



**Federal Update
for
July 7 - 11, 2014**



***VA Private Care Access Update ► GAO Questions
Need for New Law***

Veterans facing long wait times, long distances or lack of specialty care are already eligible for medical care outside Veterans Affairs, calling into question the need for a law that allows private care, the Government Accountability Office said 18 JUN. However, there's no way to determine whether veterans will receive timely care through private facilities because VA does not collect that data. "VA is authorized to obtain health care services from non-VA providers to help ensure that veterans are provided timely and accessible care," said Randall Williamson, director of health care at GAO, at a House Veterans Affairs Committee hearing. "It is not only important to ensure that veterans will obtain timely treatment from non-VA providers but also to ensure that non-VA medical care is a reliable and cost-effective means for VA to deliver services." Both the House and Senate passed bills that would allow veterans access to private care if they faced long waits, but the bills also provide some extras, such as money to hire providers and the ability to fire inefficient VA employees.

VA is unable to determine how sending veterans to private care could cut down wait times and costs because it does not collect data on wait times data or on all health services provided, Williamson said. A 2013 report found VA does not collect data to determine that information, and a 2014 report found "non-compliance" at four VA facilities because they did not provide emergency care to veterans, as required by law, even if the care was not for service-connected issues. About 20% of claims were denied inappropriately, GAO found. Veterans also do not know they are eligible for that care. GAO made numerous recommendations to fix the problems, and VA agreed to the recommendations, but they have yet to be implemented, Williamson said. Philip Matkovsky, assistant deputy under secretary for health for administrative operations at the Veterans Health Administration at VA, apologized again for the scandal Wednesday. He agreed that VA is already authorized to send veterans to private care, adding that

VA is working to improve management, oversight and delivery of non-VA care.
[Source: USA Today | Kelly Kennedy | Jun 18, 2014 ++]

VA Whistleblowers Update ► Whistleblowing and its Consequences

The Department of Veterans Affairs is encouraging its employees to expose any wrongdoing they see, but a series of government reports has shown that many federal employees are reluctant to do so—and possibly with good reason. Many federal employees feel vulnerable to retaliation if they make such disclosures, according to data from two central personnel agencies, the Office of Personnel Management and the Merit Systems Protection Board. The role of whistleblowers — and the potential for retaliation against them — is an ongoing issue in the VA scheduling scandal. The department last week sent a memo encouraging employees to make disclosures and promising to crack down on anyone who retaliates against them. However, a 2010 survey from the MSPB, which hears appeals of personnel actions taken against federal employees, showed that nearly 30 percent of respondents felt that their lives might become more difficult if they reported inappropriate practices.

The survey, a follow-up to a similar one MSPB conducted in 1992, also asked whether employees had personally observed illegal or wasteful activities at their agency in the prior 12 months. In 2010, 11.1 percent of employees answered yes, down from 17.7 percent in 1992. In both years, though, more than a third of those said they did not make a report. Among the major considerations driving a decision whether to make a report or not were fear of retaliation and a belief that nothing would be done to address the problem, the survey showed. “One of the most important things that an agency can do to learn about internal wrongdoing is to establish a culture that encourages employees to report perceived problems,” the MSPB said in an analysis this month of its survey. “Agencies should know where their culture stands so that they can determine the extent of their need for improvement and measure whether improvement is occurring.”

The MSPB has not conducted a similar survey since 2010. But the OPM includes a related question in its annual government-wide poll, asking whether employees agree or disagree with the statement that “I can disclose a suspected violation of any law, rule or regulation without fear of reprisal.” Last year, 19.5 percent of

employees disagreed or strongly disagreed with that statement, up 0.4 percentage points from 2012; 61.2 percent of employees agreed or strongly agreed, down by 0.3 percentage points, and the rest were neutral. Employee views about potential whistleblower retaliation have varied relatively little since 2010 in the OPM poll. The high point in employee confidence was 2011, when 62.5 percent responded positively and 17.8 percent responded negatively. The 2014 version of that survey closed last Friday and results are to be announced later in the year.

In the MSPB survey, of those who did step forward and were identified as the source of a disclosure, about a third said they were threatened with or actually experienced retaliation, compared with just 7 percent who were given credit by management for identifying a problem. Forms of reprisal included firing, suspension, grade level downgrade, and transfers to different locations or to jobs with less desirable duties. The MSPB's survey further found that 13 percent of respondents indicated that their agencies did not actively encourage them to report wrongdoing, compared to 63 percent who said their agencies did encourage such disclosures; the rest were neutral. MSPB's recent analysis provided some agency-specific information on that issue not in its earlier report. For example:

- 82 percent of NASA employees agreed that their agency encourages them to expose wrongdoing, but only 43 percent at Housing and Urban Development personnel said the same;
- Within the VA, 69 percent of Veterans Health Administration employees agreed, compared to 61 percent within the Veterans Benefits Administration; and,
- Within the Department of Homeland Security, 69 percent of Customs and Border Protection employees agreed that they were encouraged to step forward, but only 58 percent in the Transportation Security Administration said the same.

“Wrongdoing will often be seen and reported on the local level. For this reason, whistleblowing culture is like real estate — location matters,” MSPB said in its recent analysis. In addition, the original report said that “Saving lives is more important to respondents than whether they will experience punishment or a

reward, and whether the agency will act on a report of wrongdoing matters more than any fear of an unpleasant consequence for the employee making the report.” The Office of Special Counsel, which protects federal whistleblowers against reprisals, is investigating alleged retaliation against 37 VA employees who reported wrongdoing, although not all of it related to the scheduling scandal. Additionally, the House and Senate have passed bills to end or limit the rights of senior VA employees to challenge demotions or firings, which could undercut their ability to defend themselves against retaliation. The Senate legislation would provide for a much-shortened appeal process, allowing workers to appeal the decisions and requiring the MSPB to issue a final determination within one month. [Source: The Washington Post | Eric Yoder | June 17, 2014 ++]

VA Credibility Update ► VA Brass Knew of False Data for 2 Years

Department of Veterans Affairs administrators knew two years ago that employees throughout the Southwest were manipulating data on doctor appointments and failed to stop the practice despite a national directive, according to records obtained by The Arizona Republic through a 4 MAR Freedom of Information Act request for materials concerning wait-time falsifications. The 2012 audit was released to The Republic this week. The audit by the VA's Southwest Health Care Network found that facilities in Arizona, New Mexico and western Texas chronically violated department policy and created inaccurate data on patient wait times via a host of tactics. The practice allowed VA employees to reap bonus pay that was based in part on inaccurate data showing goals had been met to reduce delays in patient care, according to the VA Office of Inspector General. At the Phoenix medical center alone, reward checks totaled \$10 million over the past three years.

Top officials at the Phoenix VA Health Care System, including Sharon Helman, who was suspended as director last month, have repeatedly claimed they were not aware of scheduling misconduct until complaints by whistle-blower physician Sam Foote were made public in April. But audit findings, based on a review of data from the second quarter of fiscal 2011, show the violations proliferated throughout the Southwest and were common nationwide. The report notes that former VA Undersecretary Robert Petzel, who resigned under fire in May, convened a conference call with Health Administration Services leaders

nationwide in September 2011 to confront the problem. According to the audit, Petzel pressed department executives "not to 'game' the system." A year earlier, William Schoenhard, then a VA deputy undersecretary, described and prohibited various "gaming strategies" used nationwide to falsify wait-time data. His directive made top regional administrators responsible for ensuring the integrity of medical appointment systems, and required annual reviews.

Acting VA Secretary Sloan Gibson last week directed all VA medical center and health care system directors to do monthly in-person site inspections and reviews of scheduling practices in every clinic within their jurisdiction to ensure adherence to policies. That sort of scrutiny was supposed to have occurred after the 2012 audit. Helman became director of the Phoenix VA Health Care System in February 2012, a month after the Southwest audit was issued. She made timely medical appointments her system's No. 1 priority and implemented a "wildly important goal" program. E-mails between Helman, Bowers and others — obtained via a public records request — verify that VA leaders in Arizona were intensely aware of scheduling compliance problems during 2013. Yet, as late as last December, Helman continued to paint a rosy picture for outsiders. In a letter to Sen. John McCain (R-AZ) Helman discounted allegations of a Phoenix whistle-blower who reported fraudulent record-keeping. By that time, investigators from the Office of Inspector General were in Phoenix, verifying that appointment data had been manipulated. In her letter to McCain, Helman noted that she and VA staffers had met with Tom McCanna, the senator's liaison for veterans, months earlier "to discuss wait-time issues and scheduling concerns." Helman told McCain her compliance office had performed an audit in July 2013, and "the results validated local data collection efforts regarding EWL (electronic wait list) and access were correct."

Rep. Jeff Miller (R-FL), who has spearheaded congressional investigations as chairman of the House Committee on Veterans' Affairs, said the new revelations in Arizona offer "continued proof of how VA leaders looked the other way while bureaucrats lied, cheated and put the health of veterans they were supposed to be serving at risk. "Most disturbingly," Miller told The Republic, "those charged with enforcing VA policies and holding employees accountable for gaming the system never even lifted a finger to do so. The only way for Acting VA Secretary Sloan Gibson to rid the department of this widespread corruption is to pull it out by the roots, and he needs to begin that process right now." Helman could not be

reached for comment on the audit or e-mails. But Susan Bowers, who was forced to retire last month as director of the VA's southwest regional health care office, said she ordered the compliance review in 2011 based on suspicions of false data on appointments. "We knew scheduling was a high-risk area" for violations," Bowers said. "The compliance review was done and, as a result, we had a number of goals developed to address those issues. That was the thing to fix when (Helman) got to Phoenix. My first instruction to her was, 'We've got to deal with the wait-time issue.'"

Bowers and regional VA spokeswoman Jean Schaefer said action plans were developed based on the audit. They also said the findings were briefed during a network leadership meeting just days after Helman took command of the Phoenix VA medical center. Bowers acknowledged her scheduling goals focused on reducing delays in care, rather than stopping the falsification of data. She also agreed that using untrustworthy statistics made it impossible to determine whether goals were met, and thus whether bonus pay was justified. Bowers said she did not issue a regional directive specifically ordering compliance with VA scheduling rules, or warn employees they would be fired for violations, because such memos are not part of the agency culture. "In retrospect, I wish I would have done that," she added. "But there were constant messages from my office that basically said, 'We don't game the system. We need to know how bad it is.' The southwest regional audit analyzed 573,000 appointments at 3,423 VA clinical offices in the three states. The audit uncovered a spider's web of tactics used to produce inaccurate wait-time data. Among them:

- Appointments routinely were canceled in blocks by VA clinics, eliminating backlogs and artificially reducing wait-time statistics. But those same clinics indicated in data reports that the appointments had been canceled by patients. In El Paso, VA health care schedulers canceled one in four appointments during the period examined. Some clinics showed suspected cancellation clusters on more than half of the days during the quarter.
- VA employees often recorded walk-in patients as scheduled visits to make it appear veterans were seen without any wait at all when, in fact, they showed up uninvited because they could not schedule appointments. In Phoenix, 77 percent of the walk-in patients were improperly listed as scheduled appointments. At Prescott's VA medical center, 85 percent of the

clinics engaged in the deceptive practice, which apparently skewed wait-time data. It also allowed veterans to collect round-trip travel expenses for their clinic visits, rather than one-way benefits authorized for walk-in patients under the VA claims system.

- Appointments were entered into computers without listing a desired date, making it possible to insert an untrue date later. That form of manipulation occurred at all seven major medical centers investigated: Phoenix, Prescott and Tucson; Albuquerque; and El Paso, Amarillo and Big Springs, Texas.
- When first-time appointments for new patients were not available within 90 days, those veterans' names were not even entered into the electronic wait system. The result? Protracted delays that were not counted in wait-time data.
- Some VA facilities misrepresented wait times by incorrectly recording the date patients were seen by physicians as the desired appointment date. At the VA medical center in Prescott, administrators claimed four of five patients were seen on the date they wanted an appointment. Although auditors could not determine the data accuracy without analyzing each appointment, they concluded the numbers were "artificially high" and "could have the appearance of inaccurately capturing the patient's true desired date."

Records show that, for at least four years, data manipulation was not just a Phoenix concern, but a national problem. The VA inspector general is now investigating similar conduct at more than 40 facilities. Since the health care scandal was first exposed in April, VA Secretary Eric Shinseki and Petzel have resigned; Bowers was forced to retire early; and Helman was placed on administrative leave along with two other top administrators at the Phoenix VA. Termination proceedings have been initiated against the latter three. [Source: Arizona Republic | Dennis Wagner | Jun 22, 2014 ++]

VA Credibility Update 2 ► Sen Coburn | 1,000+ Vets May Have Died

Over the past decade, more than 1,000 veterans may have died as a result of misconduct by employees of the Department of Veterans Affairs, according to a report released 24 JUN by Sen. Tom Coburn (R-OK). "Too many men and women

who bravely fought for our freedom are losing their lives, not at the hands of terrorists or enemy combatants, but from friendly fire in the form of medical malpractice and neglect by the Department of Veterans Affairs,” Coburn said in a letter addressed to taxpayers, which was attached to the report. In a press release, Coburn said the scandal surrounding secret waiting lists and delays in patient care at VA facilities is “just the tip of the iceberg.” The findings in the report, titled “Friendly Fire: Death, Delay, and Dismay at the VA”, are based on a yearlong investigation of VA hospitals around the country conducted by Coburn’s office, according to a press release and one of Coburn’s aides. Some of the report’s most disturbing allegations include:

- The federal government has paid out \$845 million for VA medical malpractice since 2001.
- Criminal activity at the department is “all too common,” including cases of drug dealing, theft and even murder.
- Whistleblowers, health care providers, veterans and their families are subjected to bullying, sexual harassment, abuse, and neglect. Examples include: female patients received unnecessary pelvic and breast exams from a sex offender; a noose was left on the desk of a minority employee by a coworker; and a nurse who murdered a veteran with a morphine overdose harassed the family of the deceased and pressured them to admit guilt for the death.
- Some VA health care providers have lost their medical licenses, and the VA is hiding this information from their patients.

The report also paints a picture of a department plagued by mismanagement, waste, and poor patient care. According to the report:

- Patients experience significant delays when it comes to doctor’s appointments, disability claims, and urgent care.
- Many VA doctors and staff are overpaid and underworked, some employees are not showing up for work, and some are even paid not to work.
- VA doctors are seeing far fewer patients than private doctors, and some leave work early.

- Hundreds of millions of dollars intended for health care have gone unspent each year.
- Bad employees are rewarded with bonuses and paid leave, while good employees who try to bring attention to problems or errors are punished, bullied, put on “bad boy” lists, or transferred to other locations.

The report identifies \$20 billion in waste and mismanagement that the authors say could have been better spent providing health care to veterans. Most disturbingly, it alleges that poor patient care and mismanagement at the hands of the VA may have led to the deaths of more than 1,000 veterans. Coburn partly blames Congress for some of the problems identified in the report. “The Senate Veterans Affairs Committee largely ignored the warnings about delays and dysfunction at the VA for decades, abdicating its oversight responsibilities and choosing to make new promises to veterans rather than making sure those promises already made were being kept,” Coburn said in a press release. The Senate Veterans Affairs Committee has only held two oversight hearings over the past four years, according to Coburn. Coburn is not a member of the committee.

[Source: Stars & Stripes | Jon Harper | Jun 24, 2014 ++]

GI Bill Update ► Gibson Predicts Benefit Cut Unlikely in Near Future

Acting Veterans Affairs Secretary Sloan Gibson said he “can’t imagine” lawmakers cutting back on veterans education benefits in the near future even with the continued fiscal pressures facing Congress. Speaking at an event marking the 70th anniversary of the GI Bill, Gibson said the benefit remains one of the most significant pieces of legislation ever passed by Congress, helping millions of veterans not only transition but thrive in post-military life. And he’s confident its significance isn’t lost on Congress. “It’s one of those things you can point to for an outstanding return on investment,” he said. Veterans groups have been less assured of the future of the benefit, especially in terms of the generous Post-9/11 GI Bill offerings. Through that benefit, troops who have served three years on active duty since September 2001 are eligible for four years’ free tuition at their home state’s public university, plus a monthly housing stipend.

As the Post-9/11 GI Bill approaches its fifth anniversary, the VA has already paid out \$41 billion to roughly 1.2 million beneficiaries. That’s a sizable price tag for

lawmakers, who this week will consider a veterans health expansion program that could total up to \$50 billion annually. House leaders have said they want to find an offset for any new spending, and reducing education benefit costs could help fill that gap. But so far lawmakers have stayed away from GI Bill trims. Meanwhile, groups like Student Veterans of America have worked to quantify graduation rates and post-college success for student veterans, as an advance response to the question of the value of the cost for the public. Steve Gonzalez, assistant director of the American Legion's National Economic Commission, said the benefit not only serves to help veterans catch up to their civilian counterparts in the private sector, but also is an important reintegration tool. "To us, it's not just about the economic impact these vets will have" after graduation, he said. "It's the readjustment impact too, the extra support it gives."

Before Monday's ceremony, Gibson met with a panel of student veterans from George Washington University to discuss their college experience. Both Gibson and his father received academic degrees thanks to the GI Bill, and the acting secretary said he expects the benefit to be as transformative for this generation as earlier ones. "What we're celebrating here are lives being changed, society being changed, America being changed for the better," he said. [Source: NavyTimes | Leo Shane | Jun 23, 2014 ++]

PTSD Update ► IOM Report Cites DoD/VA Inconsistent Treatments

Despite spending billions of dollars a year to treat military service members and veterans with post-traumatic stress disorder, the government has little evidence that its efforts are working, according to a new report commissioned by Congress. The report described PTSD care in the military health system as "ad hoc, incremental and crisis driven" and said the Department of Veterans Affairs had not hired mental health providers fast enough to keep pace with the rising demand. The government spent \$3 billion on PTSD treatments for veterans in 2012 and \$294 million more for service members, according to the report. But neither the Defense Department nor the VA have consistently collected data on how patients are faring or even what treatments they have received, making it impossible to assess the quality of care. "Both departments lack a coordinated, consistent, well-developed, evidence-based system of treatment for PTSD," said Dr. Sandro Galea, a Columbia University epidemiologist who led the Institute of

Medicine committee that produced the 301-page report available at <http://www.iom.edu/Reports>.

Researchers estimate that between 7% and 20% of veterans of the recent wars have suffered from PTSD at some point. As the stigma of the disorder has lifted, large numbers of veterans from earlier eras are also being diagnosed. They account for more than 75% of the roughly half a million VA patients receiving treatment for PTSD. The VA has trained more than 6,000 mental health care providers in prolonged exposure therapy or cognitive processing therapy, two methods that have proved effective in clinical trials.

“Both [the Defense and Veterans Affairs] departments lack a coordinated, consistent, well-developed, evidence-based system of treatment for PTSD.” But the authors of the report noted that the VA was still not meeting its own requirement of offering those therapies to every veteran in need. Both the VA and the Defense Department offer a wide range of other treatments and programs for the disorder, from medications to unproven alternatives such as yoga, acupuncture and relaxation exercises.

"There have been many well-intentioned programs done quickly," said Dr. Elspeth Ritchie, a former Army psychiatrist who served on the committee. "The critical importance of objectively measuring the effects of those programs has not been given the proper priority." A Pentagon spokeswoman said that all branches of the military had already been working to solve that problem. Last fall, they began collecting data on symptom severity and treatment outcomes for PTSD as well as depression and anxiety, said Lt. Col. Cathy Wilkinson. The VA is currently modifying its electronic medical record system to specify which type of PTSD treatment a patient is receiving. But those records will not report outcomes.

[Source: Los Angeles Times | Alan Zarembo | 20 Jun 2014 ++]

Congressional Gold Medal Update ► President Approves 4

The president has signed legislation to award the Congressional Gold Medal to the Doolittle Raiders, American Fighter Aces, the Allied Armies' Monuments, Fine Arts, and Archives unit --- better known as the "Monuments Men" --- and to Puerto Rico's 65th Infantry Regiment. The Congressional Gold Medal is the

nation's highest civilian honor, and is often awarded long after the recipient's mission was accomplished.

- Doolittle Raiders -- Named after their leader, Col. Jimmy Doolittle, their bombing raid over Tokyo four months after Pearl Harbor provided a critical morale boost for the American public, proved to the Japanese they weren't invulnerable to American attack, and forced their military to shift vital resources to homeland defense. Only four of the original 80 raiders are still alive.
- American Fighter Aces -- More than 60,000 U.S. military fighter pilots have taken to the air since World War I, yet less than 1,500 earned the coveted title of fighter ace for shooting down five or more enemy aircraft. The last American air aces were during Vietnam, and due to the evolving nature of warfare, there may not be another.
- The Monuments Men (and women) were artistic and architectural experts charged with the task of protecting Europe's cultural treasures in the midst of World War II. They followed soldiers into battle to preserve churches from the devastation of war, and to track down art stolen by the Nazis and return them to rightful owners. Six members of the Monuments Men are still living.
- 65th Infantry Regiment -- Puerto Rico's 65th Infantry Regiment, nicknamed the Borinqueneers, were formed and served courageously during the time of a segregated military during World War I and World War II, and they later served with distinction in Korea, Iraq and Afghanistan. [Source: VFW Action Corps Weekly Jun 14, 2014 ++]

POW/MIA Recoveries

"Keeping the Promise", "Fulfill their Trust" and "No one left behind" are several of many mottos that refer to the efforts of the Department of Defense to recover those who became missing while serving our nation. The number of Americans who remain missing from conflicts in this century are: World War II (73,000+), Korean War (7,921) Cold War (126), Vietnam War (1,642), 1991 Gulf War (0), and OEF/OIF (6). Over 600 Defense Department men and women -- both military and civilian -- work in organizations around the world as part of DoD's personnel recovery and personnel accounting communities. They are all dedicated to the single mission of finding and bringing our missing personnel home. For a listing of

all personnel accounted for since 2007 refer to http://www.dtic.mil/dpmo/accounted_for. For additional information on the Defense Department's mission to account for missing Americans, visit the Department of Defense POW/Missing Personnel Office (DPMO) web site at <http://www.dtic.mil/dpmo> or call or call (703) 699-1169. The remains of the following MIA/POW's have been recovered, identified, and scheduled for burial since the publication of the last RAO Bulletin:

Cold War

The Department of Defense announced 18 JUN that 17 service members have been recovered from a C-124 Globemaster aircraft that was lost on Nov. 22, 1952. U.S. Army Lt. Col. Lawrence S. Singleton, Pvt. James Green, Jr., and Pvt. Leonard A. Kittle; U.S. Marine Corps Maj. Earl J. Stearns; U.S. Navy Cmdr. Albert J. Seeboth; U.S. Air Force Col. Noel E. Hoblit, Col. Eugene Smith, Capt. Robert W. Turnbull, 1st Lt. Donald Sheda, 1st Lt. William L. Turner, Tech. Sgt. Engolf W. Hagen, Staff Sgt. James H. Ray, Senior Airman Marion E. Hooton, Airman 1st Class Carroll R. Dyer, Airman 1st Class Thomas S. Lyons, Airman 1st Class Thomas C. Thigpen, and Airman Howard E. Martin have been recovered and will be returned to their families for burial with full military honors. On Nov. 22, 1952, a C-124 Globemaster aircraft crashed while en route to Elmendorf Air Force Base, Alaska, from McChord Air Force Base, Washington. There were 11 crewmen and 41 passengers on board. Adverse weather conditions precluded immediate recovery attempts. In late November and early December 1952, search parties were unable to locate and recover any of the service members. On June 9, 2012, an Alaska National Guard (AKNG) UH-60 Blackhawk helicopter crew spotted aircraft wreckage and debris while conducting a training mission over the Colony Glacier, immediately west of Mount Gannett. Three days later another AKNG team landed at the site to photograph the area and they found artifacts at the site that related to the wreckage of the C-124 Globemaster. Later that month, the Joint POW/MIA Accounting Command (JPAC) and Joint Task Force team conducted a recovery operation at the site and recommended it continued to be monitored for possible future recovery operations. In 2013, additional artifacts were visible and JPAC conducted further recovery operations. DoD scientists from the Armed Forces DNA Identification Laboratory (AFDIL) used forensic tools and circumstantial evidence in the identification of 17 service members. The remaining personnel have yet to be recovered and the crash site will continue to be monitored for future possible recovery.

Vietnam - None

Korea

- The Department of Defense POW/Missing Personnel Office (DPMO) announced 13 JUN that the remains of a U.S. serviceman, missing from the Korean War, have been identified and will be returned to his family for burial with full military honors. Army Sgt. Paul M. Gordon, 20, of Dry Ridge, Ky., will be buried June 20, in Williamstown, Ky. In 1951, Gordon was assigned to Company H, 2nd Battalion, 38th Infantry Regiment, 2nd Infantry Division, deployed in the vicinity of Wonju, South Korea. On January 7, 1951, following a battle against enemy forces, Gordon was listed as missing in action. In September 1953, as part of a prisoner exchange, known as Operation Big Switch, returning U.S. service members reported that Gordon had been captured by the Chinese during that battle and taken to a prisoner of war camp, where he died in June 1951. Between 1991 and 1994, North Korea gave the U.S. 208 boxes of human remains believed to contain 350 - 400 U.S. servicemen who fought during the war. North Korean documents, turned over with some of the boxes, indicated that some of the remains were recovered from a POW camp in North Hwanghae Province, near the area where Gordon was believed to have died. To identify Gordon's remains, scientists from the Joint POW/MIA Accounting Command and the Armed Forces DNA Identification Laboratory used circumstantial evidence and forensic identification tools, including DNA comparisons. Two types of DNA were used, mitochondrial DNA, which matched his sister and brother, and Y-STR DNA, which matched his brother.
- The Department of Defense POW/Missing Personnel Office (DPMO) announced 13 JUN that the remains of a U.S. serviceman, missing from the Korean War, were recently identified and will be returned to his family for burial with full military honors. Army Cpl. Lucio R. Aguilar, 19, of Brownsville, Texas, will be buried June 13, in Corpus Christi, Texas. On the night of Nov. 27, 1950, elements of the 25th Infantry Division (ID) and 35th Infantry Regiment (IR) established a defensive position at Yongsan-dong, North Korea, about 10 miles north of the Ch'ongch'on River, when Chinese forces attacked their position. Due to extensive losses and casualties, Aguilar's unit began a fighting withdrawal. On Nov. 28, 1950, Aguilar was

reported missing in action. When no further information pertaining to Aguilar was received and he failed to return to U.S. control during prisoner exchanges, Operation Glory and Operation Big Switch, a military review board changed his status from missing in action to presumed dead on Dec. 31, 1953. In 1956, his remains were declared unrecoverable. Between 1991 and 1994, North Korea turned over to the U.S. 208 boxes of human remains believed to contain 350 - 400 U.S. servicemen who fought during the war. North Korean documents, turned over with some of the boxes, indicated that some of the remains were recovered from the vicinity where Aguilar was believed to have died. In the identification of Aguilar's remains, scientists from the Joint POW/MIA Accounting Command (JPAC) and Armed Forces DNA Laboratory (AFDIL) used circumstantial evidence and forensic identification tools, such as mitochondrial DNA, which matched his maternal-line sister and nephew.

- The Department of Defense POW/Missing Personnel Office announced 23 JUN that the remains of a U.S. serviceman, missing from the Korean War, have been identified and will be returned to his family for burial with full military honors. Army Cpl. William N. Bonner, 23, of Sault Sainte Marie, Mich., will be buried June 28, in his hometown. On Nov. 2, 1950, Bonner was assigned to Medical Company, 8th Cavalry Regiment, 1st Cavalry Division, when his unit was attacked by Chinese forces near Unsan, North Korea. Bonner was reported last serving as a litter bearer near the battalion aid station when the area was overrun by enemy forces. In 1953, as part of a prisoner exchange, known as Operation Big Switch, returning U.S. service members reported that Bonner had been captured by the Chinese and died from malnutrition in early 1951, in the prisoner of war (POW) camp known as Camp 5, near Pyoktong, North Korea. During Operation Glory in September 1954, United Nations and Chinese forces exchanged the remains of war dead, some of which were reportedly recovered from POW Camp 5. When a military review board declared the remains as unidentifiable, the remains were transferred to Hawaii to be buried as unknown in the National Memorial Cemetery of the Pacific, known as the "Punchbowl." In 2013, due to advances in forensic science, scientists from the Joint POW/MIA Accounting Command (JPAC) determined there was a possibility of identifying the remains. After extensive historical and analytical research, the unknown remains were disinterred for analysis and

possible identification. To identify Bonner's remains, scientists from JPAC used circumstantial evidence and forensic identification tools, including radiograph comparisons and dental records which matched Bonner's records.

World War II

The Defense POW/MIA Office announced the identification of remains belonging to Marine Corps Pfc. Randolph Allen, Company F, 2nd Battalion, 2nd Marine Division, who was lost on Tarawa on Nov. 20, 1943. He was accounted for on June 17 and will be buried with full military honors tomorrow in Arlington National Cemetery. [Source: http://www.dtic.mil/dpmo/news/news_releases/ Jun, 27 2014 ++]

Don't Ask, Don't Tell Update ► Separation Pay H.R.5009

California Democratic Rep. Jackie Speier wants Congress to give millions in lost separation pay to service members dismissed from the military under the old "don't ask, don't tell" policy, calling it a way to make amends for a shameful chapter in American history. Under her Military Separation Pay Fairness Act (H.R.5009) filed 26 JUN, troops kicked out of the military under the policy — in effect from 1993 to 2010 — who received only partial separation pay would be eligible to receive their lost payouts, with interest. The measure builds on a class-action lawsuit settlement in January 2013 under which the government agreed to pay about \$2.4 million to dozens of former troops whose separation pay was cut in half when they were dismissed for being gay. That provision covered only about 180 former service members, all of whom had served at least six years before their dismissals. The settlement also covered cases only as far back as 2004 because of issues related to the statute of limitations.

Speier's legislation would push the eligibility for payouts back another 11 years, to include any troops with six years of service who received less than their full expected separation pay. For years, Pentagon policy held that troops honorably discharged under DADT would receive only half of their separation pay, putting an additional penalty on their forced separation. In the 2013 settlement, the average makeup payout was about \$14,000. Speier could not say how many troops might qualify under her measure. About 14,000 service members were dismissed from

the military under DADT, originally constructed to offer protection for gay troops from discrimination by commanding officers. Speier's bill mandates that Congress send out checks within 90 days of the measure becoming law.

But that's unlikely, given the potential cost and lingering conservative opposition to the repeal of DADT. Speier did not address the cost issue, but in a statement said America still carries wounds from the "unjust policy that punished service members" based on sexual orientation. "Thousands and thousands of men and women were discharged from the military under a discriminatory directive that stipulated homosexual service members receive only one-half of the separation pay they rightfully earned," she said. "It's deplorable that this discrimination has been allowed to continue." Members of the Human Rights Campaign, ACLU, OutServe/SLDN and the American Military Partners Association have offered support for the legislation. [Source: MilitaryTimes | Leo Shane | Jun 26, 2014 ++]

VA Overhaul Bill ► Joint Conference to Discuss Pending Legislation

Chairmen Bernie Sanders (I-VT) and Jeff Miller (R-FL), respective chairs of the Senate and House Veterans Affairs Committees, gaveled the opening of a rare conference 24 JUN to discuss pending legislation that seeks to speed up access to VA care for thousands of veterans on waiting lists at VA medical facilities across the country. Though cordial, the conferees offered competing views on how best to resolve the access problem.

- Republicans, led by Senator John McCain (R-AZ) House Veterans Affairs (HVAC) Chairman Miller, Senate Veterans Affairs (SVAC) Ranking Member Richard Burr (R-NC) and others, would give veterans a 'gold choice' card that would allow them to get care from outside the VA system if they met certain criteria to trigger the election.
- Democrats, led by Sen. Sanders and HVAC Ranking Member Mike Michaud (D-ME), voiced preferences for expanding VA's capacity through various measures addressed in the legislation including more effective use of existing purchased care contracts.

In his opening remarks, Sen. Burr denounced the Congressional Budget Office's (CBO) high cost estimate to field a 'choice,' card. Burr said the CBO's \$35 to \$40

billion price tag was ludicrous. The numbers are “grotesquely out of line” and, in his view, were actually higher than the cost of providing care to currently enrolled veterans. He said it made no sense to expect that almost 8 million veterans would drop other coverage such as TRICARE, Federal Employee Health Benefits insurance, Medicare or private insurance to get a VA choice card for the two-year pilot program set out in the Senate bill. Democrats fretted that the focus should be on fixing the VA, not diverting resources by expanding outside referrals beyond current arrangements (The VA will spend about \$5 billion this year for contracted – purchased – care from outside providers). Former SVAC Chairman Sen. Jay Rockefeller (D-W.V.) said the goal should be to “improve the VA, not tear it down.” A number of conferees agreed that the focus should be on how to quickly resolve the backlog of wait-listed patients, change the culture within the VA and establish greater accountability at all levels.

House panel member Rep. Phil Roe (R-TN), a physician and former Army Reserve medical officer, said throwing more money at the VA won’t solve the problem. Two members endorsed seizing the moment to take a longer view on the future of VA health care. Rep. Tim Walz (D-MN), a former Army National Guard sergeant major and Iraq war veteran, asked rhetorically why there isn’t an over-arching strategy on veterans. Rep. Dan Benishek (D-MI), who served veterans for 20 years as a physician at a VA facility, said the best health care minds should be brought in to compare and contrast VA performance with outside health care practices. Along these lines, MOAA continues to endorse the establishment of a high-level, independent commission to chart the future of VA health care in the 21st century. Sen. McCain warned that the “last shoe” had not dropped on the VA scandal. He emphasized that the situation in the VA was an “emergency” and urged his fellow conferees to lay out the parameters of what needs to be done and move forward. The conferees are expected to hammer out a compromise after returning from the July 4 recess. [Source: MOAA Leg Up 27 Jun 2014++]

Defense Appropriations Bill 2015 ► House Passes H.R.4870

In a flurry of activity that wrapped up early on the afternoon of June 20, the US House of Representatives pushed through several controversial amendments to the \$570.4 billion 2015 defense appropriations bill H.R.4870 before handing its

version to the Senate for its own markups this summer. The legislation included several hot-button amendments opposed by the Pentagon and the White House. The bill includes:

- \$491 billion in base budget funding plus a \$79.4 billion “placeholder” for the overseas contingency operations (OCO) account, which the White House has yet to deliver to the Hill.
- \$128 billion for military personnel spending, \$830 million less than what the White House had asked for in its fiscal 2015 spending plan, and \$31.6 billion for military health and family programs, \$360 million below what the White House wanted.
- \$789 million to refuel and overhaul the aircraft carrier George Washington. The Senate Armed Services Committee last month authorized \$650 million for the same purpose.
- \$5.8 billion on 38 F-35 aircraft, \$975 million for the Navy to purchase 12 more EA-18G Growlers, and \$1.6 billion for seven KC-46A tankers, in addition to approving amendments to block the mothballing of the venerable A-10 attack plane and the KC-10 refueling tanker, both platforms that the Pentagon has said it wants to begin to retire in favor of newer aircraft. The Air Force has said that retiring the A-10 alone would save the service \$4.2 billion over the next five years. The amendment adds to the earlier Senate Armed Services Committee authorization bill that would block the retirement of the A-10, and the House’s passage of the 2015 National Defense Authorization Act, which did the same when passed this year.
- The bill would prohibit another base closure round, includes fully funding housing stipends next year and a 1.8 percent pay raise, \$100 million more for defense commissaries, and no major restructuring of the Tricare program — all items Pentagon leaders had strongly lobbied for over the last four months. It imposes a one-year ban on transfers of prisoners out of the Guantanamo Bay, Cuba, detention facility.

The bill will now wait until the Senate Appropriations Committee marks up its version after the 4 JUL recess. That would give the Senate about two weeks to pass its version before Congress goes home for August. The vote came after two days of floor amendments and repeated complaints from military leaders that

Congress has again failed to help them hold down long-term spending, instead rejecting program cuts to avoid short-term pain. The White House has said it “strongly opposes” the bill in its current form, but has not said whether the president would consider a veto. Speaking to reporters 18 JUN, Air Force Secretary Deborah Lee James said “we need to continue to explain that we have to move on, that we have these other missions that we need most of the units to do with other aircraft.” [Source: Defense News | Paul McLeary | Jun 21, 2014 ++]

Electronic Health Records: Fiscal Year 2013 Expenditure Plan Lacks Key Information Needed to Inform Future Funding Decisions

What GAO Found

The Departments of Veterans Affairs' (VA) and Defense's (DOD) fiscal year 2013 integrated Electronic Health Record (iEHR) expenditure plan satisfied one and partially satisfied five of the six statutory conditions specified in the Consolidated and Further Continuing Appropriations Act, 2013. Specifically, the plan:

- Satisfied the condition to relay detailed cost-sharing business rules by including a memorandum of agreement between the two departments that outlined cost-sharing provisions and principles within the VA/DOD Interagency Program Office (IPO).
- Partially satisfied the condition to define the budget and cost baseline for the development of the iEHR program by including the budget and cost baseline from fiscal years 2012 through 2018 for each department. However, the baseline, as reported, was not based on accurate estimates that reflected changes in the program's direction.
- Partially satisfied the condition to identify the deployment timeline for the system. While the plan outlined milestone dates for achieving enhanced data interoperability and other near-term activities, it did not include a deployment timeline that could be linked to an integrated master schedule.
- Partially satisfied the condition to break out information related to the IPO's annual and total spending for each department on iEHR. For example, the plan included the total amount obligated as well as a funding profile that showed the funds available for execution in 2013. However, program officials could not provide the basis for the spending estimates, as

reported. In addition, according to VA officials, estimates reported did not consistently reflect the current approach to pursue two separate systems.

- Partially satisfied the condition to establish data standardization schedules by including high-level data mapping activities. However, the plan did not include a schedule for achieving data standardization.
- Partially satisfied the condition to comply with acquisition rules, requirements, guidelines, and systems acquisition management practices of the federal government. IPO officials asserted compliance with acquisition rules, but the plan did not explain the basis for this assertion.

Program officials stated that the focus of the work described in the plan was on the near-term activities that were prioritized following the change in approach to iEHR, but the budget and estimated spending amounts in the expenditure plan did not reflect the new direction of the program because the acquisition guidance from the department was not issued until after the plan had been completed. Thus, the expenditure plan did not provide an accurate view of the cost of the work to be done, nor offer significant insight into the future path for building electronic health record interoperability between the departments. As such, the plan does not provide adequate information for Congress, VA, and DOD to use it as a basis for measuring program success, accounting for the use of current and future appropriations, and holding the departments accountable for achieving an interoperable electronic health record.

Why GAO Did This Study

VA and DOD initiated the iEHR program with the intent of developing a single, common electronic health record system to replace their existing health record systems. However, the departments subsequently changed their approach and instead began pursuing separate efforts to modernize or replace their existing systems and ensure their interoperability. The 2013 appropriations act restricted the obligation of VA and DOD fiscal year 2013 funds for the development of iEHR to not more than 25 percent until an expenditure plan that satisfied statutory conditions, including being reviewed by GAO, was submitted to the Senate and House Appropriations Committees. GAO's objective was to determine the extent to which the iEHR expenditure plan satisfied six statutory conditions. To accomplish this, GAO analyzed the contents of the plan against the statutory

conditions and applicable documentation, such as the President's budget, to determine whether the plan met the conditions.

What GAO Recommends

GAO is recommending that the departments ensure that any future expenditure plans include verifiable and accurate budget, cost, and spending information; a deployment timeline that is consistent with an integrated master schedule; a data standardization schedule; and the basis for their assertion of compliance with acquisition rules, requirements, guidelines, and systems acquisition management practices of the federal government. In joint comments on a draft of this report, DOD and VA concurred with GAO's recommendation.

Recommendations for Executive Action

Recommendation: To ensure that Congress has the information necessary to effectively oversee the efforts of VA and DOD to deliver an interoperable health record and hold the departments accountable for program results, the Secretary of Defense and the Secretary of Veterans Affairs should direct the appropriate organization to ensure that any future expenditure plans (1) include verifiable and accurate budget, cost, and spending information reflecting the approach to the departments' electronic health records programs; (2) provide a deployment timeline that is consistent with an integrated master schedule and shows how deployment activities are related to one another within the scope of the electronic health records programs; (3) include a data standardization schedule for facilitating interoperability as it relates to the departments' electronic health records programs; and (4) provide the basis for an assertion of compliance with acquisition rules, requirements, guidelines, and systems acquisition management practices of the federal government.

Agency Affected: Department of Defense

Recommendation: To ensure that Congress has the information necessary to effectively oversee the efforts of VA and DOD to deliver an interoperable health record and hold the departments accountable for program results, the Secretary of Defense and the Secretary of Veterans Affairs should direct the appropriate organization to ensure that any future expenditure plans (1) include verifiable and accurate budget, cost, and spending information reflecting the approach to the departments' electronic health records programs; (2) provide a deployment

timeline that is consistent with an integrated master schedule and shows how deployment activities are related to one another within the scope of the electronic health records programs; (3) include a data standardization schedule for facilitating interoperability as it relates to the departments' electronic health records programs; and (4) provide the basis for an assertion of compliance with acquisition rules, requirements, guidelines, and systems acquisition management practices of the federal government.

Agency Affected: Department of Veterans Affairs