,852	$6,564
Pension–Death	230,267	7.0%	$649,484,556	$2,821
TOTAL	3,290,864	100.0%	$24,201,947,607	$7,354

[1] This category represents the Dependency and Indemnity Compensation Program.
[2] Includes only Surviving Spouses.
[3] Source: This table directly taken from VBA Annual Benefits Report, FY 2002, pg 2-15.

Table 5: Frequency of Users, FY 2002

Healthcare Priority Group	Users	Enrollees	Users/ Enrollees
1	13%	9%	84%
2	7%	6%	67%
3	12%	13%	58%
4	4%	3%	73%
5	36%	35%	65%
6	1%	2%	37%
7	25%	31%	50%
90	2%	0%	NA
All Vets	4,246,584	6,788,780	63%

Note: Priority Groups 1 through 6 require a compensation or pension claim.
Priority Group 7 may require a claim and does entail enrollment qualifications.
Group 90 is essentially walk-ins.
Source: origin is VHA/CFO report, Enrollment Cost Summary, Sep 2002 Data

Table 6: Veteran Characteristics from Table 1, Census 2000 Brief: Veterans

Number and Percentage of Civilian Veterans Aged 18 and Over by Period of Service and Other Characteristics: 2000

(Data based on sample. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see *www.census.gov/prod/cen2000/doc/sf3.pdf*)

Period of service	Number in 2000	Percentage of all veterans	Median age	Percentage women	Percentage employed	Percentage in poverty in 1999	Percentage disabled
All veterans 18 years and over	**26,403,703**	**100.0**	**57.4**	**6.0**	**54.7**	**5.6**	**29.1**
August 1990 or later (including Gulf War)	3,024,503	11.5	33.3	15.7	81.4	6.2	16.3
September 1980 to July 1990	3,806,602	14.4	38.8	13.0	82.7	5.5	18.2
May 1975 to August 1980	2,775,492	10.5	45.5	9.9	78.0	5.6	22.7
Vietnam era (August 1964 to April 1975)	8,380,356	31.7	53.2	3.2	75.4	5.1	24.8
February 1955 to July 1964	4,355,323	16.5	62.8	2.4	51.4	4.9	29.4
Korean War (June 1950 to January 1955)	4,045,521	15.3	70.1	2.2	24.6	4.5	33.6
World War II (September 1940 to July 1947)	5,719,898	21.7	76.7	4.2	11.6	4.8	45.2
Some other time	323,785	1.2	74.3	4.5	16.1	6.6	46.4

Note: The figures do not add to 100 percent because veterans may have served in more than one time period.
Source: U.S. Census Bureau, Census 2000 Summary File 3 and special tabulations.

Table 7: The Information Pipeline

Response	Total
The Department of Veterans Affairs (VA)	66.6
VA: Toll-free telephone number	12.4
VA web site	12.2
Other Internet or web site	5.0
Veterans Service Organization (VFW, American Legion)	13.8
VA Benefits Booklet (Federal Benefits for Veterans and Dependents)	0.9
Social Security office	0.7
Another government agency	10.0
Senior citizens group (AARP)	0.2
Health advocacy group (MS Society; American Association for the Blind; Easter Seals; March of Dimes)	0.4
Doctor or doctor's office	0.7
Employer or former employer	0.2
Another veteran	1.7
Family or friends	2.1
Newspaper or magazine	0.7
TV or radio	0.1*
Some other person or place	5.3
Nowhere	3.9
Number of veterans†	25,196,000

*Low precision and/or sample size for the denominator between 30 and 59.

† Estimate of number of veterans is rounded to the nearest hundred; percent estimates will not sum to 100 because veterans could indicate more than one source of information about benefits.

Source: This is Table 1-1: Percent Distribution of Veterans by Sources of Information about VA Benefits, 2001 NSV

Table 8: Percent Distribution of Veterans by Reasons Veterans Did Not Apply for VA Disability Benefits

Response	Total	Less than 35 years	35-44 years	45-54 years	55-64 years	65-74 years	75 years or older
Not aware of VA service-connected disability program	12.7	24.2	16.2	12.8	15.9	10.4	10.4
Didn't think was entitled or eligible	40.6	38.1	42.4	41.2	43.8	40.9	37.3
Getting military disability pay	0.9	0.5*	1.2*	1.3*	0.4*	0.3	1.6
Getting disability income from another source	2.1	0.2*	0.8*	1.9*	2.7	2.8	1.6*
Didn't think disability was severe enough	5.1	1.6*	3.3*	7.8	4.8	5.3	4.4
Didn't know how to apply	3.2	16.1	4.5*	3.3	4.7	2.0	1.3*
Didn't want any assistance	3.1	3.5*	1.8*	2.2*	2.0*	4.2	3.8
Didn't need assistance	22.7	15.4	17.5	14.2	20.1	27.2	27.4
Applying too much trouble or red tape	4.8	8.2*	8.8	7.6	3.2	4.0	3.5
Never thought about it	7.1	5.2*	5.7*	5.0	7.0	7.4	8.9
Other**	17.0	11.7*	19.3	22.7	15.4	14.6	17.2
Unknown	1.5	2.7*	0.3*	1.1*	1.3*	1.0*	2.3
Number of veterans†	4,534,500	134,600	321,600	722,000	892,100	1,214,400	1,231,100

1. * Low precision and/or sample size for the denominator between 30 and 59.
2. ** Reasons for not applying for benefits was asked as an open-ended question with ten pre-established categories for interviewer coding of responses. When interviewers could not readily code responses into one of the pre-established categories, responses were transcribed and coded as "other." The "other" category contains a variety of responses, including: disability not service-related; lost records; inconvenience; and bad treatment by VA in past. None of the themes in the "other-specify" comments were frequent enough to permit analysis across groups.
3. † Estimates of number of veterans are rounded to the nearest hundred; the total estimate is larger than the sum of the groups because some veterans did not provide their age; percent estimates will not sum to 100 because veterans could indicate more than one reason.

NOTE: This table only includes responses of those who indicated they had a disabling condition but had not applied for VA disability benefits.
Source: This is Table 7-5 from VA's 2001 NSV

Table 9: Percent Distribution of Veterans by Understanding of Disability Benefits

Response	Total	Less than 35 years	35-44 Years	45-54 years	55-64 Years	65-74 years	75 years or older
Strongly agree	15.1	12.1	12.8	16.6	15.9	18.3	12.5
Agree	36.1	25.1	30.4	35.1	33.8	42.5	44.2
Neither agree nor disagree	12.0	14.1	13.0	12.5	15.6	10.2	8.0
Disagree	21.2	28.2	27.2	21.8	19.4	15.3	19.2
Strongly disagree	12.6	20.2	15.8	12.1	11.8	11.5	8.5
Unknown	3.0	0.3*	0.8*	1.9	3.5	2.2	7.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of veterans†	4,425,400	350,600	536,000	1,233,200	771,300	665,600	818,600

1. * Low precision and/or sample size for the denominator between 30 and 59.
2. † Estimates of number of veterans are rounded to the nearest hundred; the total estimate is larger than the sum of the groups because some veterans did not provide their age.

NOTE: This table only includes responses of those who indicated they had a disabling condition that they thought was service- related
Source: This is Table 7-9, 2001 NSV

Table 10: Percent Distribution of Veterans by Ease of Getting VA Disability Benefits

Response	Total	Less than 35 years	35-44 Years	45-54 years	55-64 Years	65-74 Years	75 years or older
Strongly agree	8.7	6.6*	5.4	7.7	9.9	11.0	10.3
Agree	29.2	23.0	24.9	25.5	29.9	33.3	36.4
Neither agree nor disagree	13.1	22.0	17.0	14.0	12.5	11.0	7.2
Disagree	23.1	22.0	25.4	24.5	22.5	20.8	22.7
Strongly disagree	21.9	24.5	25.3	26.1	21.3	19.1	14.9
Unknown	4.0	1.9*	2.0*	2.2*	3.9	4.8	8.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of veterans†	4,425,400	380,600	536,000	1,233,200	771,263	665,600	818,600

1. * Low precision and/or sample size for the denominator between 30 and 59.
2. † Estimates of number of veterans are rounded to the nearest hundred; the total estimate is larger than the sum of the groups because some veterans did not provide their age.

NOTE: This table only includes responses of those who indicated they had a disabling condition that they thought was service-related or those who indicated they had a service-connected disability rating.
Source: This is Table 7-6, 2001 NSV

Table 11: Veteran Service Officer Populations in Selected States

State	VA Public Contact Officers	Estimated Accredited Vet Org VSOs	Accredited State VSOs	Estimated "Qualified" County VSOs*	Total	FY 2003 Veteran Population	Veterans per VSO
PA	unknown	50	4	50 (67)	104	1,180,309	11,349
FL	unk	58	46	133 (67)	237	1,829,761	7,721
NY	unk	61	55	80 (62)	196	1,211,909	6,183
OH	unk	39	0	144 (88)	183	1,062,906	5,808
TX	unk	55	50	220 (254)	325	1,679,056	5,166
NC	unk	34	25	105 (100)	164	772,814	4,713
WV	unk	9	35	0 (55)	44	192,348	4,372

Notes: Qualified means either state trained or accredited. * (xx) indicates no. of counties.
Source: LVMAC survey, Mar-Apr 2004 (phone, email, Internet); concept of this chart from Dave Heiland, DMVA-VA.

Table 12: Major Points of Service in Selected States

State	DVA Regional Offices	VAMC	Estimated DVA "Field" Offices	State "Field" Offices	State Homes	County Service Offices	Total Major Node Points of Service	FY 2003 Veteran Population	Veterans per Major Node Point
FL	1	6	6	10	4	67	94	1,829,761	19,466
PA	2	10	2	1	6	67	88	1,180,309	13,413
OH	1	4	2	0	2	88	97	1,062,906	10,958
NY	2	12	1	53	4	62	134	1,211,909	9,044
WV	1	4	0	16	1	0	22	192,348	8,743
NC	1	4	2	15	1	91	114	772,814	6,779
TX	2	10	10	18	4	220	264	1,679,056	6,330

Notes: VSO and SDVA offices co-located with VAMC or RO not counted separately but as one point of service. Hospitals on separate campuses counted as separate VAMC. Field Office includes serviced clinics, vet centers, offices, and military installations. County Offices included if manned, regardless of the qualifications of service officers. Level of manning not considered. Source: LVMAC survey, Mar-Apr 2004

SUMMARY/MINUTES
Special Veterans Affairs Committee Meeting
18 November 2003

INTRODUCTION: The LVMAC Veteran Affairs Committee met with county, state, and federal veterans' service officials and veteran service organizations on 18 November 2003, from 10:00 AM to 4:30 PM to discuss the veteran benefit services situation in the Lehigh Valley. Based on anecdotal information there seemed to be a problem. Consequently, a meeting was suggested. The following is Summary/Minutes of a meeting that was far-ranging in its scope.

ATTENDEES: See attachment.

DISCUSSION:

1. It was generally agreed that improvement in veterans benefits services was required both in manpower and coordination of the existing assets.

2. When one talks to a valley veteran, the key topics are disability compensation (and pensions) and medical care: discontent with claims processing and access to the health care system.

3. To provide quality service, [t]he[re] must be a veterans service officers (VSO), carefully selected and properly trained: VA accredited and regularly updated. VA accreditation means the individual is a member of a VA recognized organization and has completed a VA approved/recognized course of instruction (such as the one the state DMVA provides to county officers on an annual basis at Indiantown Gap). This has been a continuing problem in many counties. The guiding regulation for this is 38CFR14.629.

4. The VA provides one counselor once a week to the valley. The state, while it requires county veteran officers, does not require them to be VA accredited. County director job requirements do not <u>require</u> VA accreditation. Currently, the counties have been undergoing staffing problems. Department of Labor and Industry veterans representatives (both at CareerLink and in the Governor's Outreach and Assistance Center (GVOAC)) are not required to be VA-accredited. In fact, GVOAC employees are contracted; they are not state employees. Veterans' service organization post service officers are not required to be VA-accredited either, and their levels of qualification vary. Only at the national/state level are service organizations providing VA-accredited personnel. Also, these veterans organizations are having staffing problems of their own.

5. The state itself has no DMVA Veterans Affairs 'Bureau' presence in the counties. It only provides "AGO" veterans service officers for the counties and homes at the VA claims processing centers. The county officers are intended to be part of its system of service. Towards this end, it trains county veterans officers (at the discretion of the counties). Actually, its major focus is upon operating its veteran's homes and the Scotland School.

6. Many veterans do not understand that the Veterans Benefit Administration (VBA) provides veterans service representatives (veterans benefit counselors, veterans claims officers, veterans claims examiners) and the Veterans Health Administration (VHA) does not. For them, the Allentown Outpatient Clinic is the VA presence in the valley, a presence made all the more important by the problem suggested in the preceding paragraphs: marginal county services beyond burial benefit services and veteran observances. The county directors do not have the staff to dedicate exclusively to claims processing, the major problem.

7. The valley has a tradition of providing volunteer veteran benefit services in a room at the clinic. Formerly, there were five volunteers. By luck, most were accredited. But this arrangement has also had its fair share of problems. One from the American Legion died this year and has not been replaced. Two others left over a bitter dispute concerning qualifications and competence which jeopardized the arrangement at the clinic altogether. Currently, only two volunteers remain, both provided by the American Ex-POW, Inc. They are about 80 years of age and have had severe health problems. Attempts to re-staff have been marginally successful: the national service officer in Philadelphia for the Military Order of the Purple Heart (MOPH) has agreed to service the clinic twice a month.

8. The arrangement poses another problem: how to ensure continuity of effort when a veteran needs attention. The current "confederacy" does not really address this problem. No one is in charge. No real coordination occurs. No file management system exists at the clinic to assist in follow-ups. Since the clinic is governed by 38CFR14.635, the clinic administration will not allow the keeping of files at the clinic by volunteers and the VA and MOPH representatives, who would qualify, do not.

9. The clinic administration is willing to provide the space for service representatives, but is also concerned that if service is improved, the clinic will become overcrowded. A call-in, appointment arrangement was discussed in this regard. However, walk-in traffic will continue to occur. A discussion occurred about using the space and additional volunteers to redirect veterans to those who could serve them best, e.g., the county veterans' office. This concept was called "Ambassadors". [It pans the problem. A subsequent practice attempt on Mondays has not proved successful: the veterans wanted on-site service, not referral.]

10. Establishing a Veterans Center for services other than medical was discussed. Its location within a city seems to be a negative for many veterans though not out of the question. The vicinity of the clinic seemed a good location for reasons of administration and transportation access, and it is a well-known location to veterans. Co-location of Veteran Employment Representatives was suggested to support the concept of one-stop shopping, like the Philadephia Multi-Purpose Center(?).

11. Few people seem to know about the CareerLink-stationed veterans employment representatives. While funded through the federal Department of Labor via the Wagner-Peyser Employment Act, they are an important component of veterans benefits: vocational rehabilitation and training.

12. The local regional Governor's Outreach and Veterans Assistance Center personnel and funding could be better employed to assist those in this valley. It has no solid presence. Also funded through the Wagner-Peyser Employment Act, a lot of the local regional organization's time and money seems to be used for traveling. It does not appear to coordinate its efforts with County Directors, nor really seem to be a vital component of vocational rehabilitation [little tie-in with the veterans employment representatives]. It is a program that could be more effectively integrated with the efforts of others. It needs a management review.

13. The Red Cross no longer provides VSO services.

14. The VFW offered to provide a national service officer twice a month to the clinic. The State Bureau offered a VSO, once hired for the Wilkes-Barre office and qualified, on perhaps a weekly basis. The Carbon County veterans director stated he would be willing to also provide assistance at the clinic on a temporary basis. The Veterans Employment Representatives offered their services as "Ambassadors" during the normal course of their liaison with the clinic, if a set space were provided. No offer of assistance was made by the American Legion, AMVETS, or GVOAC.

15. A discussion on how LVMAC could help the counties occurred. What a county veterans office is supposed to do seems to a subject not clear to all. A statistical assessment of the situation to justify a greater commitment of governmental resources towards veterans services was suggested. The idea of a cost-benefit study was bandied about. Unfortunately, the counties do not keep meaningful data for this, other than for burial information; and provided no ideas on what information would be most useful. Supposedly, the county executives see their veterans' offices as a source of outflow of funds (burial benefits), bringing nothing into the community. [This is a strange argument for a government to make, since one of the primary purposes of government is service to its citizens. Also, most of the veterans programs originate with the federal government.] Consequently, county veterans programs do compete with others for funds perhaps at a disadvantage. The VA representative had nothing to contribute to this topic, but the state representative suggested reviewing his Dave Heiland's briefing presented to the Pennsylvania State Association of County Directors of Veterans Affairs. A sample of that briefing was shown.

16. Methods for getting the word out on services available were discussed fragmentarily: Internet, newspapers, information posters, and handbooks. A cheat sheet for Ambassadors, a pocket card, and a handbook were suggested.

17. The need for follow-up meetings to improve coordination and to disseminate information seemed a good idea.

/s/
Richard J. Hudzinski
Veterans Affairs Committee
Lehigh Valley Military Affairs Council
20 December 2003

Attachments
1 - List of Attendees

LIST OF ATTENDEES

Date: 18 November
Location: American Red Cross Building, Lehigh Valley Industrial Park
Purpose: Special Meeting, Veterans Affairs Committee, LVMAC
Type of Meeting: Open Discussion

William T. Harris, President, LVMAC
Nathan Kline, VP, LVMAC
Herb Farnsler, Treasurer, LVMAC
Charles Kowalchuk, VeteransAffairs Committee (VAC), LVMAC; MOPH
Stanley R. Staples, VAC, LVMAC
Mary Ann Lewellyn, Chairman, VAC, LVMAC; former Lehigh County Veterans Director
Richard J. Hudzinski, VAC, LVMAC
Richard Kram, VAC, LVMAC
Nancy Jordan, Chief of Public Contact, VA Regional Office and Insurance Center, Philadelphia
Jeffrey Vollum, Administrative Officer, Allentown Outpatient Clinic
Jim Davison, Deputy Director for Veterans Affairs, DMVA-VA, Pennsylvania
Joseph Prusak, Veterans Employment Representative, CareerLink Team Pennsylvania
Leo Oropeza, ditto
Mario Lopez, ditto
Samuel Jones, ditto
Ron Pennypacker, Director, Governor's Veterans Outreach and Assistance Center (GVOAC)
Ray Greene, Director, Veterans Affairs, Northampton County
Earl B. Stafford, Director, Veterans Affairs, Lehigh County
Charles J. McHugh, Director of Veterans Affairs, Carbon County
Robert Shalala, Cdr, Dept. of Pennsylvania, American Legion
Frederick Smith, PA Dept. Service Officer, American Legion
John J. Novak, 14th District Cdr, The American Legion
Kenneth Cahill, Executive Dir, AMVETS, Dept of PA
Joseph Hart, PA Dept. Service Officer, VFW
Franklin L. Homme, Cdr, Chapter 7, DAV
Cordelia Miller, Director, Emergency Services, American Red Cross of the Greater Lehigh Valley
Carol Lewis, Emergency Services, Red Cross
Mary T. Ensslin, Special Assistant. , U.S. Senator Rick Santorum

The information below was collected by various means to include telephone calls to the state directors in most instances. Any errors are due to LVMAC's misunderstanding of conversations and data.

States divide up the responsibilities for veteran homes, cemeteries, and benefits counseling differently. The focus of this study was how they addressed veterans' benefits services.

Certain patterns and concepts emerged for successful state programs. Those are summarized in Part 4 of the main body.

OHIO

Organization:

- Ohio has a Governor's Office of Veterans Affairs. It does not have a combined military and veterans agency.

- County offices (directors) for veterans affairs are required by the state, like Pennsylvania. There are 88 veterans affairs offices with about 144 service officers total. The number of county service officers depends upon the financial well-being of the community.

- Ohio is the only state sampled that does not have its own state-level accredited service officers.

- County service officers turn over Power of Attorney (POA) to a veterans organization which has the veteran service officers at the VA Regional Office, as the state has no representatives at the VA Regional Office at Cleveland.

DVA Interaction: Nothing special noted.

Training:

- State has a formal training program for those who are county veterans service officers, number depending upon county's ability to pay. It requires county service officers to complete 5 credits of training a year. Their county supervisors must also complete 3 credits per year.

- This training does not necessarily result in accreditation, however. Ohio uses an internal state certifying process and does not involve the VA except in assisting their training.

Management and Reports:

- Requirements are specified by state statute.

- The relinquishing of POA to veterans organizations has sometimes caused problems in communications, since the VA and often the veteran organization will not communicate except the duly veterans representative empowered by that POA. Consequently, county veterans' service officers are left out of the loop after preparing and forwarding the initial paperwork. Iowa, Indiana, and Michigan have all noted this problem when their officers are not accredited and the state does not have POA.

- No annual reports were discussed.

- It does not track claims.

- The system is derived from the post Civil War era. In the main it is not as thorough-going as the others. Dependent more on good will than control.

Awareness: Its web site, www.state.oh.us/gova/ , is decent. State statutes can be found on the web site.

Other: Homes are the responsibility of another agency.

WEST VIRGINIA

Organization: It has a Division of Veterans Affairs. West Virginia does just the reverse of Ohio.

- It does not use county level personnel at all and instead relies on 35 state employed, accredited service officers located in 16 field offices and at the VA Regional Office at Huntington to perform all the service officer tasks.

- Two service officers man the Huntington office.

- It also fields an office to the Pittsburgh Regional Office since it derives support for a few of its counties from there. Washington Regional Office also supports them in a few counties.

DVA Interaction: No special programs were noted, but West Virginia appears to have a close and cooperative relationship with the Huntington Regional Office. The DVA also fields two service officers.

Training: VA conducts training of state employees twice a year. Service officers submitted to the VA for accreditation.

Management and Reports: This is system seems to have the highest return per veteran.

- This state has entered into agreement with the veteran organizations whereby their employees are dual accredited by the state and one or more veteran organizations, except for the PVA and DVA. This streamlines their process and improves their communications. It overcomes the problem experienced in Ohio.

- Increasing the number of service officers from one to two has significantly improved performance.

- It emphasizes control of the process from cradle to grave for its state veterans.

- It has a claims tracking system. It reviews all VA determinations before final issue to the veteran. This procedure provides an excellent system double check that saves time later by reducing appeals or suits.

Awareness: Its web site, www.nasdva.com/westvirginia.html/, could be improved.

Other: Homes and orphans education are the responsibility of this state agency. The state is proactive in educational area, having effectively extended the GI bill beyond the 10 yr limit with a $1000/yr educational supplement. It was noted that West Virginia has close to, if not the highest, educational expenditures per veteran population by a significant margin.

Comments: West Virginia is a small state and not a prosperous one -- on the extreme end of the scale. These two factors may have more influence than for other states. Veterans would be more likely to seek help and not hold back. On the other hand, if the state could did not have the capability to handle the situation, it would not perform nearly as well regardless.

NEW YORK

Organization:

- New York has a Division of Veterans' Affairs under its Executive Office.

- New York state law requires county offices and directors for those counties not wholly within a city. Otherwise they are called city service officers.

- In reality the state overlays a highly professional, accredited group of state employees (about 55, exclusive of assistants) distributed into 3 regions and thence further into the counties, VAMCs, Regional Offices at Buffalo and New York, veterans homes, etc. on either a permanent or itinerant basis (The itinerancy is partly the result of staffing reductions.).

DVA Interaction: The state has worked with the VA on a pilot project to bring cases to "rating ready status". This involves greater access to the VA's internal system and has expedited processing in the test case. The DVA fields one known service officer.

Training: The state does not train or ensure the accreditation of the county officers, though most are supposedly accredited. That is left to the veteran organizations. The state trains their employees and submits them to the VA for accreditation.

Management and Reports:

- The Division instituted internal performance tracking between FY 2001 and FY 2002. It emphasizes its productivity. It has also moved to a concept of evaluating where the work is and redistributing the effort accordingly.

- It has a claims tracking system, which allows it to reevaluate claims as laws change.

- It is emphasizes advocacy (its officers located in the Regional Offices form an appeals division) and "linking veterans to benefits" while not adjudicating at the local level.

- It claims a 75% success rate in cases filed.

- Retirements are about to become a problem affecting a third of the work force. Already there are shortfalls in manpower.

- New York publishes an annual report for public dissemination.

Awareness: Its web site, www.veterans.state.ny.us, is excellent veterans' information.

Other: It has an education bureau for certification of schools and for approving apprenticeship/OJT programs. It is not responsible for homes or cemeteries.

Comments: Executive Law 17 provides 50% funding reimbursement, within a fund ceiling, to cities and counties for veterans programs.

FLORIDA

Organization:

- It has a Florida Department of Veterans Affairs, created in 1987 by statute, approved by the voters for the sole purpose of being a veterans' advocate.

- Florida has no requirement for counties to establish veterans' offices or to provide service officers. This nevertheless happens and all are accredited by the organization in accordance with state statute: 133 service officers in 80 counties.

- The state deploys its own professional, veterans' service officers with a heavy concentration of 12 officers to the St. Petersburg VA Regional Office and 34 others to the VAMCs and VA Outpatient Clinics (12 locations total).

DVA Interaction:

- The DVA actively outbases itself in this state. There are at least two mini-centers for benefits services, one in West Palm Beach, the other in Orlando. Each staffed with several people. The VA also situates itself in VAMC and VA Outpatient Clinics. Total effort estimated by the state is 12 to 18 VA veteran service officers in the "field."

- The DVA has instituted a "Separation Examination Program" for service members in conjunction with DoD at Jacksonville and Pennsacola Veterans Service Centers. This is another "out basing or outreach" initiative.

- It has partnered with the VA with the PARD project which seems to be similar to New York's in nature: more access to the VA's BDN system and bring cases to "ready-to-rate" status for the VA. [PARD was the forerunner of TRIP.]

Training: No requirement for County Directors to be accredited exists, but Florida statute does require county service officers, when provided, to be "certified" and annually recertified. As stated, 133 are accredited. Training is conducted biannually. The state trains its employees and they are accredited.

Management and Reports: It has designed a "Veterans Benefits on Line Tracking System" that enables it to keep track of submitted claims. When a law changes, it has the ability to identify those claims previously denied and have them resubmitted.

Awareness: Its web site, www.floridavets.org, is useful.

Other: It has picked up responsibility for homes in the recent past, seems to be a new thing for Florida. More are planned.

Comments:

- Florida's system was created out of the concern was that its veterans were not receiving the DVA dollars they deserved and the state needed a VA "watchdog" (sic).

- It probably also benefits from a migrating retiree population that has had their claims already processed before they relocate. However, it also realizes that older veterans especially are intimidated by the VA system and tend to shy away so as not to be a "bother".

TEXAS

Organization:

- Texas has the Texas Veterans Commission as a state level organization. It is more than what we normally think of a commission as being: it is their Division of Veterans Affairs.

- Texas only requires those counties with more than 200,000 veterans to have county service officers. Nevertheless 220 out of 254 counties do have trained service officers. TVC is pushing them to take advanced courses for accreditation, probably since its own manpower is an issue. As of June 2002, 26 of them had done so. The number must be higher by now.

- Equally important it fields a solid, motivated, skilled team of accredited state employees, assigning them to one of two regions and then further down to where the work is. They field 50 state veteran counselors in 29 locations including hospitals, outpatient clinics, military installations, and the VA Regional Offices (Totally, it has 92 FTE employees). The county service officers are then aligned with these. Texas, like Pennsylvania, has two DVA Regional Offices. Hence, its state regions parallel.

DVA Interaction:

- It is highly organized and so closely works with the DVA, that sometimes veterans mistake it for the DVA's ombudsman. This is partly because the VA provides it office space and some equipment, free of charge, in 23 of its locations.

- The VA has a number of outbases in Texas, more than in the other sampled states, and also has deployed Separation Examination Program teams to the major military installations, of which Texas is fortunate to have many.

Training: Texas does assume responsibility for the biannual training of county service officers and reimburses that training. It uses training modules. County service officers are required to attend training once a year. The state runs formal training occurs twice a year and is very proud of it. State service officers (counselors) are trained and accredited.

Management and Reports:

- It emphasizes advocacy beyond just forwarding paperwork. It sees the VA as a budget-driven creature that with an eye to cost cutting sometimes sacrifices the entitlements of veterans. To wit:

> Budget driven decisions by [the] VA have especially affected low-income elderly veterans. For example, veterans who are in receipt of pension annually complete an income questionnaire. To save cost and reduce claims processing, the VA has eliminated this requirement in many cases. Those veterans with significant medical expenses during the year, which is the norm for aged veterans, could have some of those expenses reimbursed by reporting them on the questionnaire. Many of those aged veterans can miss this opportunity for this reimbursement because they will not complete the questionnaire. To help these veterans the TVC is contacting those veterans on our caseload and offering our assistance in reporting

their medical expenses. Direct contact on this issue is only available to veteran on our caseload.[1]

- As it sees it, when a veteran can not receive care in a VA hospital or does not establish entitlement to DVA compensation and pension, the burden is shifted to the state, county, and city.

- TVC has a claims tracking system and performs statistical analyses. It has fully computerized. Paperwork is only maintained on ongoing cases. Access to the DVA's system seems to be routine.

- It has fully developed management performance measures. It produces performance reports. It "sunshines" its strategic plan.

- It suffers from losing personnel to the VA because of the pay disparity and the proximity of state and DVA offices. [VA employees are well paid.]

- Texas uses a biennial budget system which has the advantages for programming, but sometimes does not allow it to react quickly to changes in VA rules, procedures, and initiatives

Awareness:

- It has recently been promoting an "Awareness" campaign, a perceived shortfall. In addition to using the media, under legislative direction the TVC entered into Memorandums of Understanding between various state agencies who provide other veterans services like the Texas Workforce Commission, their labor department, to increase the available services and dissemination of information to the veterans.

- The DVA has also been doing considerable Community-Based Outpatient Clinic (CBOC) work (contracted, small private operations) which has made the TVC's ability to cover the terrain more difficult. This is another reason for the emphasis on their awareness campaign.

- Its web site, www.tvc.state.tx.us, is excellent, perhaps the best of them all. Brochures and directories can be obtained from it.

Other: It is not responsible for homes and cemeteries. Texas Veteran Land Board has that responsibility.

Comments:

- According to the state director, they have been a model for other states. Their performance statistically is certainly very high.

- The current system has a long history, but essentially was borne of frustration with the DVA. "Texas matters most." is the overarching, impelling principle.

- The VA handles 62% of all the caseloads. This is consistent with the findings of the 2001 NSV. It has a 30% error rate, which is also consistent with information from the 2002 Veterans Benefit Administration's Annual Report and other later data

[1] Strategic Plan, 2003-2007, Texas Veterans Commission, 1 Jun 02, p. . .20

NORTH CAROLINA

Organization:

- North Carolina has the Division of Veterans Affairs, which falls under the Department of Administration, since 1977. Formerly in was part of the Department of Military and Veterans Affairs, like Pennsylvania's system.

- Counties are not required to provide veterans services but if they do they must come under a state district office for the purposes of training, work review, and supervision. If they do not, the state district office will handle claims processing directly for the county. 91 out of 100 counties participate.
The state encourages all this with a $2,000 stipend to each county if it provides a full or part-time veteran service officer. Some have more than one. .

- North Carolina deploys one-person 15 district offices to which certain counties are assigned for administrative and jurisdictional authority. It mans the VA Regional Office with 10 accredited personnel. Consequently, it has at least 25 accredited veterans service officer state employees.

- The veterans organizations are well represented at the Regional Offices, VAMC, Ft. Bragg and Camp LeJeune with full or part-time personnel.

DVA Interaction: The DVA outbases with Separation Examination Program offices at Ft. Bragg and Camp LeJeune.

Training:

- Each county service officer, upon meeting the 1000 hr FTE requirement, completion of the state training program of 22 to 24 training modules, achieving a score of at least 75%, and receiving his training coordinator's recommendation has his name forwarded to the VA for accreditation pursuant to 38 CFR 14.629. 80 are currently accredited. Additional assistants are becoming accredited which will raise the total to about 105 in the near future. State service officers are trained and accredited.

- The county employees, like the state employees, go on to take TRIP training that allows them into the DVA's BDN (Benefits Delivery Network) database system. The training certification allows them to use computers to streamline their claims processing and allows them to monitor the progress of a claim. This reinforces the thought that North Carolina has a highly developed training program.

- North Carolina's program was the best in getting county officers accredited. It has the highest number of verifiable, accredited officers of any of the states surveyed

Management and Reports:

- The agency sees itself as a supplementing and augmenting the efforts of others.

- It uses and encourages county integration into the BDN network.

- Like West Virginia, state-level accredited officers are dual accredited with the major veteran service organizations. It has formed a particularly close bond with the American Legion, which helped to create this state system.

- This state tracks claims and other statistical data for effectiveness and efficiency. Currently, it is developing procedures for improving claims submissions.

- It is trying to get the counties to improve their claims preparations while not driving them to use alternative routes for submission. It prefers the pipelining to be done through the state.

- It tends to emphasize using a lot of immediate "informal claim" submissions. This allows a claim to be dated to the time the veteran first appears before them. Since claims can take a considerable amount of time to properly prepare for rating, this is to the advantage of the claimant as it means more money when the case is finally settled.

Awareness: Its web site, www.doa.state.nc.us/doa/vets/va.htm, is average and not as well developed as Florida's and Texas'.

Other: It is responsible for state homes. Like Florida, there has been considerable nursing/domiciliary care building going on (DVA is the primary source of funding for these.). [Pennsylvania has recently completed its own expansion of veterans homes.]

Comments:

- The division's origin is post-World War I, when it became apparent that the veterans organizations' capabilities exceeded their capacity to meet the demands for assistance.

- As in the other states, the DAV and PVA go their own way (no dual accreditation agreements). They appear to work effectively on their own.

QUESTION: How much more money could potentially be brought into the community (Lehigh and Northampton Counties) or to the veteran in services if we improved veteran service representation and performance?

ANSWER:

	Current	Potential	Delta	Per Cent Increase
Total C&P:	$31,265,000	$65,011,732	$33,746,732	107%
Total Med:	$17,655,000	$51,363,891	$33,708,891	190%
Total Other:	$ 6,509,000	$ 9,310,050	$ 2,801,050	43%
Grand Total:	$55,429,000	$125,685,673	$70,256,673	127%

Note: Uses FY2002 dollars; not indexed to FY 2004; VA index not known. Other includes Educational and Voc Rehab, Insurance and Indemnity programs. Figures do not include revolving funds, such as mortgage guaranties (important to the real estate business); construction and general operating expenses; and do not reflect state and county programs.

1. ASSUMPTION: Bases calculations on the expected average for veterans with a disability. This figure is not the maximum possible.

2. SOURCE INFORMATION: 2001 DVA National Survey of Veterans (2001 NSV), 2000 U.S. Census, and the statistical appendices to the FY 2002 DVA Performance and Accountability Report.

3. DISCUSSION:

- FY 2001 and 2002 data used, not indexed to FY 2004.
- Veterans having a disability:

  2000 US Census: 29.1%
  2001 VA NSV : 32.1%

Point here is that VA survey data can be considered reasonably accurate for further use. It is also more current. Any errors in applying 2001 data to use with 2002 data will fall within a 5% or less error range. Data therefore will be statistically sound.

- Veterans having a service-connected disability:

  2001 VA NSV: 43.1%

  This translates as .431 x 32.1% or 13.8%

- Veterans with a service-connected disability and are compensable (a.k.a. living vet C&P):

  Factor, from my own analysis: .86 nationally

  This translates as .86 x 13.8% or 11.9% (rounded).

  Note: some states slightly higher, some slightly lower.

- Service-connected, compensable disability cases to Total C&P Cases (DIC, burial benefits, non-service connected pensions added):

  Factor, from my own analysis: 1.21 nationally

  This translates as 1.21 x 11.9% or 14.4% (rounded)

  Note: some states slightly higher, some slightly lower

- Total Veterans in the Lehigh Valley:

Lehigh:	30,260
Northampton:	26,852
	57,112

- Total C&P Cases:

  .144 x 57,112 = 8,224 veteran cases

- Average Dollars per C&P Case:

  US: $25,311,731,000/3,201,892 cases = $7,905 per case
  PA: $948,493,000/126,092 cases = $7,522 per case

  Use $7,905 as more reflective of where we should be. Pennsylvania is a poor performer.

- Estimated Total C&P (all kinds) direct to the individual and consequently, the community by and large:

  8,224 x $7,905 = $65,011,732 (rounded)

- Comparison with current situation:

		Delta	Per Cent Increase
Lehigh:	$17,603,000		
Northampton:	$13,662,000		
	$31,265,000	$33,746,732	107%

- Now let's take a look at medical. This is more variable in nature. But to produce a number, a conservative average is useful:

  Medical Utilization to Live C&P Case Factor (from my own analysis):

  US: 1.68
  PA: 2.01

  Use 1.68 as more conservative.

- Unique Patients per annum:

  .119 x 1.68 x 57,112 = 11,418

Comment: Compare this with current 5,596. This is a 204% increase in patients. Divide by .60 to get enrollees estimate, or 19,030 enrollees. VISN-4 will experience loss of any residual capacity.

- Average Medical Dollars per Unique Patient:

  US: $5,091
  PA: $4,498 (both from Table 4)

  Use $5,901 as more reflective of where we should be

- Total Medical Dollars required:

  11,418 x $5,091 = $51,363,891 of medical service

- Comparison with current situation:

		Delta	Per Cent Increase
Lehigh:	$10,705,000		
Northampton:	$ 6,905,000		
	$17,655,000	$33,708,891	190%

- The Total so far is: $116,375,623 for medical and comp and pension versus $48,920,000 currently.

- Working out education, training, vocational rehabilitation, insurance and indemnity are more difficult. We are already more than double what we have now, but let's make a stab at it for talking purposes:

  Using the US level VA pie chart, they total 7.4% of the total direct expenditures. Thus they cost:

  (3.6% + 3.8%)/(44.2%+48.4%) = 7.4/92.6 = 8% more

  This translates as:

  .08 x $116,375,623 = $9,310,050

- The total package then comes to $125,685,673 potentially versus the $55,429,000 currently (in FY 2002 dollars). The answer is about double. The figure is the best guess possible considering the variety of additional factors that can influence the figures. Since we are not seeking the maximum possible, the estimations can be considered conservative.

RJH
12 Mar 04

GLOSSARY

Accredited – as in an "accredited veterans service officer". The term "accredited" has a specific meaning in DVA and veteran service organization parlance. 38 CFR 14.629 provides the general guidance. It means the individual has been trained through a VA-approved course of instruction and sponsored by an organization that it recognizes (generally chartered by Congress). Furthermore, that organization has forwarded documentation to the effect that they wish the individual to work on their behalf and has been properly trained, plus some supporting information. The Office of Counsel then forwards a Letter of Accreditation and an identity card (pocket card) to the individual. The terms "registered" and "certified" do not mean the same thing. These are internal veteran service organization terms used to describe post or chapter level service officers or state, county, and local political entity service officers who have undergone a special course of training to assist veterans. They can "certify" documents as true copies of the originals, hence the term. The level of their duties is in no measure the same, and the DVA will not talk to them directly, unlike accredited officers. The quality of their training and the quality of their performance has been an ongoing problem over at least the last decade. See also Veteran Service Officer.

a.k.a. – "also known as"

Benefits Delivery Network (BDN) – is the major computer system used by the Veterans Benefits Administration to process claims, records, fiscal awards, and related actions. This collection of databases and component programs is the source of the master record files for veterans and their beneficiaries, and generates the payment information that is sent to Treasury for producing the benefits checks. The system installation began in the late 1970's and was formerly known as the TARGET system. ***As used in this study, the term connotes outbased computer access to the VA claims processing and information system which includes BDN and other components, key among these being MAP-D and the States Benefits Reference System.***

Certified or Registered – See "**Accredited**" for an explanation of this often confusing term.

Community-Based Outpatient Clinics (CBOC) – Changes have been made in VA's identification of its outpatient clinics. Over the years, the following terms have been used: hospital-based clinics, independent clinics, mobile clinics, satellite outpatient clinics, community-based clinics, and outreach clinics. VHA Directive 97-058 (Department of Veterans Affairs, Veterans Health Administration, Washington, DC, November 24, 1997) clarified how the clinics are to be identified. The nomenclature "hospital-based clinic" -- which is defined as an outpatient clinic that functions in a hospital – has not been changed. The same is true for "independent outpatient clinics," which are full-time, self-contained, freestanding ambulatory care clinics with no management, program, or fiscal relationship to a parent facility, and for "mobile clinics," which are specially equipped vans with multiple, scheduled stops, providing outpatient care. However, "satellite outpatient clinics," "community-based clinics," and "outreach clinics" are now all categorized as "community-based outpatient clinics." Some may be staffed with VA personnel, but the majority of the clinics are contracted.[1] See VHA.

Dependency and Indemnity Compensation (DIC) -- sometimes called "compensation based on service-connected death". It is a benefit for survivors of certain deceased veterans or service members. DIC is potentially payable to surviving spouses, children, and/or dependent parents of the following:

- Service members who die during military service of causes that are not due to the person's willful misconduct;

[1] From the Senate Democratic Report, "Community-Based Outpatient Clinics in the Veterans Health Administration, DVA," 3 May 2001.

- Veterans who die of a service-connected disease or injury;
- Veterans who die from a nonservice-connected disability but who were continuously rated 100 percent disabled for service-connected disabilities for at least 10 years immediately preceding death (or at least five years from the date of discharge to the date of death)[2] and
- Veterans who are former POWs who die after September 30, 1999, and were continuously rated 100 percent for service-connected disabilities for a period of not less than one year immediately preceding death[3].

Disability Compensation – is a monetary benefit paid to veterans with service-connected disabilities. "Service-connected" means that the disability was the result of a disease or injury incurred or aggravated during active military service. To be eligible for disability compensation, the veteran must have been discharged under conditions other than dishonorable and the disability must not have resulted from the veteran's willful misconduct.

Disability compensation is graduated according to the degree of the veteran's disability on a scale from 0 percent disabling to 100 percent disabling, in increments of 10 percent. Benefits in addition to the 100 percent disability rate are payable to veterans with extremely severe disabilities such as the anatomical loss or loss of use of a hand or foot, blindness, or deafness

DVA – The Department of Veterans Affairs, most commonly referred to as the "VA."

Disability Pension – A monetary benefit paid to wartime veterans who are age 65 or older, or permanently and totally disabled as the result of a nonservice-connected disability. In either case, the veteran's annual income must not exceed the limit set by statute in order to qualify for this benefit.

Eligibility -- Most VA benefits require that the veteran be discharged from active military service under any condition other than dishonorable. In addition to this general requirement, there are specific statutory and regulatory requirements for each of the benefits programs.

FTE – "Full-time Equivalent". Can be expressed in years or man hours. In the federal government, a full-time employee is calculated as being hired for 2086 man hours in a year, of which 1776 man hours is actually calculated as effective labor for project management purposes (excludes sick time, holidays, training, etc.). Originally, FTE referred to the authorized position and work time allowed and not an employee. For example, two 1000 FTE hour employees are one FTE position.

FY – Fiscal Year. See Fiscal Year 2002.

Fiscal Year (2002) – a.k.a. FY 2002. The fiscal year beginning October 1, (2001) and ending September 30, (2002). The Department of Veterans Affairs operates under this budgetary schedule.

Healthcare Enrollment Priority Groups (a.k.a. Medical Priority Groups) – A simplified definition follows. The Veterans' Health Care Eligibility Reform Act of 1996 established a national enrollment system to manage inpatient and outpatient care for veterans. The law required that most veterans must enroll to receive care. Veterans who have a service-connected disability rated 50 percent or more or if seeking care for a service connected disability do not have to enroll, although all veterans are encouraged to enroll. The national enrollment system is based on seven groups of patients, with group 1 receiving the

[2] 38 U.S.C. 1318
[3] Section 501 of P.L. 106-117 enacted on November 30, 1999.

highest priority [for enrollment]. Following enrollment, health care service is provided on a first-come, first-served basis, rather than the health care priority groups. Enrollment priority groups are defined in Title 38, Section 1705 as follows. Groups 1 through 6 are considered Category I, “must treat”, if the budget allows (which is incidentally discretionary and not mandatory in the current federal authorization and appropriation system). However, all others are Category II. That means the VA “may treat” in accordance with its capacity or capability.

- **Priority Group 1:** Veterans with service-connected disabilities rated 50% or greater
- **Priority Group 2:** Veterans with service-connected disabilities rated 30% or 40%
- **Priority Group 3:** Veterans who are former prisoners of war, veterans awarded the Purple Heart, veterans who have service-connected disabilities rated 10% or 20%, and veterans who were discharged from active duty due to disability incurred or aggravated in the line of duty, and veterans awarded special eligibility classification under to 38 USC Sec.1151
- **Priority Group 4:** Veterans in receipt of increased pension benefits based on need of aid and attendance or permanent housebound status and veterans who are catastrophically disabled.
- **Priority Group 5:** Veterans with nonservice-connected and veterans with noncompensated service-connected conditions who are rated zero percent disabled, and whose income and net worth are below an established threshold.
- **Priority Group 6**: All other eligible veterans who are not required to make co-payments for their care. This includes: World War I and Mexican Border War veterans; Veterans solely seeking care for disorders associated with exposure to a toxic substance, radiation, or for disorders associated with service in the Persian Gulf; and Veterans with service-connected conditions who are rated zero percent disabled but who are receiving compensation from VA.
- **Priority Group 7**: Includes Priority Groups (7-1) and (7-2). Veterans with nonservice-connected disabilities and veterans with noncompensated service-connected conditions who are rated zero percent disabled, and who have income or net worth above the statutory threshold and who agree to pay specified co-payments
- **Priority Group 8 (added by LVMAC**): Veterans with no rating, do not fit in the other above groups, and have the ability to defray the cost of treatment. This group was closed to new accessions on 17 January 2003 for lack of service capacity and congressional budget.
- **Priority Group 90**: Veteran user not in Enrollment File

Insurance and Indemnity – Philadelphia Insurance Center’s (the headquarters for the program) uses this term for “insurance”. See Life Insurance.

Life Insurance – Government life insurance programs were created to provide life insurance at a “standard” premium rate to members of the armed forces who are exposed to the extra hazards of military service, including deadly hazards of war. Few commercial insurance companies offer insurance that includes coverage against death while in the armed forces. Those that do offer coverage charge a high premium rate because of the additional risk. Members leaving the armed forces are eligible to maintain their VA insurance following discharge. In general, a new life insurance program was created for each wartime period starting with World War I. The various Insurance programs can be conveniently grouped into the following three categories: Matured Insurance Programs, Disabled Veterans Insurance Programs, and Uniformed Services and Post-Vietnam Veterans Insurance Programs.

Major Programs (an Overview):[4]

- **Burial:** Primarily through the National Cemetery Administration, VA honors veterans with a final resting place and lasting memorials that commemorate their service to the nation.
- **Compensation:** The compensation program provides monthly payments and ancillary benefits to veterans, in accordance with rates specified by law, in recognition of the average potential loss of earning capacity caused by a disability, disease, or death incurred in, or aggravated during, active military service. This program also provides monthly payments, as specified by law, to surviving spouses, dependent children, and dependent parents, in recognition of the economic loss caused by the veteran's death during active military service or, subsequent to discharge from military service, as a result of a service-connected disability.
- **Pension:** The pension program provides monthly payments, as specified by law, to needy wartime veterans who are 65 years old or who are permanently and totally disabled. This program also provides monthly payments, as specified by law, to needy surviving spouses and dependent children of deceased wartime veterans who die as a result of a disability not related to military service. [Currently Compensation and Pension programs are grouped under one organizational entity of the VBA to administer.]
- **Education:** The education program assists eligible veterans, service members, reservists, survivors, and dependents in achieving their educational or vocational goals.
- **Housing:** The housing program helps eligible veterans, active duty personnel, surviving spouses, and selected reservists to purchase and retain homes.
- **Insurance:** The insurance program provides veterans, service members, and family members with life insurance benefits, some of which are not available from other providers such as the commercial insurance industry due to lost or impaired insurability resulting from military service. Insurance coverage will be available in reasonable amounts and at competitive premium rates comparable to those offered by commercial companies. The program ensures a competitive, secure rate of return on investments held on behalf of the insured.
- **Medical Care:** VA meets the health care needs of America's veterans by providing primary care, specialized care, and related medical and social support services. Also included are health care education and training programs designed to help ensure an adequate supply of clinical care providers for veterans and the nation.
- **Medical Research:** The medical research program contributes to the Nation's overall knowledge about disease and disability.
- **Vocational Rehabilitation and Employment:** The vocational rehabilitation and employment program assists veterans with service-connected disabilities to achieve functional independence in daily activities. It provides the support and assistance necessary to enable service-disabled veterans to become employable and to obtain and maintain suitable employment.
- **Program Participants:** VA serves a significant portion of the veteran population. In 2002, more than 4.6 million patients used VA healthcare, over 2.7 million veterans and survivors received monthly VA disability compensation payments, and more than 2.5 million graves of deceased veterans and eligible family members were maintained at our national cemeteries. The following table summarizes the number of veterans or dependents who received benefits or services in each of our major programs during 2002.

Modern Award Processing – Development (MAP-D) – is the replacement for the Claims Automated Processing System (CAPS). It contains records for all cases and reduces manual data entry and the potential for data input errors. When provided to outbased locations, it will expedite and streamline claims processing.

[4] FY 2002 Performance and Accountability Report, DVA, pp 15-17.

Non-rating actions - average days pending – Elapsed time, in days, from date of receipt of a claim (for which work has not been completed) in the regional office to current date. Non-rating actions include the following types of claims: original death pension, dependency issues, income issues, income verification matches, income verification reports, burial and plot allowances, claims for accrued benefits, and special eligibility determinations. (from DVA P&A Rpt FY02)

Outbase – is a VBA term for a field office, a place of service not located at the Regional Office. Sometimes the term also excludes VAMCs.

Outreach – is a VBA term meaning "the act or process of reaching out in a systematic manner to proactively provide information, services, and benefits counseling to potentially eligible beneficiaries to ensure they are fully informed about and receive assistance in applying for benefits."[5] It can be done either from a Regional Office or an outbase location. Examples are the Separation Examination Program, the "Benefits Delivery at the Discharge Site" Programs, TAP, and Homeless Veterans Program

Rating-related actions – average days pending – Elapsed time, in days, from date of receipt of a claim (for which work has not been completed) in the regional office to current date. Rating actions include the following types of claims: original compensation, original disability pension, original DIC, reopened compensation, reopened pension, routine examinations, and reviews due to hospitalization. (from DVA P&A Rpt FY02)

SDVA – is an acronym meaning State Department/Division of Veterans Affairs. The DVA commonly uses this acronym when it wishes to distinguish a state-level governmental veterans' service organization from a nonprofit veterans service organization. See Veterans Service Organization.

State Benefits Reference System – is a comprehensive, computerized DVA inventory of state veterans benefits. The new State Benefits Reference System enables front-line VA employees and approved VSOs to link veterans to state services that can range from special vehicle license plates to personal property tax exemptions. Accreditation and TRIP training are required for VSOs.

Training, Responsibility, Involvement, and Preparation of Claims (TRIP) – is a DVA initiative begun in 1998 and intended to expand its partnership with veterans' service organizations through the training and certification of their VSO to enhance their ability to assist veterans with the claims process. This training occurs subsequent to "accreditation." The concept is a work in progress: varying from improving and expediting claims submissions to bringing cases to ready-to-rate status by the veterans' service organizations themselves. A large degree in the success of the program hinges upon outside (outbased) access and the use of the BDN and other VBA information and claims filing system components, but delays have occurred for various reasons beyond the prerequisite of TRIP training. The dissolution of the Veterans Services Division in the 1990's has caused the DVA to increasingly seek veterans' service organization assistance at the input stage of claims processing. TRIP formally recognizes that need.

Transition Assistance Program (TAP) – is a workshop with benefits information and resources for service members who are separating from the military and transitioning into civilian life. It is authorized by legislation and jointly implemented by DoD, DOL, and VA as agreed upon in a memorandum of understanding.

[5] Statement of Daniel L. Cooper, Under Secretary for Benefits, before the Senate Committee on Veterans' Affairs, 10 Jul '04.

VA – The abbreviation for Veterans Administration, the predecessor of the Department of Veterans Affairs (DVA). Most veterans and officials today still refer to the DVA as simply the "VA."

VBA – The Veterans Benefit Administration, one of the three major administrations that constitute the Department of Veterans Affairs. It is the organization that is responsible for veterans' benefits services less healthcare, the responsibility of the Veterans Healthcare Administration (**VHA**) and cemeteries, the responsibility of the National Cemetery Administration (**NCA**).

VHA – The Veterans Healthcare Administration, which is responsible for veterans' healthcare. The current drive within the VHA has been outpatient clinics, including creating Community Based Outpatient Clinics (CBOC), most of which are essentially contracted offices, a private medical practice of varying but small size. The VHA is reassessing its workforce and facilities under the Capital Asset Realignment for Enhanced Service (CARES) program, which is the DVA version of the Department of Defense Base Realignment and Closure (BRAC) program. It will have far-reaching effects on future services.

Veteran – A person who served in the active military for a specified period of consecutive days (changes from time to time) and who was discharged or released under conditions other than dishonorable.

Veterans Service Organization (VSO) – In the study the term is used to denote a state, county, or local political entity or a veterans' organization that provides accredited veterans' service officers (VSO). It is an organization that represents the interests of veterans. The term is more commonly used to denote a nonprofit, chartered veterans organization such as the VFW or American Legion. Most veterans' service organizations have specific membership criteria, although membership is not usually required to obtain assistance with benefit claims or appeals. Note that the acronym is used to denote a veterans' service officer as well.

Veterans Service Officer (VSO) – At national level, often called a National Service Officer (NSO) in a veterans organization. See also "Accredited" and "TRIP." ***The acronym is also used to denote "veterans' service organization", but will not be used for this purpose in the study.*** Their closest equivalent DVA counterpart is the combining of a veteran service representative on the Public Contact team with a Pre-determination service officer, both found in the Veterans Service Center of the Regional Office.

The following description of a VSO's duties and responsibilities was copied and slightly altered from its original form on the Vietnam Veterans of America, Inc. web site. It provides a fairly complete description of a VSO's function. The term VSO includes state, county, local and veteran organization service officers <u>when</u> <u>accredited</u>. See above for the definition of "accredited."

In accordance with 38 CFR 14.629, after completion of a VA-approved course of instruction and an internship (in some organizations like the DAV), an organization (recognized by the DVA) sponsors the individual and sends a request for accreditation to the VA Office of General Counsel. Upon review the individual is credentialed with a Letter of Accreditation and receives a pocket card stating the individual is accredited to do business. The work is then done for the sponsoring organization. The VSO's work is mainly with claims and their initial preparation and follow-up, although he may counsel on a full range of benefits. The veteran applying is allowed to direct that the claim be forwarded to another veteran organization for the rest of processing. In either event, the veteran must give the final processing veteran organization Power of Attorney to act on his behalf before the VA. Naturally, the VSO tries to direct the business through his sponsoring organization, since this is the only way to assure a clean chain of custody and a follow-up mechanism.

Purpose of a VSO: To provide quality advocacy for all US Veterans, Armed Forces members, their dependents and survivors, through benefit counseling and programs, claims, and outreach services. To reach out to all Veterans Organizations, and veterans through traditional public relations, community involvement, and by initiation and implementation of activities that encourage them to access their rightfully earned entitlements and benefits. To respond to the needs of all veterans, armed forces members, and their dependents and survivors; and to provide linkage for them to other support services.

Duties of a VSO:

- Advises and assists veterans or their beneficiaries in presenting claims for benefits under Federal, State or local laws.
- Works in cooperation with the Department of Veterans Affairs, other governmental agencies, his headquarters National Service Officers
- Conducts telephonic communication and/or written correspondence with various Federal, State, County and City Governmental agencies concerning problems or questions on behalf of veterans or their beneficiaries.
- Submits DVA claims to the appropriate DVA Regional Office. Other claims are submitted to the government agencies involved.
- Have a complete working knowledge of DVA requirements concerning the processing of claims for all types of veterans benefits. Must be able to develop a knowledge, where required, to process claims for other governmental benefits.

    1. Compensation: (i.e., claims; aggravation; presumptive service connection; rates, etc.)
    2. Pension: (i.e., applications; aid and attendance; income restrictions; etc.)
    3. Special Service-Connected Benefits: (i.e., automobile; housing; prosthetics, etc.)
    4. Medical: (i.e., hospital eligibility categories; nursing home; domiciliary; outpatient; etc.
    5. Education: (i.e., vocational rehabilitation; war orphans; dependents; etc.)
    6. Life Insurance: (i.e., NSLI; government; conversions; loans; death applications, etc.)
    7. Death Benefits: (i.e., widow's pension; DIC, burial; grave marker; National Cemetery; Insurance; burial squad; etc.)
    8. GI Loans: (i.e., eligibility; financing; business, etc.)
    9. Records: (i.e., St. Louis Personnel Records Center; Hospital; Regional Office and office.)

- Have a complete working knowledge of other agencies veterans benefits. VSO must be able to develop knowledge to process claims within the following areas:
    1. Social Security (SSI)
    2. Vet State Loans
    3. County assessor (tax exemptions)
    4. SDI (Job disability)
    5. Employment Development Department Jobs for veterans)
    6. SBA (business loans)

- Must be familiar with the Freedom of Information and Privacy Acts, and DVA regulations concerning the release of claims information.

Zero (0) Percent Disability – A zero percent disability rating means that a disability exists and is related to the veteran’s service but is not so disabling that it entitles the veteran to compensation payments. Also called a non-compensable disability.