AGENCY OVERSIGHT: DEPARTMENT OF VETERANS AFFAIRS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

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AGENCY OVERSIGHT: DEPARTMENT OF VETERANS AFFAIRS

MONDAY, MARCH 13, 1995

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:07 p.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Morella, Davis, Scarborough, and Green.

Staff present: Lawrence Halloran, staff director and counsel; Christopher Allred and Robert Newman, professional staff members; Thomas Costa, clerk; Cheryl Phelps, minority professional staff; and Elisabeth Campbell, minority staff assistant.

Mr. SHAYS. Mr. Secretary, I want to welcome you to our hearing today. I feel a little guilty that we gave you such a small table here, but you honor our committee with your presence and we thank you very much for being here.

The purpose of this hearing is to give us an opportunity to get to know each other better and to give you an opportunity to state for the record where you think your successes are, where you feel your challenges are, and then just to respond to questions that we have.

This is really your Department's day, so we are not going to ask you to summarize any testimony if you don't want to. Whatever you want to put on the record, we would be delighted to have you do that. I am joined here by the acting ranking member, Mr. Green, from—I was going to say Texas, but I have to be more precise and say Houston. Is it kind of like a State within a State?

If I could, I will ask the three of you to allow us to swear you in which is what we do for all witnesses that come before the committee. We can just take care of that business, then get on with our testimony.

[The prepared statement of Hon. Christopher Shays follows:]

PREPARED STATEMENT OF HON. CHRISTOPHER SHAYS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Our witness today is Jesse Brown, Secretary of Veterans Affairs, and we are pleased to have him with us as we begin a series of oversight hearings on the VA.

We invited him here to discuss the department's mission. We will raise fundamental questions about the department and the challenges it faces. What is VA's current mission? Is it the right mission in 1995? Is the mission being reached? Is it worth

doing? Should the federal government start such an activity if it did not exist today? These questions must be asked about each program and every policy.

Today we will also discuss VA's organization, operations, policies and programs. We want to know what is working well in addition to what is not working so well. We will examine the Secretary's plans for cost reduction, improved efficiency and departmental reform.

For FY96, the VA is requesting $39.5 billion in budget authority, a $1.3 billion or 3.4% increase over FY95 budget authority. Discretionary spending in the budget request is $19.2 billion, a 5.5% increase over FY95. VA's employment level request is for 230,077 FTEs, a very slight rise over FY95 levels. We hope to identify opportunities for cost reduction in these numbers.

The subcommittee is particularly interested in hearing the Secretary's plans for restructuring the VA's vast health care system and improving the effectiveness, efficiency and quality of its health care services. The Veterans Health Administration (VHA) now operates 173 medical facilities, 376 outpatient clinics, 39 domiciliaries, and 133 nursing homes. VHA also administers 1,800 research projects for the VA.

The failure of health care reform legislation leaves unanswered the question of how the VA will adapt its health care delivery system to the changing health care marketplace. The subcommittee would be interested in the Secretary's vision of how the VA will be providing health care in 5 or 10 years and if the VA is still interested in being a competitive provider.

We are planning additional hearings on the VA. Witnesses will include VA's Inspector General, the General Accounting Office, Congressional Budget Office, and others from the public and private sectors familiar with the VA and its programs.

We look forward to Secretary Brown's testimony. It will be helpful to this subcommittee in discharging its responsibilities and we thank him for his time and views.

[Witnesses sworn.]

Mr. SHAYS. It is wonderful to have you here.

Before I call on Mr. Green, I would just ask unanimous consent that Members be permitted to insert opening statements for the record and also to allow our witnesses to do the same, and further ask unanimous consent that the hearing record remain open for 3 days to allow Members to submit statements and questions for inclusion in the record.

Without objection, I would then proceed, and just invite Mr. Green to make any comments he would like to make before we ask you to speak.

[The prepared statement of Hon. Edolphus Towns follows:]

PREPARED STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Military service is the most basic and sometimes the most necessary form of national service. For that reason alone, the Department of Veterans Affairs should embody our federal commitment to honor and support veterans, their families and their survivors. If we are to responsibly carry out that commitment, VA's dual mission of providing specialized care for veterans with service-connected medical problems and functioning as a safety net for veterans with low incomes must be sustained.

With the potential number of VA beneficiaries now totaling about 70 million, and a staff of 260,000 throughout the United States and abroad, the policies and operations of the Veterans Administration affect the lives of one-third of the American population. I welcome today's hearing as an important first opportunity to consider the Administration's strategy for restructuring and revitalizing VA. And I thank you, Chairman Shays, for scheduling this hearing which I know you have planned as a candid and balanced first look at Department of Veterans Affairs operations and meaningful discussion of its future.

May I point out, however, that even this agency did not escape the cuts proposed by the Republicans in their 1995 rescissions package. How we can invite the Secretary to testify as to the efficacy of VA operations when the House is at the same time planning to cancel six outpatient medical clinics—clinics serving one of the most vulnerable and venerable groups in our society, is beyond me. These actions are indefensible, and are a slap in the face to those who put their lives and limbs

on the line to protect this country. Including, I should add, our esteemed Secretary of the Department of Veterans Affairs.

Mr. Secretary, I appreciate your hard work and look forward to hearing your views on the future of your agency and the population you serve, both as you have planned, and possibly as a casualty of some more draconian agenda. I am particularly interested in your progress toward restructuring the VA, but invite your comments on how this 104th Congress can better advance your goals.

Mr. GREEN. Thank you, Mr. Chairman. I will be real brief and submit my opening statement.

I appreciate the VA officials being here. This is the first, I am not on Veterans Affairs or even now National Security, but I work well with my local veterans hospital and VA in Houston because of our constituent service. I want to thank you for that.

Obviously you play a vital role, not just in the Nation, but particularly in a lot of our individual districts, and I look forward to hearing the testimony today and continuing to work particularly from the health side with veterans.

And thank you, Mr. Chairman.

[The prepared statement of Hon. Gene Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you, Mr. Chairman. Like every other federal department the Department of Veterans Affairs is undergoing a "reinvention" effort to reduce the size and cost of government. The reinvention effort at the VA requires special attention because its customers are those who sacrificed for their country in wartime and in peacetime. Despite the wide support for the aims of the Department, it has been criticized in the past for inefficiently handling its programs, particularly health care programs.

At the VA in Houston, for a long period of time there was no pay phone, so they had to cart a phone around the hospital on wheels. Mr. Secretary, how can we provide better medical care to our veterans during times of limited resources? One of the perennial complaints at VA hospitals is that there are not enough doctors or nurses to give the patients the immediate attention they need. I would like to ask if the VA believes that is a priority or do you believe you can improve service through other means?

I look forward to hearing the testimony of the Secretary and I appreciate his attendance today.

Mr. SHAYS. Thank you. Mr. Secretary, I just want to say that you have been a real pleasure to work with. You have always been available to Members of Congress. You have been extraordinarily responsive when Members have come with specific concerns, and we just thank you for the work that you are doing and again thank you for coming before the committee.

I just have to ask so I don't feel guilty, when I asked you to raise your right hand, was that causing you any discomfort, I meant physically? If so, I apologize.

Mr. Secretary.

STATEMENT OF JESSE BROWN, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. BROWN. Thank you very much, Mr. Chairman. I am delighted to be here, and I am especially pleased that I have this opportunity to discuss our vision for a more efficient and customer-focused department in the Veterans Affairs.

I think it is important as I take advantage of this window of opportunity to state for the record that, in my view, VA is different from most other Federal agencies. Our mission is the direct deliv-

ery of services to veterans and their families. We provide health care, loan guarantee, educational benefits, vocational rehabilitation, life insurance, pension and disability benefits, and burial services.

VA's health care mission separates it from most other agencies. VA staffs and manages the largest direct health care system in the Nation. We provide more than 1 million episodes of inpatient care and 26 million outpatient visits each and every year. VA trains future health care providers and has a widely recognized medical research program.

VA has an excellent record, contrary to what is reported in some of our media, of providing high quality, cost-effective service. But like the private sector, we are being challenged to meet rapidly changing needs in the national health care environment. Therefore, reinventing government is a tremendous challenge and clearly a worthwhile endeavor. We will continue the momentum created by Phase I, and we are looking into many other major improvements as we move toward Phase II.

I am very proud to report that the VA is the best in government in four of the six categories rated by the National Performance Review—the ratio of supervisors to employees, the ratio of headquarters staff to all VA employees, the ratio of personnel specialists to employees, and the ratio of budget specialists to employees. Nevertheless, VA is moving ahead in many areas to restructure, streamline and further improve our operations.

We are working hard to provide even better and more efficient service. Our primary goal is to divert our resources from headquarters and administration support to direct service. Here, Mr. Chairman, are some of our examples of that effort.

The VA's Veterans Health Administration is planning a significant and fundamental structural change in both headquarters and its field structure. Its headquarters will be more flexible, focusing on strategic planning, performance monitoring, and policy support instead of operational control. VA has eliminated its supply depots and converted to direct vendor delivery, 1,639 of our 3,500 directives have been reviewed, 96.5 percent of those reviewed have been eliminated.

The VA regional office in New York City has completely reengineered its organizational structure and word processes for handling compensation and pension claims. By reducing the steps in processing, the service provided to veterans is better, faster, and less costly. These initiatives received special recognition when Vice President Gore presented the very first Hammer award to the regional office in March 1994, and these principles are being exported nationwide.

Under the Government Performance and Results Act, we initiated three performance measurement pilot projects in 1994. They involve our loan guarantee program, New York regional office reinvention lab, and the National Cemetery System operation. We are also looking very hard at our benefit delivery system.

Two special panels were convened to make recommendations for improvements in processing claims and appeals. The blue ribbon panel on claims processing made 42 recommendations. Twenty of

these recommendations have been implemented and the rest are in the process.

In the area of adjudicating claims for benefits, I am happy to report that we have made great progress in reducing our processing time. With our proposed budget, we will reduce processing time for original disability compensation claims from 213 days in May 1994 to 140 days in 1996. That is a reduction of more than a third, and we are working toward a goal of 106 days by 1998.

The Board of Veterans Appeals continues to address the unacceptable amount of time it takes to process an appeal. The board of appeals is now authorized to issue decisions by individual board members rather than by three-member panels, provide pay comparability with administrative law judges, and increase the number of board members.

In fiscal year 1996, we are requesting 28 additional positions which increase the board's staff to 477. We expect a reduction in average response time from 745 days to 687 days. We are also shifting resources from administrative areas so we can increase the number of decisionmakers, and we are making other changes to improve productivity. For example, we are now using more automation, and we are bringing board members into the review process earlier.

Also, we have established performance standards for board members. The implementation of the recommendations by the select panel on productivity improvement for BVA has resulted in a 19 percent improvement in appeals processing time, and we will do better, Mr. Chairman.

Last month VA activated a toll free telephone number to provide information on benefits and issues of direct concern to Persian Gulf veterans and their families. We have received almost 30,000 telephone calls during the first month of service.

Mr. Chairman, we are working very hard to incorporate information technology in our reengineering in spite of the significant investment required. VA and DOD are sharing services and facilities through 670 agreements in effect with 140 military medical treatment centers. This is an effort to maximize utilization of Federal health care resources.

Several of the recommendations of the National Performance Review are the elimination of restrictive provisions and appropriations laws, multiyear funding and the cessation of management by FTE. VA would find it very easy to manage and provide service and benefits to veterans if these restrictions were removed or reduced.

We therefore, Mr. Chairman, recommend that all action taken to improve the Federal Government as a whole should recognize the differences between agencies. One size does not fit all. Solutions must include the flexibility needed to suit the circumstances of each individual agency.

In closing, Mr. Chairman, VA is very eager to apply the principles of reinventing government to become even more customer focused, to streamline our processes, procedures, and operations, and to be more cost-effective and efficient. As we work toward those goals, we must keep one thing in mind, Mr. Chairman, and this means a lot to us. We must not ask our veterans to fit into the so-

lutions that meet our needs. We must develop solutions that fit their needs.

Mr. Chairman, my comments cover only a small portion of the changes we have made recently and plan for the future. We welcome the opportunity to work with this subcommittee. Thank you very much, Mr. Chairman, and now I will be pleased to respond to any questions you or the members of this committee may have.

[The prepared statement of Mr. Brown follows:]

PREPARED STATEMENT OF JESSE BROWN, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, I appreciate this opportunity to testify on the progress being made by the Department of Veterans Affairs toward our vision of a more efficient and customer-oriented department.

Our Nation must honor its sacred trust with our veterans—a commitment that America will be there to serve them as they were there to protect us.

I will describe some of the many efforts we are making to improve our ability to carry out this obligation.

Service to veterans and their families is VA's primary mission.

Our goal is to deliver veterans benefits and services in a high quality, cost-effective, and timely manner.

We intend to ensure a dedicated, highly motivated, and well trained work force empowered with as much authority as possible to make operational decisions in their day-to-day work activities. We encourage them to contribute their ideas on ways to creatively improve their work. We also will use advanced technology to the maximum extent possible.

UNIQUENESS OF VA

VA is different from most federal agencies.

Our mission is the direct delivery of services to veterans and their families.

VA provides health care, service-connected disability and death benefits, home loan guaranties, vocational rehabilitation, education benefits, life insurance, and non-service connected pension and disability benefits, and operates and maintains veterans cemeteries and a headstone and marker program.

VA's health care mission separates it from most other agencies.

VA staffs and manages one of the largest direct health care systems in the world. We provide more than one million episodes of inpatient care and more than 26 million outpatient visits each year.

Managing such a system requires operations on a 24 hour per day basis, 365 days per year, often under extremely stressful conditions for employees.

The VA health care system is also a national resource for training future health care providers and has a widely recognized medical research program.

VA has an excellent record of providing high quality, cost-effective care. But, like the private sector, we are being challenged to meet rapidly changing needs in the national health care environment.

To meet these challenges, we must continually examine how and why we operate as we do. Therefore, Reinventing Government is both a tremendous challenge and a most worthwhile endeavor for us.

We will, on a Department-wide basis, continue the momentum created by Phase I of the Reinventing Government initiative. We are looking into many other major improvements as part of Phase II.

I am very proud to report that VA rates best in government in four of the six categories rated by the National Performance Review.

We currently lead the government in (1) the ratio of supervisors to employees, (2) the ratio of headquarters staff to all VA employees, (3) the ratio of personnel specialists to employees, and (4) the ratio of budget specialists to employees. In this regard, we are already lean, and we intend to become even more efficient.

CUSTOMER SERVICE STANDARDS

Last fall, VA issued customer service standards, telling our customers what to expect from us and allowing them to judge our performance.

The standards are specific to VA's programs and cover many dimensions of service—such as timely delivery of quality service, involvement of the veteran customer

in decision making, keeping a benefit claimant informed of the status of a claim, and compassionate, courteous treatment.

That was a vital step toward providing true customer service. But it is only a first step in a long journey.

Now we must benchmark ourselves against others in the public and private sectors doing similar functions and providing similar services.

We must monitor our performance to ensure that we are meeting the standards we set for ourselves.

Finally, we will use the results of our surveys and other feedback mechanisms to revise our standards and provide even better service.

One way to provide better service is by making sure that basic amenities are available to our inpatient veterans. For example, a new way of improving customer service is being used to provide patient phones. Until recently, VA patients had no easy access to telephones.

PT Phone Home, Inc., a charitable nonprofit service organization, is providing engineering support, cable, supplies, funding and thousands of hours of skilled labor to install patient phones in VA hospitals.

This is a partnership of business, labor, and veterans service organizations that is working. The partnership is comprised of the seven regional Bell operating companies, GTE, AT&T, Telephone Pioneers of America, the Communications Workers of America, the International Brotherhood of Electrical Workers, The American Legion, Veterans of Foreign Wars, and Paralyzed Veterans of America.

This endeavor is being done completely on a handshake and a promise of cooperation.

Patient phones have been installed at 83 of 172 VA medical centers, and the remainder will be completed by the end of 1996.

RESTRUCTURING AND STREAMLINING

VA will continue to restructure, streamline and improve operations to provide even better and more efficient service in the future. This will permit us to redirect resources from overhead and control functions toward direct service to our customers.

To accomplish this, we have two broad goals:

(1) to achieve an overall departmental supervisory ratio of approximately 1 supervisor to 15 employees, and

(2) to reduce headquarters by approximately 30 percent over the next five years.

The Veterans Health Administration is planning a significant, and fundamental structural change in both headquarters and its field structure.

Its headquarters will be a less hierarchical, more flexible organization. It will focus on strategic planning, performance monitoring, and policy support instead of operational control.

Services will be provided through Veterans Integrated Service Networks. These will be geographic networks of VA Medical Centers based on patient referral patterns.

This realignment is designed to trim unnecessary management layers, consolidate redundant medical services, and use available community services.

Networks will place management decisions closer to patients and their needs. Networks will also streamline and consolidate services and administrative activities, and encourage and promote management innovations.

We will eliminate medical center positions such as assistant service chiefs and assistant directors that represent layers of supervision.

We will further combine activities and integrate services such as laundry, personnel, finance, and supply among facilities to achieve greater efficiency.

Our Inspector General will consolidate eight field offices into four, and our District Counsels will be consolidated from 54 to 24 offices.

VA has already eliminated its three supply depots and converted to a just-in-time system of direct vendor delivery. This will save $79 million in recurring costs over five years.

This action also enabled us to reduce our inventory and transfer to the Treasury $45 million last year and another $44 million this year.

VA is the first federal agency to comply with President Clinton's mandate to implement electronic commerce in procurement having implemented a full business cycle with the vendor community. Although VA is in the early stages of processing purchase orders electronically, it currently receives 22% of its invoices and 99% of its receiving reports electronically: more than 3,300 vendors (29%) receive their payments by this means.

In an effort to streamline directives and cut red tape, we have reviewed 1,638 of VA's 3,500 directives, and we have eliminated 96.5 percent of those reviewed. So far, we have reduced the amount of directions given within our organization by 17,285 pages; and we are working on additional reductions.

VA has four Reinvention Labs—the Baltimore and Milwaukee Medical Centers, the Sioux Falls VA Medical and Regional Office Center, and the New York Regional Office. These labs have led the way toward patient- and customer-focused approaches to health care and claims processing.

The VA Regional Office in New York has completely re-engineered its organizational structure and work processes for handling compensation and pension claims.

By reducing the number of steps involved in processing, we are now providing veterans improved service. These efforts resulted in special recognition when Vice President Gore presented the very first Hammer Award to the Regional Office in March 1994.

Self-managed work teams empower employees and inspire enormous change in their duties and responsibilities. Veteran customers have testified eloquently on their satisfaction with the new process.

We continue to consider contracting out cemetery operations where it is cost beneficial and feasible. Full-service contracts are in place at 24 closed and 2 open cemeteries with low burial rates. Contracting is good practice at these 26 locations as full-time employees are not required and the sites are not located where other national cemeteries could maintain them.

PERFORMANCE MEASUREMENT

VA is actively involved in the implementation of the Government Performance and Results Act (GPRA) of 1993.

Three performance measurement pilot projects were launched in FY 1994 covering the loan guaranty program, the New York Regional Office reinvention lab, and national cemetery operations.

GPRA is the primary vehicle through which VA is developing more complete and refined performance information to better determine how well its programs are meeting their intended objectives.

TIMELINESS OF CLAIMS PROCESSING AND APPEALS

Timeliness of appeals processing has been of major concern for some time. Over the last few years, a primary focus of the Veterans Benefits Administration has been the study of its entire adjudication process. This multi-faceted study has included a review of the current process, the identification of areas for improvement and restructuring, and the development and implementation of plans for improving the service provided to our customers.

Two special panels were convened to make recommendations for improvements in processing claims for both the Veterans Benefits Administration (VBA) and the Board of Veterans Appeals (BVA).

The VA's Blue Ribbon Panel on Claims Processing for VBA and the Select Panel on Productivity Improvement for BVA included representatives of the major Veterans Service Organizations who are knowledgeable about claims processing and who represent our customers.

The Blue Ribbon Panel on Claims Processing analyzed the problems of the adjudication process and the issue of claims backlog in our Regional Offices. The Panel made 43 recommendations.

Twenty of these recommendations have been implemented and another ten will be implemented by the end of March of this year. The remaining thirteen will be implemented by the end of 1995.

At the end of December 1993, the pending backlog at our regional offices peaked at almost 574,000 claims. A year later, the backlog had been reduced to less than 462,000 claims. During that same period, the average time to complete an original disability compensation claim was reduced by 43 days (from 213 to 170).

VA plans to sustain and expand this success by taking advantage of a number of improvement opportunities.

Additional changes in organizational design and claims processing are underway in all of our regional benefits offices. These changes have been inspired by our Veterans Benefits Administration's intense interest in reengineering its business process to improve customer service.

Our Adjudication and Veterans Assistance Divisions will be realigned to improve processing time and service.

Because timeliness of processing is of such concern, Public Law 103-446 mandated formation of a nine-member Veterans' Claims Adjudication Commission to evaluate

VA's process and recommend solutions. The Commission has been appointed, has begun operations, and is scheduled to submit its report to the House and Senate Veterans' Affairs Committees by May 2, 1996.

The Veterans' Benefits Improvements Act of 1994 authorized the Board of Veterans' Appeals to issue decisions made by individual Board members rather than by three member panels.

This authority and implementation of recommendations by a Select Panel on Productivity Improvement that I convened have resulted in a 17 percent improvement in appeal processing time. And we will do better.

USE OF TECHNOLOGY

On February 2, 1995, VA activated a toll-free telephone number for Persian Gulf War veterans and their families to access information on benefits and issues which directly concern them. This effort to provide Persian Gulf Veterans direct information has already proved very successful. We have received almost 30,000 telephone calls during the first month of service.

Medical and benefits information is now available at all times through the VA-ON-LINE bulletin board. Anyone with a personal computer that includes a modem and a communications package may access this information.

We are also developing a Master Veteran Record (MVR) to integrate multiple independent veteran files. This will permit the most common data about each veteran to be shared by all service providers, whether at a benefits office or a VA medical center.

The MVR will permit prompt and complete updates in a veteran's record, such as changes in family dependents or mailing addresses. Veterans will experience fewer delays and fewer repetitious questions, faster response from service providers, and access to a unified view of their benefits status.

VA education claims processing is being consolidated from 58 to four sites as a part of our re-engineering efforts. Our aim is to enhance the already high quality service and improve customer satisfaction through more timely benefits delivery and to provide operational efficiencies. The consolidation has been completed for 22 of our 58 sites and the balance will be consolidated by the end of 1996.

Mortgage loan accounting activities are being consolidated for improved fiscal control. Six offices have been consolidated into three other offices in pilot form. Based on the success of the pilots, we plan to expand this approach to more offices in 1995.

This year our Veterans Benefits Administration is consolidating into four sites the human resources functions now performed at 52 locations. The consolidation will allow VBA to maximize the use of its Human Resources Management professionals across state lines. The resulting personnel savings will be redirected to the delivery of benefits.

We are also working with a Navy Reinvention Lab to acquire their software designed to significantly reduce paperwork processes associated with personnel activities.

In addition, the Veterans Benefits Administration is consolidating the management of its two records centers (retired benefits records and service medical records) located in St. Louis, MO. Through this initiative, we will streamline records operations; provide more focused, responsive management control; take advantage of greater flexibility to use employees between operations at the two sites; and reduce administrative costs.

Information technology is a tool that all agencies need in order to help in the process of restructuring, re-engineering and improving how we do business. While a tremendous and indispensable tool, information technology requires significant investment. The President's FY 1996 budget includes $99.6 million for VBA information technology initiatives.

SHARING PROGRAMS

A principle objective of sharing programs is to maximize utilization of federal health care resources through agreements between the Department of Veterans Affairs and the Department of Defense.

We are very proud of our medical sharing program with the Department of Defense. We now have 670 agreements in effect with 140 military medical treatment facilities representing 4,170 shared services. This is a 19 percent increase over the FY 93 number of agreements.

VA and the Air Force have shared a medical center for several years at the New Mexico Federal Medical Center in Albuquerque. We have similar sharing agreements with the Air Force at the Nellie Federal Hospital in Las Vegas, and at the Army's Lawton, Oklahoma clinic .

The extent of cooperation that can be achieved can be seen in the additional joint ventures we are planning in Anchorage, Alaska, and Travis Air Force Base, California (USAF); Honolulu (Army); and Key West, Florida (Navy).

In Asheville, North Carolina, we provide medical services and are reimbursed by CAMPUS for treatment of active duty personnel and military retirees. We will continue looking for other opportunities for sharing and cooperative endeavors with the Department of Defense.

APPROPRIATIONS

Several of the recommendations of the National Performance Review are the elimination of various restrictive provisions in appropriations laws, multi-year funding, and cessation of management by FTE.

Appropriations laws contain a myriad of ceilings, floors, and restrictions on travel, training, and personnel funds. VA would be able to improve management and delivery of services and benefits if these restrictions were removed or greatly reduced .

Let us manage to the "bottom line." Give us the flexibility to decide whether it is more cost effective to perform activities with VA staff or contract for the services with the private sector.

CONCLUSION

The challenges or obstacles to improvement are diverse. Because VA is unique in so many ways, we recommend that all actions taken to improve the federal government as a whole should recognize the differences between agencies.

One size does not fit all.

Solutions must include flexibility which accommodates the needs and circumstances of each individual agency. Agencies that have managed themselves in a very frugal manner for years should not be penalized. We should change the way we do business so we build upon our strengths and successes and develop organizational structures focused on our customers.

In closing, VA is very eager to apply the principles of Reinventing Government to become even more customer-focused, to streamline our processes, procedures, and operations, and to be more cost-effective and efficient.

As we work toward these goals of greater efficiency and effectiveness we must keep one thing in mind.

We should not ask veterans to fit into solutions that meet our needs. We must develop solutions that meet the needs of veterans.

We welcome the opportunity to work with this Subcommittee.

Mr. Chairman, thank you very much. I am ready to respond to any questions you or members of the Subcommittee may have.

DEPARTMENT OF VETERANS AFFAIRS—BUDGET AUTHORITY

Discretionary/Entitlements

Entitlements	Medical Care	All Other
$19.945	$16.215	$2.030
1995 Enacted $38.190 Billion.		
20.235	16.961	2.284
1996 Request $39.480 Billion.		

Medical Care

[In Billions]

1994	1995	1996
Budget Authority:		
15.6	16.2	17
Employment:		
203,884	200,987	201,254

Medical and Prosthetic

[In Millions]

Research Total Resources	1994	1995	1996
Appropriation	252	252	257
Medical Care Support	370	380	391
Grants	204	216	223
DoD Reimbursements	20	20	0

MAMOE

[In Millions]

1994	1995	1996
Budget Authority:		
71.0	69.8	72.3
Employment:		
827	802	790

VETERANS BENEFITS ADMINISTRATION

Budget Authority

[In Millions]

1994	1995	1996
734	798	820

AIncludes Credit Reform

Compensation and Pensions—Budget Authority

[In Billions]

1994	1995	1996
17.491	17.622	17.990

AIncludes Proposed Legislation (there is no supplemental)

Readjustment Benefits—Budget Authority

[In Millions]

1994	1995	1996
1,081	1,287	1,333

AIncludes proposed legislation

Veterans Housing Programs

[In Millions]

Program Accounts Budget Authority	1994	1995	1996
Direct Loan	3	1	1
Loan Guaranty	-60	103	75
Guaranty & Indemnity	198	573	582

National Cemetery System

[In Millions]

1994	1995	1996
Budget Authority:		
70.5	72.6	75.3
Employment:		
1,311	1,340	1,340

Construction Programs

Budget Authority

	1994*	1995	1996
Parking	1.4	16.3	0
Minor Projects	155.5	152.9	229.1
Major Projects	460.1	354.3	513.8

* Includes Emergency Supplemental Funding

Office of Inspector General

[In Millions]

1994	1995	1996
Budget Authority:		
31.4	31.8	33.5
Employment:		
411	400	399

GOE—General Administration

[In Millions]

1994	1995	1996
Budget Authority:		
223.2	219	227.1
Employment:		
2,997	2,922	2,903

Aincludes Credit Reform funding from Entitlements

Mr. SHAYS. Thank you, Secretary Brown. I wanted to first welcome Dr. Kizer and Mr. Vogel. It is nice to have both of you here. I would be happy if you have any comments that either of you would like to make, we have time, we would be happy to hear any comment or would you just like to go into questions?

Dr. KIZER. I will defer mine to questions.

Mr. VOGEL. Same thing, Mr. Chairman.

Mr. SHAYS. Mr. Secretary, if I could just have you tell me, what is the first thing that comes to mind when you think of your biggest successes? You have had a number, but where are you most pleased?

Mr. BROWN. Well, I am most pleased, I would think, and probably maybe some of the bureaucrats would not agree, but I am most pleased personally with our efforts to bring a higher level of sensitivity to the Department, and that has resulted in our ability to respond even faster to the needs of our veterans.

And I am talking about in the area of, for instance, what we did with Agent Orange, that war has been over for 20 years, and we are now, the science is catching up and we were able to add two additional disabilities to our presumptive list, and they are multiple myeloma and respiratory cancers.

I am pleased that we learned a tremendous lesson from how we managed or mismanaged Agent Orange as we tried to deal with the issues of the Persian Gulf, and I think, quite frankly, when we compare the time lines, we are about 15 or 20 years ahead of where we were on the same type of issue in Agent Orange.

We are, for instance, doing four things I think very well. One, we are providing medical care basically on demand for any Persian

Gulf veteran who feels that he or she is suffering from a problem that developed concurrent with their service in the Persian Gulf; No. 2, because of the cooperation of this body, we are now paying compensation as of February 3, we are actually issuing checks and decisions that grant service-connected benefits to veterans who are suffering from undiagnosed illnesses. I am very happy about that.

Three, we are moving forward with all speed in trying to find out exactly what the cause is, and that is one of the reasons why our research initiatives are so very important to us. We have about 40 projects that are out there. We have set up our own research centers. We have three of them, one in Boston,. one in East Orange, NJ, and one in Portland, OR.

Then the last thing that I am really extremely proud of because it ties in with the real genesis of your question, and that is our outreach effort.

We believe very strongly if people have been hurt or somehow disadvantaged as a result of having served in the Nation, we think those benefits that the Congress set aside should be made available to these individuals, so we have undergone a massive effort trying to contact all of the people who have been possibly exposed to problems that would interfere with their ability to become a part of mainstream America.

Mr. SHAYS. What is the first thing that comes to mind when you think of your biggest challenge or your least successful venture to date?

Mr. BROWN. I would think it is the massiveness of the system. This is a system, sir, where we have over 200,000 employees, we operate off of a $38 billion budget which means spending somewhere around $100 million each and everyday. As you try to bring about change because the system is so huge, that change comes very, very slowly, and with that, you end up having a higher frustration level.

But I think that we are now moving in the right direction, and I say that primarily with respect to two, just two of our programs. Everything that we do, when we talk about our mission, and we talk about all of the VA employees and all of the resources that we have, we are really only talking about three missions.

The mission is quality health care, timely benefits and services, and burying our veterans with dignity. Now, I believe, and this is an area that we are going to have to fix, there is no doubt about it, and Dr. Kizer I think is well on his way to fixing it, is that the Nation has already decided that it is going to provide medical care to our veterans, and as such I think that we must do whatever is necessary to make sure that they are receiving good, strong comprehensive quality health care.

If you are going to provide health care, then that is what you should do. If you are, you can't nickel and dime it to death because you are making life and death decisions. If you are not going to provide it, then get out of the business.

Mr. SHAYS. The outpatient clinics, is this a program that you are pursuing or is this a program that you are just basically doing pilot programs on?

Mr. BROWN. It is a program that we are pursuing. I would say to you, sir, that it is not something that the VA all of a sudden

thought of by itself. All we have to do in many cases is just to look at what is going on in the medical industry itself, and that is what you see. There is merging taking place, many hospitals are moving from inpatient treatment modalities to outpatient treatment modalities. That is the most cost-effective way of providing care.

When we talk about access, we are talking about two types of access. We are talking about one is to make sure that our eligibility rules that allow us to treat someone is consistent with what we really, really want to do, that we are not still just responding to a patchwork approach that has been in existence over the last 50 years.

And then, two, is that we have to respond in a way that we take advantage of the economies of scale that all of the other facilities are doing. You take, for instance, many hospitals went out of business in the mid-1980's and the late 1980's, many of them simply because they refused to look at the tea leaves, and the tea leaves said you cannot stay in business if you are going to continue to treat people on an inpatient basis when you can do those same procedures on an outpatient basis.

The last point I want to make in terms of access, which was the point I was getting at, is that, one, we are talking about eligibility criteria, and, two, is that we are talking about a facility where people physically can gain entry into the system, so that is what we are trying to do.

Mr. SHAYS. It strikes me that we are being told that some hospitals will literally go out of business based on the demand of bed space or the lack of demand. We have a number of hospitals nationwide, which the number is again——

Mr. BROWN. 172.

Mr. SHAYS. 172. I am struck by the fact that if we really want to improve service to our veterans, we have a Hobson's choice in a way, we ideally would want to provide them the service right in the town they live at their local hospital, yet you have these facilities, 172 of them, that need patients in order to be cost-effective.

Two choices. One, you shut some down and let veterans go to their hospital in their own area. Another is to begin to allow for patients who aren't veterans to use some of these facilities, and, candidly, both are unacceptable to veterans. I am struck by the fact that we are going to have to wrestle with this issue, that we may need to bring people into our veterans hospitals who aren't veterans in order to have the bed demand.

Mr. BROWN. I don't think so. Quite frankly, I don't see those as the only options. First of all, let us just talk about that. When I got out of the military 30 years ago, any veteran that received an honorable discharge could come to the VA if they were sick and get taken care of. Today we only treat our service-connected and our poor veterans. Those are the only people that can get into the hospital. We now, at least in 1996, will treat about 2.9 million patients.

Now, all of the rest of them have been locked out by design simply because we did not have the resources to treat them. That was the bottom line. So if we are talking about filling our beds, all we have to do is just open that system up to the people that we locked out—that we actually terminated the benefit for.

Mr. SHAYS. Let me just be clear on this. If you have someone on Medicare who is a veteran but who has income, they can come to a veterans facility, can't they, and just use their Medicare?

Mr. BROWN. We have an income test, it is a means test.

Mr. SHAYS. I know you have the income test, but if they are willing to pay?

Mr. BROWN. No, they cannot come.

Mr. SHAYS. I have always made the assumption, and I have been here 7 years——

Mr. BROWN. We tried to get legislation through in the national health care reform initiative where we could get reimbursed back from Medicare and, therefore, anyone who had Medicare entitlement could come to the VA. Today we only treat service-connected veterans and if your income is below about $20,000 a year, you can get into the VA hospital. Everybody else, even if you wanted to pay the cost yourself, you could not gain entry into our system.

Mr. SHAYS. This committee looks at HHS as well as the Veterans Administration, and this gives us a wonderful opportunity to investigate the logic of that because it would strike me, and I am going to defer this conversation until a little later, but I am just struck by the fact that why shouldn't a Medicare patient who is a veteran be able to go to a veterans facility, and that is news to me after being here 8 years.

I knew there was the income test, I just didn't know they were denied the opportunity to use the facility if they were willing to pay or Medicare was.

Gene, do you have any——

Mr. GREEN. Thank you, Mr. Chairman. I want to follow up on that because I know it was part of the national health care and I thought that was one of the great parts of it because all of us have experience with veterans who, because of the means test or the income test, can't get in because they are just barely over it, and I would hope that if not this committee, then some other committee would allow that maybe on a one-shot basis to where VA could provide for that extra—use those extra beds that you have for the veterans, like you said, who have been locked out because of the changes over the last 30 years.

I always recall my father telling me as a World War II vet that he could go to the VA anytime he wanted. Of course over the late 1940's, 1950's, and 1960's, and now he is retired, he couldn't go and he never did, although I have an uncle who did because it was service connected, and we made that commitment. But over the years, Congress has withdrawn that commitment, whether it be Vietnam veterans or earlier to that. So I would like to see how we could respond to that for veterans.

Let me ask a specific question and hopefully you can answer it as quick as possible. Under the VA Direct Home Loan Program for Native American veterans, it authorizes home loans for home purchase and construction on trust lands, and as of last December 1994, only six loans have been made.

Can you tell the committee where we are at in that program and also has the number of loans increased because I know this program expires in September 1995?

Mr. BROWN. Yes, sir. We have signed 26 memoranda of understanding, in fact I personally signed three of them with the Southern Ute tribe and the Mountain Ute tribe and the Navajo Nation. What we see here, while we have these memoranda of understanding in effect, which basically says that we will go ahead and guarantee properties on reservations and so forth, we have not actually seen an effort to take advantage of this program aggressively by Native Americans, and I think they have some reasons for that.

One is that while the benefit is there, in many of these reservations, there are simply no jobs. We make the benefit available, but there still is a requirement that they are going to have to pay the loan back, but there are no jobs. I do think, sir, we will be asking for an extension of this program as it moves toward its expiration date because we need to continue to try to invest in it, we need to bring forth that opportunity to those who want to use their entitlement to purchase a home on trust land.

I am going to ask Mr. Vogel if he has anything else to add to that.

Mr. VOGEL. We have a number of loans in progress that we will close in the near future. They are mostly new construction loans that won't close until the construction is completed. Most of those are on the Hawaiian homelands where, in fact, there seems to be more economic vigor, if you will.

The Memorandum of Understanding that the Secretary referred to that he signed with the Navajo Nation was recent. We haven't seen any activity there yet. With respect to the Southern Utes and the Mountain Utes, as an example, we haven't had an application yet despite our best efforts. We expect to see more in the way of construction and remodeling loans.

One of the laws recently closed was for specially adapted housing for a severely disabled veteran, but it is moving along. We are dealing, too, with another government. Sometimes our government and their government don't agree. The bureaucracies in tribal governments can be just as impeding as some of the things we have in place. We feel that the program is beginning to take off just a bit and we would like to see it do so. We likely would ask for an extension of authority to make those direct loans.

Mr. GREEN. Thank you.

Let me ask an overall question, the Department of Veterans Affairs is the largest Federal civilian employer, and under the reinvention strategy the number of FTEs, how will the reinvention strategy affect the number of full-time equivalents? And what staff reductions would we like to see over the next few years? And let me explain from a local basis why I think that is important.

We have seen staffing, particularly in nursing, in my hospital in Houston, cut back, and yet I looked at the budget and we showed that over the last year that particular facility received about $2 million more for other things, and yet I still continue to hear from my veterans about, you know, the nursing staff is being cut back because of the FTEs, I guess, or whatever, but if you could address that. I am sure it is not just in Houston, I am sure it is around the country.

Mr. BROWN. As you know, Mr. Green, we have a floor on our FTE, which I think is misleading because many people seem to

think, well, you don't have to take any reductions, but out of that floor we are going to have to absorb our activations.

Let us say, for instance, the hospital that we are going to activate this year in Detroit, that may require—how many people in Detroit? About 1,500. Well, we are going to have to take that out of our base. We can't add that to the base. And we want to move forward with these two new hospitals that we have in the 1996 budget and provide Travis Air Force Base and in Bevard County, FL, that staffing, too, is going to have to come out of our base.

So what we are doing, as I mentioned to you in my opening statement, we are trying to move as many people from our headquarters out to the field. We are trying to convert as many of our support positions to the front line. And one of the things, one of the commitments we made early on was that the last to suffer in terms of any type of adjustment would be the folks that are providing hands-on care, that is what is very important to us.

Now, this is not to say that we can't use more people out in the field. I am really concerned about that whenever I travel, I always stop into our SCI, our spinal cord injury units, where veterans are suffering from catastrophic disabilities, and I want to know how long does it take our nursing staff to get them up. They can't just lie in bed all day. I don't want to go into a hospital and it is 2 and they haven't gotten our veterans up and cleaned them so that they can get the blood circulating. Those are the kinds of things that we are concerned about. I am sure Dr. Kizer has some other ideas.

Dr. KIZER. I would only add that in the little over 4 months that I have been with the Department, I have visited various facilities and heard from directors that the issues of nurse staffing, as well as other staffing, is a universal concern in the system.

Mr. GREEN. Thank you, Mr. Chairman. We will be contacting you because I know last year we passed a provision that exempted VA medical from the staff reductions, particularly on the hands-on care, and I know when you hear something different from your local hospital or your veterans, local veterans, you need to have an answer and say, well, we know we exempted it.

Mr. BROWN. One of the things that you might be interested in, Mr. Green, we elevated the status of our chief nurses in the hospitals to associate directors because they play a critical role. In fact, they are the managers of the largest component of the hospital, at least in our hospitals, and I suspect that that would hold true in the private sector. So we want them sitting right there with the hospital director and the chief of staff as they go about planning to make sure that we are able to accomplish our mission, that mission of providing good, strong comprehensive health care.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you, Mr. Green. Mr. Davis.

Mr. DAVIS. Mr. Secretary, thank you for being here. I represent a district across the river over in Northern Virginia that has a lot of veterans. I was pleased to see today that the backlog had been reduced in benefits and claims, it looks like from 530,000 which was the 1993 figure we saw to 462,000 claims.

I just finished a series of town meetings. It seems everyone with a veterans claim was there asking questions, but from looking—I read your appropriations testimony. It looked like your goal is to

bring the processing time for benefit claims from 140 days to 106 days and keep bringing that down. How is that coming?

The other complaint I hear is the fact that when you get an appeal at the Board of Veterans Appeals it just seems to take forever. Is there anything we can do on that from our perspective and what are you doing?

Mr. BROWN. Yes, sir. First of all, let me state that we are extremely, extremely happy with the numbers on the Veterans Benefits Administration side, that is Mr. Vogel's side. As you correctly pointed out, we expect by 1998 to have our original compensation claims down to about 106 days. Two hundred fifty thousand in terms of a backlog is really where we want to be. At 250,000, that will keep all 13,000 of our employees working 8 hours a day, and we are rapidly moving in that direction, so I am happy with that. I don't think that you are going to hear complaints too much longer complaints from the adjudication side of the House.

Now, as it gets to the Board of Veterans Appeals, that is another story, Mr. Davis, and this is why. In 1991, the average what we refer to as response time was about 139 days. Today, it is over 600 days at the Board of Veterans Appeals. That is from the time the case is certified to go to the board until they actually make a decision. So you can see we are talking about 2 years, and while the numbers showed a little dip primarily because of some management initiatives that we took, for instance we allowed one judge or board member to sign the case. That created an additional efficiency of about 27 percent. Right now they are in the process of restructuring the whole system. That is going to create some more efficiency, I think, but the bottom line is this, is that we still are making decisions on less cases than those that are coming in. So we haven't leveled this out yet.

Mr. DAVIS. The backlog is rising; in other words?

Mr. BROWN. That is exactly right. While the numbers that we cited to you in the official record would show that it dropped down just a little bit, but the bottom line is that we still have more cases coming in than we have going out. So our whole effort now is to try to balance this out.

I would say to you, many people would suggest that a lot of this is because of the VA's inefficient structure, but that is not really the truth. What this is all about is the court. Before we had the Court of Veterans Appeals or Judicial Review Act in 1988, each case was considered, what we used to refer to, on its own individual merit, which meant it had no precedent setting measure whatsoever. Each case was considered differently. When the court came in, every case that the court renders, whatever the decision, it then became binding on all cases throughout the system, so let's just assume for the sake of——

Mr. DAVIS. That would take care of other backlog issues?

Mr. BROWN. Let's assume for the purposes of illustration there, today the court renders a decision saying in order to comply with due process you are going to have to put an X on every case. Well, we have 46,000 cases that are already ready to come to the board. Theoretically, all 46,000 would have to be looked at again in order to comply with the decision that was made today. So that gives you an example of the kind of complexity that we are now involved in

in order to respond to all of the due process requirements and all of the mandates of the court that is pushing this thing.

Now, I think it is going to work its way out in the out years. As the court develops its case law they won't be making new decisions every day, creating new guidelines that we must follow, but in the meantime I think that we are going to have to continue to do the best that we can. All of these new initiatives that we spoke about are going to help us try to continue to manage it so we can get it level. Once we get it level, then we can begin to force it down.

Mr. DAVIS. First of all, I appreciate your frank and candid answer and realization that this is a huge problem.

Mr. BROWN. Yes, sir, it is.

Mr. DAVIS. I just wonder if there is anything from a legislative perspective that we might be able to do that would help that out where you could get some kind of precedent with these cases? I feel sorry for the poor people out there who don't know how they are going to be dealt with in 2 years to—they have to carry the financial burden.

Mrs. MORELLA. Would the gentleman yield for just one moment?

Mr. DAVIS. I would be happy to.

Mrs. MORELLA. I have situations where people have decided while their cases are still in court. And I wondered because it has taken over 2 years, and I wonder, does that mean that if the decision is made on their behalf, that their survivors would get the benefits?

Mr. BROWN. No, it doesn't, Mrs. Morella. We have about 400 cases a year where the appellant dies and that is fairly consistent with what we have observed over the years. And by that, I mean this, when our caseload was down, when our response time was down at 139 days, we expected during that period of time for about 154 people to die during that 3 or 4 months, while their cases were at the Board of Veterans Appeals.

So naturally, if the case remains at the board 1 year, 2 years, or 3 years, then that multiplies. In addition, there are other complications because many of our veterans now are 3 or 4 years older, they are in their 70's so they end up dying. Let us assume in order to respond to your question that their case is at the board. Been here 3 years, they die. And the case is allowed.

Well, the law prohibits—and correct me if I am wrong, John—it prohibits retroactivity more than 1 year on a DIC claim, so even let us say, for instance, the issue was clear and unmistakable error and the man would have gotten $500,000, then the max that the widow could get is 1 year in retroactivity. So that is a matter of law that we have to comply with. So we are very, very concerned about all of these issues and we are working very hard to try to bring that caseload and the backlog and our timeliness standards into some kind of sense that is normal.

And I would mention to you this, Mr. Davis, we are now under mandate of law to look at our entire adjudication system. This is based on a bill that was passed and we have set up this commission under the direction of Mr. Meladossian, a fine man, spent many years in the VA system, and I think he is going to be helpful. We had our own blue ribbon panel that helped us to bring it down a little bit because, at one time, we had projected as many as 1,600

days at the Board of Veterans Appeals, so we are past that. But still 700 days is too long.

Mr. SHAYS. Mr. Davis, I am going to give you some more time.

Mr. DAVIS. I just wanted to ask one other question along this line. I think we can agree, particularly with your retroactivity rules and everything else and people dying and losing rights, that is just unacceptable. To the extent—and you are dealing with very difficult problems with a very limited budget. Aside from the budget, is there anything else we can do to help you, any laws that we can pass?

That retroactivity seems especially very harsh on veterans who can win the day but they have lost 2 years just waiting in line to get those rights asserted. If you can think of anything, let this committee know and the Veterans Committee. I am sure my colleagues would like to respond to that.

Mr. BROWN. I have some very definite views. I had our attorney general counsel look at one case that was in Puerto Rico where the VA took action to reduce many of those who lived in Puerto Rico that were receiving 100 percent disabilities for mental disorders and they did it contrary to the legal standards. A lawsuit was filed and the lawsuit said, you will reinstate them. Well, I think 10 years had went by; is that right, Mary?

Ms. KEENER. Yes, sir. Actually we entered into a settlement on the case.

Mr. SHAYS. Do you mind just speaking into the mike because we have this being recorded. State your name if you would.

Ms. KEENER. Mary Lou Keener, general counsel. Actually what happened in the case the Secretary is referring to is that we entered into a settlement with all the claimants. As of the date of the settlement, some of the claimants had died. The question arose would their spouses or heirs be able to collect the veteran's full portion of the settlement.

The decision was no, because of the statutory restriction that allows only 1 year's retroactive pay for a surviving spouse. Thus they would not be able to retrieve the total amount that the claimant would have received in accordance with the settlement. Therefore, the law that the Secretary referred to earlier applies here.

Mr. BROWN. So in other words, in this case of the retroactive, if the veteran had lived, he would have gotten retroactive benefits for about 10 years. Since he died——

Mr. DAVIS. That he had earned and his spouse should have received?

Mr. BROWN. That's right. That was illegally taken away from him.

Mr. DAVIS. I know we would be happy in putting some legislation on that. Thank you very much for your candor on a tough, tough issue for you.

Mr. BROWN. Yes, sir. Thank you so much for your concern.

Mr. SHAYS. Thank you.

Mrs. Morella.

Mrs. MORELLA. Thank you. I do think it is grossly unfair and we will see what we can do legislatively, maybe with some assistance from your general counsel on that.

I wanted to ask just a couple of questions. One with regard to health care eligibility. If the health care eligibility rules forcing veterans to be admitted to hospitals were changed so that outpatient care could be received, wouldn't you save a significant amount of money and how much do you think that might be?

Mr. BROWN. Well, I am going to ask Dr. Kizer to respond to that. But to answer you up front, yes. But I would like to frame it a little bit differently.

I would not want to see legislation that says that you should treat on an outpatient basis as opposed to an inpatient basis. I would like to see legislation which says to our doctors, "you determine the modality of care. If a person needs to be hospitalized on an inpatient basis, then do that. If he can be treated efficiently and competently on an outpatient basis, then you do that."

And we know that that is exactly what's happening all throughout these great United States and the same thing is happening in the VA. If you look at our numbers, you see outpatient care going up like this and our inpatient days are going down like that. And that's happening all across the United States and in between, really represents a substantial savings.

I am sure Dr. Kizer has some other observations.

Dr. KIZER. I would affirm the basic tenet of your question and that is that if we were allowed by law to treat patients according to what their medical condition warranted, as opposed to what statutory conditions might apply, there are certainly significant efficiencies that could be achieved.

Exactly what those would be are very hard to quantify because the rules are so complex and the efforts to deal with them sometimes result in, quote-unquote, gaming of the system to get the veteran the care that he/she needs.

Many people have tried to quantify this. I think all have agreed, in frustration, that it is exceedingly difficult to quantify what those savings would be in a precise way.

Mrs. MORELLA. I appreciate your commenting on that so openly, but I don't understand when the Secretary says he doesn't think legislation would be appropriate. Did I understand that. It seems to me that if we drafted some legislation and the doctors and all were sensitized to what it means, you would be achieving it more significantly and faster.

Mr. BROWN. Yes, ma'am. Well, maybe I didn't make myself clear. I think we do need legislation, but what I'm saying is that we don't need legislation to say that you should treat on an outpatient basis. You need legislation to give the doctors the flexibility to decide whether they need to be hospitalized or that they can take care of their problems on an outpatient basis. That's how they do it in the private sector. That's good medicine.

Mrs. MORELLA. That makes sense. This is a very provincial—maybe it is not so provincial a letter—that I got from a constituent. I understand that there is a study on type H diabetes that the Department of Veterans Affairs has approved called the VA study on glycemic control and complications in type two diabetes. It would tell us whether keeping our blood glucose levels near to normal delayed complications.

Interesting. Are you doing it? Can someone give me information on that?

Dr. KIZER. I believe there is a study that the VA has participated in, as one of its collaborative studies, along with a whole host of other studies that have basically shown, or at least the medical literature in the composites shows that the closer to normal that a diabetic keeps his or her blood sugar, the less likely they are to develop complications and, in particular, complications of neuropathy and cataracts.

Mrs. MORELLA. So can you supply me with information about that study? Where it is now?

Dr. KIZER. We can certainly provide for you information about VA's involvement, although I would hasten to add that these types of studies have been done in multiple places by VA and non-VA facilities.

Mrs. MORELLA. Well, then, the VA portion of it then.

Dr. KIZER. Sure.

Mrs. MORELLA. That would be great.

[The information referred to follows:]

OVERVIEW OF DIABETES

Diabetes affects 13 million Americans and costs over $23 billion annually. The most common form of diabetes occurs in older adults. The population of people over 65 will grow from the current 31 million to over 60 million by the year 2025. Therefore, diabetes will continue to be a major health problem. Normally, insulin from the pancreas increases sugar (glucose) uptake into muscle and fat cells and decreases glucose production in liver. About 25 percent of diabetes is caused by the destruction of the insulin secreting cells in the pancreas (insulin-dependent or Type I diabetes). About 75 percent of diabetic patients in the U.S. are adults with non-insulin-dependent (Type II) diabetes, which is an inherited disease. In Type II diabetes, patients continue to make insulin but the target tissues become resistant to insulin actions.

The diagnosis of diabetes is made by finding high blood sugar levels. Because symptoms are few early in the disease, most patients are not diagnosed until 4 years after blood sugar is elevated. Obesity, high-fat-diets, low-fiber intake, and lack of exercise enhance the symptoms of this disease. A major challenge of diabetes management is helping patients to make important lifestyle changes. Maintaining normal blood sugar levels reduces the risk for complications of diabetes. When necessary, insulin and other drugs may be used to control high blood sugar levels. Many times these drugs may be given by mouth but more severe diabetes may require daily injections into muscle tissue for adequate blood sugar control.

Diabetes is the eighth most common diagnosis among veteran patients, and about 18,000 veterans are currently being treated. It is the leading cause of blindness, leg amputation, and kidney failure for veterans. Additional complications of diabetes include hardening of the arteries (atherosclerosis) and high blood pressure.

Damage to nerves (diabetic neuropathy) is the most frequent complication of diabetes. Nerves are damaged in the legs and feet most commonly causing sensory loss and loss of muscle control. Kidney damage (diabetic neuropathy) is the leading cause of kidney failure (end-stage renal disease). About 40 percent of all dialysis patients need dialysis because of diabetes, and about $2 billion is spent on their care. About 35 percent of all patients with diabetes will progress to kidney failure. The risk factors for diabetic kidney disease are a family history of cardiovascular disease and a family history of high blood pressure. There are drugs available that reduce the risk of diabetic kidney complications. Damage to the eyes (diabetic retinopathy) in diabetic patients is common. The risk of damage increases with the duration of diabetes. Although diabetic retinopathy is a leading cause of vision disability and blindness, it may be treated by laser therapy or with a procedure called photocoagulation if diagnosed early.

SCOPE OF VA DIABETES RESEARCH

In FY 94 VA spent $7.2 million in funding 72 projects for the study of diabetes. An additional $9.9 million from non-VA sources support another 182 diabetes

projects. There are active projects in all 3 divisions of VA research (biomedical, health services, and rehabilitation). In total, 236 VA investigators are funded with $17,112,071 for diabetes studies and another 286 VA investigators are working on diabetes related research projects without current funding.

GLYCEMIC CONTROL AND COMPLICATIONS IN TYPE II DIABETES

A feasibility study on glycemic control and complications in type II diabetes (NIDDM) was conducted at five VA Medical Centers (Boston, Hines, Houston, Minneapolis and West Los Angeles) between 1990 and 1993. This was a prospective randomized controlled trial to determine whether it was feasible to compare standard vs. intensive therapy in maintaining near normal blood and were followed for an average of 27 months.

The results (which are scheduled to be published in the August, 1995 issue of DIABETES CARE) indicate that such a study is feasible and that stepped insulin therapy in type II diabetic patients is effective in maintaining near normal glycemic control for over two years without excessive severe hypoglycemia, weight gain, hypertension, or dyslipidemia.

A proposal for a long-term trial to assess the relative benefits and risks of intensive therapy on macrovascular events in NIDDM patients was prepared by VA investigators from the feasibility trial and representatives from the National Heart Lung and Blood Institute (NHLBI), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and the National Eye Institute (NEI). That protocol was scientifically approved by the VA Cooperative Studies Evaluation Committee.

Since the proposed study is a 7 year trial with over 1400 patients which would cost $28 million, the original plan was for a collaborative effort between NIH and the VA in which female patients would be included. However, NIH has just independently initiated a $100 million, 7 year study in 21 centers nationwide to test the effectiveness of behavioral modification and medication in preventing NIDDM in high-risk individuals. The intended collaboration between NIH and the VA for the long-term trial did not materialize. No decision has been made whether VA alone can or should go forward with this trial because of its high cost and the difficulty of recruiting a sufficient number of female subjects.

Mrs. MORELLA. Do I have time for another question?

Mr. SHAYS. Yes, you do.

Mrs. MORELLA. All right.

It had to do with—I know I had one lined up that I wanted to ask which had——

Mr. SHAYS. Are you going to be here for a little bit? Representative Green is going to have to leave and if we could let him ask a few questions, then he can go.

Mrs. MORELLA. Certainly.

Mr. GREEN. Thank you, Mr. Chairman.

No one has asked concerning the rescission program and that we have, and I know the six outpatient care projects are going to be cut and I am——

Mr. SHAYS. I am glad you asked. I didn't want to be provincial.

Mr. GREEN. None of them are in my area, so I don't have to be provincial.

Mr. SHAYS. You keep asking questions.

Mr. GREEN. I am concerned about the effort because of in your testimony, you talk about the increase in outpatient care needs as compared to hospital days and yet we have six outpatient care projects that are being eliminated. And what is the impact on the disabled or ill veterans and their families and how will these people be reached if these six or this rescission package is successful?

Mr. BROWN. Mr. Green, this whole rescission package really disturbs me and from two perspectives. No. 1, we have never seen anything like this before. As a rule, the Congress, the American people through the Congress have always been there for our veterans and all of a sudden, without consultation from the VA in terms

of what impact it would have, we learned through the media that $206 million were rescinded from the 1995 budget. And these proposals were based on need. Let me give you a little history about that, Mr. Green.

They were not actually contained in the 1995 budget. But I felt so strongly about these proposals that I was willing to use the money that was set aside in the investment package as part of the national health care because they were needed. As I travel all across this country, we see many, many areas where we are not taking advantage of what is taking place in the private sector in reaching our people.

You take for instance, one example there in Orlando. There is a brand new hospital. They closed the base down, it was a naval base and they closed it down and a brand-new hospital is in existence. We have determined we need a nursing home and outpatient clinic because we are really, as a general rule, and contrary to what some might say, we are not really in the business of building now these big massive hospitals.

Now, based on the fact that we were able to negotiate transferring ownership to us—this is government property that was already paid for by the American people—we were going to take just $14 million, $7 million for the nursing home, 120-bed nursing home to take care of our World War II veterans and then we were going to use the other $7 million to renovate the outpatient arena, so here again we are using the most efficient form of care.

And now we may not be able to do this. Now, I might have to go back to the Navy and say, I don't want this property. I just can't envision buying property and somehow paying the maintenance costs on it and not getting a return. So, each case has the same kind of anecdote, the same kind of story that is attached to it.

In the chairman's district, we have one which is a major one. That is about $45 million. Of the six clinics that we were looking at, that one is the largest and clearly there is a need. There is a need to open up this ambulatory care center so we can treat more people. We don't need to be putting people in the hospital to take care of their needs when we can do it in 1 day as opposed to having them in the hospital for 6 days.

Mr. GREEN. It is obviously cost-effective, and I think it is much better for the veteran as some of the health care providers have told me and they have that person. I guessed frustration on our level is when I asked, well, if we are going to restore those cuts, because I talked to Congressman Montgomery about it, and I know there are Members who are looking at it.

The word I had was that Congressman Solomon would cut National Service and they are already going to be held under the rescission package at this year's budget or last year's budget or the other side and Congressman Volkmer is going to use some NASA money that they don't need maybe for this year but they will need in the future.

So—but when I saw that rescissions come through and it was going against what I understood is happening in the private market of more outpatient care and it just seemed like it was not as good—well planned as it should have been, and from what you said, you read about them in the paper so, obviously, you weren't

contacted to say, OK, give us some priorities only where we can do some rescissions.

Mr. BROWN. To make sure the record was clear, I was contacted after it was done but at the same time, I have to be honest with you. I don't have any cuts to offer. I really don't.

One other point that I would like to make about this. If you go into many of our outpatient clinics and ambulatory care centers, they were built in the 1940's, 1950's and 1960's, are very, very small and now they are trying to accommodate a demand that is five and six times what they were built to do and that's primarily because whether you like it or not, we are moving away from inpatient care to outpatient care and now we are bulging at the seams and not able to accommodate them. That is why this package is so very, very important. It is the right thing to do.

Mr. GREEN. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Mr. SHAYS. Thank you.

Mr. Secretary, we are doing pretty well, but we would love to go around a few more and I think we can get you out of here by 2:30. This is very interesting. Candidly, it is the most interesting of all the hearings I have had so far in terms of thinking about why we should weigh in and how we can be helpful to you and even though there are only two Republicans now and not a member of the minority. You can handle yourself well, so you are in good company.

I would love to be real clear on something that is bothering me. I started to get into it and you can, Dr. Kizer, you can weigh in on this as well. I am intrigued by the questions about the benefits and that issue and we could pursue that, but I would love to just first finish the issue of throughout the country, we have extra bed space, significantly extra bed space. Why is it that we don't have extra bed space in veterans' facilities?

Mr. BROWN. Well, I am going to ask Dr. Kizer to respond, but before I do, I always have to get my 2 cents in before I turn it over to the experts.

It is very interesting, if you look across the years—let me go back and do a little history. About 2 years ago, 3 years ago, the former Secretary of Veterans Affairs tried to do what he referred to as a rural health care initiative because of so-called excess capacity in our hospitals. He wanted to open those beds up for nonveterans and it caused such a firestorm that not only did he lose his job, but the Congress made it known, I think, in a vote something like 90 to 3, something like that, that they were not going to have that kind of an approach.

And the reason for that is, I don't think most veterans are selfish to the point that they are saying we don't want to allow nonveterans in our hospitals, but what they were basically saying is this: How dare you lock the doors to me. You have created a criteria, an admission criteria that locked me out. I am getting Medicare and I just so happen to have an income of over $20,000 and you lock me out of the hospital, yet you are going to allow welfare recipients in. That is the first thing that was very distasteful.

The second thing is this: Is that if you look across the board, you will find that on an average, about 65 percent of our beds in the private sector are full.

Mr. SHAYS. Are what?

Mr. BROWN. Full. In the VA, it is about 74 or 75 percent. Now, what is driving this is that I think is what we have already discussed is that—it is very expensive to do business on an inpatient setting, so people and smart business folks, and the VA is following that line, they are doing business on an outpatient basis. That's one of things that is driving it. And by the way, in our 1996 budget when we are talking about renovating hospitals and so forth, at the same time incorporated in that is a 30 percent reduction in the number of beds that we already have.

Another point that I think is important—when we talk about excess——

Mr. SHAYS. Let me, on this one issue. You say a 30 percent reduction. In other words, we have reduced the number of bed space at veterans' facilities.

Mr. BROWN. I guess what I am saying is that in the 1996 budget request, when we ask for money to do renovation projects and primarily in minor construction, in those renovations we are going to reduce our beds by—on average, by about 30 percent. So that basically is saying to the planners, we expect to use less beds out in the future because we are moving toward providing care on an outpatient basis.

Now, OK.

Mr. SHAYS. I am going to remind you of the particular question, though. What I am wrestling with is that I am being told that hospitals are basically dinosaurs. In a sense I think we need them but we don't really need as many of them. Clearly we will go to outpatient and we will go to different design type of facilities, and we have 172 hospitals.

What I am trying to reconcile is the fact that I am making an assumption that right now we are at a certain level of capacity. I should first ask you what that capacity is or what are the number of bed spaces that we use versus our capacity, and get a sense of what your tread line tells you and you have told me something that I had not been aware of. I just had always made an assumption.

You are telling me—I had always known that we had an income base test for care at a veterans facility. I always made the assumption, always, of that any veteran could go, he just had to pay or she just had to pay. And you are telling me they can't even go, which boggles my mind. In the future, if we allow veterans who can't go to go and to pay, is the next step to making sure we fully utilize our hospitals?

Mr. BROWN. Well, see, and that was the point that I am getting at. See, when a lot of people talk about excess capacity in the VA, it's a false conception. It's false in the sense, sure, we may have some excess capacity there and that excess capacity is driven by efficiency and it is also driven by a deliberate attempt to restrict admission to our hospitals. And if we wanted to change that tomorrow, we can say, all right, anyone who, say, served during World War II can gain admission to our hospitals. We would be bulging at the seams. It has nothing to do with demand. It has to do——

Mr. SHAYS. I understand that.

Mr. BROWN [continuing]. We deliberately said we don't want you because we cannot get—don't have enough resources to staff these

beds so we have got to get beyond that. We have got to put that in its proper context. A lot of folks allege that we don't have enough market out there—we don't have enough people. We have more people to use our facilities than we can shake a stick at at this point.

Mr. SHAYS. You know what would be helpful because we are talking in generalities. I would love to get a handle on what those numbers are. And Dr. Kizer, could you give me a sense? Could you respond to this question as well? Or any other comment you want to make.

Dr. KIZER. If I understand your question correctly, typically the major limitation to getting into the hospital is the number of beds that might be available that are staffed. In many cases, there may be authorized beds at a facility because of staffing constraints, funding constraints that limit staffing. The other thing that is important to recognize about the VA is that about 30 percent of our beds are psychiatric beds for long-term mental illness and other mental conditions which is very different than in most private hospitals.

Mr. SHAYS. Let me ask you, if someone has a psychiatric challenge, that they would not have income? I mean, I could draw two inferences, I could say that if you have been a veteran, you have been faced with a lot of psychological challenges that have affected you and, therefore, you are going to have a disproportionate share who are, in fact, veterans.

Or I could say that given the way we allow entrance into our hospitals, that we have in a sense have weighted it toward people who have psychological challenges because they don't have income producing ability. You see the difference?

Dr. KIZER. I see perhaps a difference. There has been a conscious effort to try to provide care for veterans who have mental illness and to provide them the appropriate facilities so that they can be treated. As I know you are aware, there are many nonveteran persons with chronic mental illness who are wandering the streets in our society today. The VA has made an effort to at least provide a place for veterans who have mental illness to be taken care of in a more humane setting than the streets of our major cities.

So that is perhaps one of the reasons.

Mr. BROWN. Let me follow up on that, Mr. Chairman. When you talk about the process being weighted, it is weighted and it's weighted toward the poor, 60 percent of the people that we treat at our hospitals are poor. And if it were not for the VA hospital, they would be welfare recipients. The private sector doesn't want them because they don't have the ability to pay.

It's weighted toward the psychiatrically impaired and it's weighted toward them because they, too, because of the nature of their illness have been economically deprived. They don't have the resources and, in addition, nobody wants to be bothered with them primarily because they are hard to treat, they are hard to manage. If you look—and the list goes on, that we are providing care to people that the private sector does not want to be bothered with.

If you look at our nursing homes—go to any of our nursing homes—and you will see all those old fellows there, World War I, World War II. They don't have any money to be able to pay for

those kinds of services which we provide. So we again are taking care of them. We are their safety net and I think that we have an obligation to continue to do that because they have done so much for the Nation.

Mr. SHAYS. Connie, are you going to be here a little longer?

Mrs. MORELLA. I won't be here much longer.

Mr. SHAYS. Let me call on you. You don't need to be brief.

Mrs. MORELLA. Thanks, Mr. Chairman.

By late January 1995, each regional office was supposed to report its choice of model to the VA along with an implementation plan. This was going to be received in April and I am not sure whether or not the regional offices have provided their plans to the central office and where is it right now?

Mr. VOGEL. Mrs. Morella, they have in fact given those plans to the central office. They came through the area directors and on to me and we are assisting them with the adoption of various organizational models. Reason being, when you administer entitlement programs as we do, which are fairly heavily prescribed by law and regulation, they can in fact cause us to measure our operations and sometimes can be without the proper amount of creativity and imagination.

We are trying to move the regional offices, the people who do the loan guarantee work and provide GI education benefits, pension and compensation, and all the things you know so well into modes of operation which are based on teams with fewer hand-offs, more decisionmakers, and coordinating all of that is the reason we have delayed our schedule.

But I have all those models in and they are being reviewed now and adopted. One size doesn't fit all. The Secretary used that phrase a little earlier in his testimony. We help—allow them to profit from the mistakes of offices that have reached out and adopted some creative approaches to the management of claims work.

Mrs. MORELLA. Would you share with this committee, when you complete it, what the decisions have been? I realize one size does not fit all, but you know, the fact that you have received all of these reports, evaluated them, and given them prematurely to the various regional offices.

Mr. VOGEL. We would be pleased to share that with you, Mrs. Morella.

[The information referred to follows:]

The Veterans Benefits Administration is currently reviewing the regional offices' initial selections of claims processing models. The plans which accompanied the selections raised several critical issues which must be addressed from an administration viewpoint before proceeding further. Included among the issues are funding impact and adequate measures of success. In addition, the models must be integrated into the other reengineering activities currently underway within the Veterans Benefits Administration.

The Under Secretary for Benefits has established a Modeling Support Group to address those issues. The group will be responsible primarily for assisting in the selection, implementation and monitoring of the claims processing models at the regional offices. The group will review the models in concert with an analysis of the findings and results of the various claims processing studies, projects, and task forces conducted by or on behalf of the Veterans Benefits Administration.

The Modeling Support Group will convene initially on April 25. The purpose of the first meeting will be to define the scope of the group's mission and a schedule for fulfilling that mission. The Veterans Benefits Administration will provide a copy of that schedule to the Committee.

Mrs. MORELLA. I have a very specific question to ask that deals with what is happening with the renovation of plans for the blind rehabilitation center at Hines Veterans Center in Chicago.

Mr. BROWN. There, we are not really doing anything at this point. That caused a controversy primarily based on misinformation. The blind center today is housed in an old, antiquated building. We have a network there where we have Hines VA Hospital, West Side VA Hospital, and Lakeside VA Hospital. Then about 20 or 30 miles to the north, we have North Chicago. What we need to do, since all of them are general hospitals, in order to become more efficient, we need to look at are we maximizing the use of those facilities which are closely interrelated.

For instance, do we need five personnel offices there? For instance, do we need each one of them to have their own medical wards and, for instance, is that hospital—where the blind center is presently located—is that the best place for it? Should it be closer to the West Side where there is an international blind center? So what is happening is that we had a private consultant come in to take a look at all of these questions and that private consultant recommended that we move it, I think, to Chicago to the West Side. But we are not doing anything at this particular point other than just evaluating the entire question. And before we do anything, we will certainly be consulting with all of our veterans' organizations and we will provide this committee with information to give you an opportunity to state your views on it.

Mrs. MORELLA. So you think it is going to be moved—as you evaluate, moved to the West Side?

Mr. BROWN. No. No. I am going to let the facts dictate that. I would say if my memory serves me correctly, even if we decided to do something now, we are probably talking about closer to the year 2000 or so before any action could be taken whatsoever. But what we are trying to do as we manage, and this falls really in line with Dr. Kizer's concept, is that we need to look at our resources and see if we are using them efficiently.

And since Chicago is a magnet with all of these hospitals in the same general area and many of them with duplicate services, that it is probably time that we take a look at them and try to figure out which is the best way to proceed. And the blind center is part of that and we would certainly keep this committee advised.

Mrs. MORELLA. I think you lost six FTEs in Palo Alto, I understand, in your blind rehabilitation center there, too. I didn't know what you were doing to try to restore or what safeguard you may have in that regard.

Dr. KIZER. As I recall, and I am not as familiar with that particular situation as I should be, and we can get you a more detailed answer for the record, but as I understood it, there were about a half dozen positions that were temporarily redirected because of some decreased utilization of the service at that point in time.

I don't believe that those positions were permanently eliminated, though, from the staffing of that unit; I believe it had to do with workload adjustment. But, again, I am not as familiar with that as perhaps I should be, and we will check that and get you some additional information, if needed.

[The information referred to follows:]

The Western Blind Rehabilitation Center (WBRC) has continued to provide excellent rehabilitative training to blind veterans. This was supported by a recent report of a site visit by Ronald L. Miller, Ph.D., Blinded Veteran Advocate. The staff vacancy levels at the Palo Alto VAMC have fluctuated over the years. On October 1, 1993, the date which VACO Blind Rehabilitation Service has used as a benchmark for staffing levels, the WBRC had 48.3 authorized FTEE. Budget restraints have prohibited the medical center from filling all of the positions resulting in ongoing vacancies. The new authorized level is 46.3 FTEE with two vacancies. One of these vacancies is currently being recruited and it is anticipated that the second vacancy will be filled by mid-summer.

One of the reduced FTEE was the Assistant Chief of the WBRC, a position which was eliminated along with other assistant service chief positions in order to reduce management layering. Despite a very rigorous hiring freeze underway at the Palo Alto VAMC, the Director has permitted the WBRC to recruit and appoint staff. In order to increase the efficiency of the program, the Chief of the WBRC developed a streamlined organization which maintains the high standards of service to veteran patients while reducing the FTEE by 2.0.

Mrs. MORELLA. Thank you. I have a constituent who has taken a big leadership position in terms of blind issues with regard to VA.

Mr. BROWN. Just one other thing I would like to state for the record. We are so concerned about our blind veterans that I asked Ron Miller, who is the former executive director of the Blind Veterans Association to come on board with us to look at and make an in-depth analysis of our programs to make sure that we are doing what we should be doing. He is a veterans' advocate and is going to make sure that we respond appropriately.

Mrs. MORELLA. Very good. Thank you. I don't know whether, Mr. Chairman, you wanted to pursue at all the Persian Gulf injuries.

Mr. SHAYS. I would be happy to have you pursue that.

Mr. Secretary, do you have—we said until 3 and I would love to be able to go until 20 of. Is that a problem for you?

Mr. BROWN. I am at your pleasure.

Mr. SHAYS. The more you say, the more I want to ask you, but I will get you out of here by 20 of.

Mrs. MORELLA. Simply, Mr. Secretary. We hear so much about it. 60 Minutes did something on it. What are you doing with regard to the Persian——

Mr. SHAYS. Would you talk just a little louder?

Mrs. MORELLA. Yes. Persian Gulf Syndrome, or whatever you want to call it, when you have all those veterans that served over there and the ailments and nobody seems to want to take the responsibility for it, how are you handling this?

Mr. BROWN. Well, the 60 Minutes piece, I like—I'd really like to respond to this question because if people look very carefully and listen very carefully to what is happening, they are not beating up on the VA too badly. It is primarily DOD and I would like to think the reason for that is we at VA are doing some things right.

As I was explaining to the chairman, one of the things that I am very happy about is that we are being proactive on these issues. We could have taken a view as was done on Agent Orange and waited 20 years before we did anything for these young folks. Under our old criteria, we were only authorized to provide compensation for veterans that are suffering from disability as a result of disease or injury.

As a result of our legislation that was passed last year, we are now providing compensation for undiagnosed illnesses, for those

veterans who served in the Persian Gulf, and not only are we providing compensation, and that compensation ranges anywhere from $89 all the way up to $5,000 a month.

Not only are we doing that, we created a presumptive period of 2 years from the time they left the Persian Gulf. So if any of these symptoms develop within that 2-year period, we can grant compensation for them.

Second, I think it is very important we are providing medical care. All the Persian Gulf veteran has to do is to walk into any VA hospital and say, I think I am suffering from something that happened to me in the Persian Gulf and we will treat him as if it is service connected unless we find out that it is due to other causes. But that is the kind of outreach and easy access that we have created.

And the third thing, of course, we are moving forward very aggressively on research. We have over 40 research projects out there. That wasn't good enough for us, so we developed our own research centers. We have one in East Orange, we have one in Boston, and we have one in Portland. And they are going to be devoted exclusively to trying to figure out exactly what is wrong.

And I say to you that we are not going to take anything off of the table. We are going to look at everything. We are going to look at leishmaniasis. We are going to look at depleted uranium. We are going to look at possible exposure to chemical and biological agents. We are looking at the toxic problems related to the environment, such as the burning of oil wells and so forth. Nothing is off of the table. We think we are ahead of the curve on this.

Of course that doesn't satisfy our veterans and it shouldn't because we can't make them well. But what we can do is we can try to improve their quality of life and make their life as comfortable as we can until we find some answers, and find some answers we will.

Mrs. MORELLA. Sounds like they are getting some access and compassion and a look toward further assistance if necessary.

Dr. KIZER. I might just embellish what was said in a couple of ways. On the medical care side there are three categories basically of care that are provided. The priority care that the Secretary referred to. Any veteran who believes he or she has a problem related to Persian Gulf service can come into any VA medical center, state their problem, and they will be taken care of on a priority basis.

A second category is what's being provided through the registry. We have over 43,000 people who have signed up in the Persian Gulf Registry. Those are for individuals who have a complaint or who don't have a complaint but want to have an evaluation of their condition so that it is documented in case an issue does arise at some future time.

Finally, the third category is for those persons who, after an initial evaluation, has a condition that is not diagnosable. As you have probably read about 15 or 20 percent of individuals, to date, have not had a readily diagnosable condition. We have established a number of referral centers where they may then go for a very extensive work-up that typically involves a 7 to 14 day stay in the hospital, during which time they are completely worked up from head to toe and every place in between.

The other point I would add to what was said is that our outreach and education efforts have targeted both our professional caregivers as well as the public. We have a variety of printed materials that are being provided. The hotlines are fielding about 5,000 calls a week now. But we are also conducting conferences for our physicians and other professional caregivers to make sure they are treating all these people as reasonably close to the same manner as possible.

Mr. BROWN. One other thing that I would like to say, we have a standing offer on the table now that if anyone can come up with a suggestion that we should be doing something that we are not doing, we want to hear about it. We are serious about that. We are not about defending anything. We want to be as responsive as we possibly can, so that is a suggestion that we always make. If someone has a better way of trying to deal with this question, we want to hear about it. Or if we are doing something that we shouldn't be doing, we want to hear about that also.

Mrs. MORELLA. Thank you, Mr. Chairman, very much.

And, Mr. Chairman, I have got to add my comment that I think these overview hearings have been terrific, a great opportunity to get kind of a one-on-one, as close as you can be in a subcommittee, response. Thank you.

Mr. SHAYS. We really appreciate your being here. Thank you.

Mr. Secretary, the staff for the minority, Cheryl Phelps, would love to ask you a question if she could.

Ms. PHELPS. Thank you, Mr. Chairman. I appreciate this opportunity to speak on behalf of Democratic Members.

Mr. Secretary, and Dr. Kizer, I just have a couple of questions related to the Veterans Integrated Services Network. I understand that the VISN is your response to the NPR recommendation that you restructure your delivery system.

Conceptually, how do you see that working in terms of not just resources but coordination with other departments? What additional fiscal year 1996 funds are committed to that project and what are the one-time costs committed to that project?

Mr. BROWN. Let me just start out and then I will turn it over to Dr. Kizer. The whole effort here is that Dr. Kizer's vision, and I share it, is that management would be better coordinating what is going on in the field and allowing the people who are providing medical care to do what they should be doing, so that is one of the reasons why we are decentralizing our whole activity because we think that it is going to increase creativity. It is going to allow us to more efficiently use our funds by asking questions about all of the hospitals in one geographical network.

Are we using all those hospitals to serve our veterans so we get away from emphasizing one hospital competing with another hospital? Because all of them will be looked at as one unit, so I think that that is going to work well.

Dr. KIZER. Thank you. I should make a minor correction to your comment as a preface. This effort to restructure the Veterans Health Administration is being pursued because we want to do a better job in providing care for our veterans; it is not as a result of NPR. Though the rationale and many of the underpinnings are

certainly consistent with the National Performance Review, and these efforts should be viewed as complementary.

As the Secretary mentioned, there are a number of underpinnings to this effort. One of the basic conceptual differences is that we want to look at populations of veterans and how we can best allocate our resources in a geographic area to serve the needs of those veterans. This is consistent with the whole concept of integrated health care systems that is being pursued so feverishly in the private sector. We will look at aggregates of our facilities and how, working together, they can provide better access to care. Typically, a service network will have anywhere from six to nine medical centers, an array of freestanding clinics, long-term care facilities, domiciliaries and other assets. We want to look at how we can achieve efficiencies in providing the services.

How then can we turn those efficiencies into better access for our veteran beneficiaries in that area focusing particularly on community-based clinics and other facilities of that type? This structure also provides the benefits of what is also known as a virtual health care organization. This is another paradigm being pursued in the private sector with considerable vigor. This is a model in which one looks at their own assets and then how to complement those by different partnerships, strategic alliances, sharing arrangements with other providers to meet your particular needs.

For example, we currently have in place 670 sharing agreements with Department of Defense providers. We have in excess of 300 agreements with different academic partners, and we are looking at seeing how we can expand those with private providers, with State and local government, and with others when that will serve the needs of our veteran beneficiaries better than perhaps we could with our own particular assets. The key to this, though, is knowing what it costs to provide those services and then negotiating the best deal, both fiscally and what will provide the best medical care.

You asked specifically about costs and savings. You asked two questions, and I don't recall exactly what they were, but let me try to lump them together. We have designed the VISN catchment areas on the basis of existing patient referral patterns, aggregations of facilities, et cetera, basically along the lines of what makes sense having taken the conservative approach to efficiencies, per se. That is, we did not approach this as an exercise in cutting FTEs. We do believe, though, that there are significant efficiencies that can be achieved in the short term as well as in the long term.

Initially, with elimination of what appears to be duplicative administrative layers, we would expect to see elimination of 157 FTE, yielding an annual savings of about $9.4 million on a recurring basis. Because there will be some reallocation of staff and some job changes and other things that will be required, we anticipate that in the first year, i.e., in the year that we implement the plan, the savings will be offset by the costs of moving people, training and other things.

On an ongoing basis, though, we expect to see at least $9-plus million in savings. I think as we implement this plan, and as it works out, we will be able to achieve some other efficiencies and, hopefully, will be able to turn those into increased resources di-

rected to patient care, i.e., toward the actual delivery of care as opposed to administrative type people.

Ms. PHELPS. And this network includes the ambulatory care facilities that you were talking about earlier? It incorporates the transition from hospital care to outpatient?

Dr. KIZER. The Veterans Integrated Service Network, or what has become known as the VISN, includes all of our assets that we may have in a given area—medical centers, nursing homes, or other long-term care facilities, clinics, our vet centers, and anything else that I may have omitted.

Ms. PHELPS. One last question, Mr. Chairman.

One of my colleagues raises the question of the World War II nurses, what kind of treatment opportunities are they getting currently and how do you envision improving their access?

Mr. SHAYS. Let me just clarify it for my own mind. These are nurses who are considered veterans or not considered veterans?

Ms. PHELPS. Yes.

Mr. SHAYS. Are they considered not veterans?

Ms. PHELPS. These are the ones that are considered veterans.

Mr. SHAYS. OK.

Mr. BROWN. OK. I'm glad you asked that question because, historically, we have not treated our female veterans the way we should have, and I don't say this in a cynical way that people sit around a table and they conspire to not treat female veterans right. Female veterans constitute about 4 percent of the entire veterans population. But if we look at the active duty forces, we see about 11 to 12 percent of the active duty force are females and reserve is as high as 15 percent female. Ultimately they will become veterans so we need to move in that direction.

That is one of the reasons why many of our renovation projects are so important. I've gone to VA hospitals where we actually had to knock on the door and put the men out of the bathrooms to allow women to go do the bathrooms. That's an outrage. They served just like their male counterparts did. But we are making progress. We have women coordinators in all of our hospitals now.

And in addition to that, they actually have a stronger benefit now than the males because it is possible that a male veteran can be confused on whether or not he is going to get outpatient care or inpatient care. If a female comes in our hospital, into our system, they get everything. We have a women's clinic and the women's clinic in some of our facilities that takes care of them and the areas are really beautiful. And when they come in, they have OB/GYN specialists there and if we can't provide that care on an inpatient basis, we contract it out.

So it is a stronger benefit that is available to our female veterans, and we are trying very hard, through our outreach initiatives, to get that word out to them because we want to do the right thing and that is also why the 1996 budget and, quite frankly, the $206 million that were rescinded in the House for 1995 both are very important to us.

Ms. PHELPS. Thank you.

Thank you, Mr. Chairman.

Mr. SHAYS. Thank you.

Just to ensure that you do get out, I'm going to ask you to hit the 5 minutes and we will call it quits when this green light gets over in 5 minutes. If you could try to keep your answers a little shorter so I could cover a lot of different territory and, if we need, we can talk about them at greater depth later on.

I am just interested to know, first off, are the outpatient clinics a program where you have a special line item or where do you find outpatient clinic activity?

Mr. BROWN. Do we fund that in the major or minor?

Dr. KIZER. That comes out of the medical care budget and depending on how the clinic is aligned—i.e., whether it is part of a medical center or a freestanding entity—then the funding, or the genesis of the funding request, may differ. But basically it is out of the medical care appropriation.

Mr. SHAYS. Is this the decision of each veterans hospital whether they will have outpatient clinics or is this a regional decision or driven out of the central office?

Dr. KIZER. Historically, it was a decision that was a bit of both. I have recently—as you may know, issued a policy directive stating that we will be looking to increase our community-based presence through outpatient care whenever we can, within existing resources. This certainly puts the priority on outpatient care.

Mr. SHAYS. Dr. Kizer, I am still wrestling in my own mind to understand the whole concept of economies of scale? A hospital. We have authorized bed space. We have appropriated bed space. When you have a Medicare patient who is a veteran who has the resources to pay their own bill with their own insurers, we are now saying they can't be in a facility, a veterans facility which is news to me. I hope you are not shocked by it.

I expose my ignorance all the time by asking questions, but I learn. But I am struck by this fact. I am wondering, is there a disincentive to allow that on the part of the veterans or an incentive? Would it be a plus, financially, or a negative?

Dr. KIZER. Well, it would be a plus if one were able to recoup any of that. Currently, the Department does recoup about $560 million or so in third-party payment under our medical care costs recovery program. All of that money goes right back into the Treasury, however, it does not include any Medicare or Medicaid funds.

Obviously human nature being what it is, and other things, it would make much more sense that the facilities would be able to both recoup and retain a portion of that money and use it for things that made their institution and patient care better.

Mr. SHAYS. It just strikes me that there could be a happy marriage in this process that we could provide more resources, better utilize the facility. Are most veterans hospitals medium to large, are they medium to small, or is it hard to characterize them?

Dr. KIZER. We have a relatively small number that would be considered large tertiary care facilities. Probably the largest number would be considered midsized community hospitals, of 100- to 200-beds, although VA hospitals often have the additional psychiatric bed component. We have some facilities that are quite small.

Mr. SHAYS. Being over 250, you start to get economies of scale. Over 300, is there a magic number that doctors agree on?

Dr. KIZER. Actually, within an institution, it is much more complicated than that. It depends on where you allocate your fixed variable costs, and your indirects. Hospitals are high cost centers, and insofar as you can get away from using them, you should ultimately end up saving money, since hospitalization accounts for the largest amount of the health care dollars.

Mr. SHAYS. Would the issue of post traumatic stress disorder—one of the hearings I had in the full committee of then-Government Operations, national security was something that has haunted me, and I have never really found to my satisfaction—and I won't even give the statistic that was given to us—but a large number of Vietnam vets who came home and had this disorder and committed suicide.

Do we have any handle on the number of veterans from the Vietnam War who have taken their own lives?

Mr. BROWN. Yes. I think we have our own research center that looks at that kind of issue. We have about 500,000 of them that we have identified and we treat about 20 percent of them. I am sure we can get some information on that question to you, Mr. Chairman.

Mr. SHAYS. The statistic was so large, it almost seemed to duplicate the number of veterans that we lost during the war, not committed suicide in the hospital, but just in general, just taking their own lives.

Mr. BROWN. I understand. We will get some information to you.

[The information referred to follows:]

A study in the American Journal of Psychiatry, June 1990, indicated that fewer than 9,000 suicides occurred among all Vietnam veterans from the time of discharge through the early 1980s. This contrasts with unsubstantiated reports of up to 100,000 such suicides. However, VA researchers have concluded that Vietnam veterans who were hospitalized for wounds or who were wounded more than once had statistically significant increased risk for suicide. This information is used by members of VA's psychosocial services to help identify hidden emotional wounds and stop preventable deaths.

Mr. SHAYS. You all three have been very cooperative and very helpful witnesses, and Mr. Secretary, we will probably not need to call on you and your valuable time, but it is possible that Dr. Kizer and Mr. Vogel, that we will be asking you to come before the committee again.

And I just want to state for the record our intention will be to work with you to help you do the job we have requested you to do as a Congress and the American people, and we are very grateful for the services of all three of you and we are very grateful that you came here today.

Thank you very much.

Mr. BROWN. I would like to say, Mr. Chairman, I think you know I have nothing but the deepest respect for you since I first met you.

Mr. SHAYS. Since you first dissed me the first time.

Mr. BROWN. I think you are a wonderful person, and I want you to know that anything I can do to cooperate with you to achieve your goals, I am ready to do that, sir.

Mr. SHAYS. Thank you very much. Thank all three of you. This hearing is adjourned.

[Whereupon, at 2:45 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

QUESTIONS SUBMITTED BY HON. MARK E. SOUDER AND ANSWERS FROM MR. BROWN

Question: I am concerned regarding the proposed integration of a Veterans Administration Medical Center located in Fort Wayne, Indiana with another located in Marion, Indiana. I fully support efforts to provide cost-effective, quality medical services for the veterans who have served our country so well. And, I understand that increasing administrative costs have reduced the ability of the Department of Veterans Affairs to provide services at the level of quality it has traditionally provided American veterans.

My concern rests not with the necessity of more cost-effective efforts, but with the process in making the decision to integrate the services of these two facilities. Specifically, I would like to know more about what factors are considered in making a decision to integrate the services of two Veterans Administration Medical Centers. For example, is the size of the city in which the facility resides a consideration? Is the number of potential veterans to be served by the facility considered? Is the proximity of an alternate VAMC of importance? Finally, are the ages and conditions of the facilities involved a factor upon which to make a decision such as this?

Answer: The process used to plan for the integration of medical centers is predicated upon maintaining and expanding (to the extent possible) high quality services to veterans while streamlining operations. It is expected that the medical center integrations will make the continuum of care provided to veterans more accessible and cost effective. As a direct result of the integrations, resources currently dedicated to redundant administrative functions will be shifted to enhance direct, hands-on patient care activities to the maximum extent possible.

Four major factors entered into the decision to integrate these two facilities: complementary missions, history of shared services, shared patient base, and distance between facilities.

- Complementary Missions: One major factor in the decision to integrate VAMCs Marion and Fort Wayne is the complementary missions of these two medical centers. Fort Wayne VAMC, which currently operates 95 hospital and 53 nursing home beds, provides primary and secondary medical and surgical care. Marion VAMC, which currently operates 450 hospital and 69 nursing home beds, provides primary and secondary medical care and all levels of neuropsychiatric care. A new 240-bed psycho-geriatric nursing home care unit is under construction at Marion, which will be activated from the conversion of 171 hospital beds plus the existing 69 nursing home beds.
- History of Shared Services: Another factor taken into consideration is the history of shared services between the two sites. For example, Fort Wayne VAMC has no inpatient and very limited outpatient psychiatric capabilities and has traditionally relied on the Marion VAMC for these services. Marion VAMC, having no inpatient surgical capabilities, has historically referred patients requiring primary surgery to the Fort Wayne VAMC.

  The implementation of a single, unified computer system will provide clinicians at each location with seamless access to shared patient data. Opportunities are currently being explored to implement a telemedicine computer system linking clinicians at each location to further enhance the timeliness and quality of diagnostic and patient treatment activities.
- Shared Patient Base: The long-standing inter-relationship of these two medical centers is illustrated by their shared patient base. Approximately 28 percent of the unique patients served by each are shared with their integration partner.
- Distance Between Facilities: The distance between the Fort Wayne and Marion VAMCs is 65 miles. This relatively close proximity has undoubtedly contributed to the existing levels of cooperation and coordination.

In this case, neither the size of the city nor the number of potential veterans to be served were taken into consideration when making the decision to integrate these facilities; neither would impact the success or failure of implementation. These factors are taken into consideration when localized facility planning takes place, such as determining programmatic needs, staffing ratios and bed levels, and will continue to be used in specific planning efforts for the integrated entity. The age of existing buildings was also not considered, because it would not impact the potential for successful integration. The Department of Veterans Affairs construction process continually assesses the condition of its buildings and provides for their upkeep as needs arise.

The goals for this integration include a unified vision and mission between the facilities, a full continuum of care to veterans not currently available through each facility separately, enhanced continuity of care to veterans, and one standard of care enveloping quality and access. Upon implementation of the integration, the facilities

will be able to offer more services to veterans, bring their care closer to home and raise the standard of care provided to patients.

Specifically, it is anticipated that veterans served by the facilities will also experience the following benefits: decreased waiting times for clinical appointments due to improved scheduling, increased primary care clinics and coordination of care between the integrated facilities; more choices of physicians, care providers and a wider scope of services provided by an integrated staff; better coordination of patient transfers and referrals between physical locations and timely admissions processing; potential development of additional clinical services based on savings achieved through streamlining; and enhanced access to primary care services which would be initiated with savings generated from reducing or eliminating duplicative activities.

DEPARTMENT OF VETERANS AFFAIRS

TUESDAY, MAY 9, 1995

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:37 a.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Souder, Morella, Davis, Chrysler and Towns.

Majority staff present: Lawrence J. Halloran, staff director and counsel; Doris F. Jacobs, associate counsel; Kate Hickey and Robert Newman, professional staff members; and Thomas M. Costa, clerk.

Minority staff present: Ron Stroman, deputy staff director; Cheryl Phelps, minority professional staff; Liz Campbell, staff assistant.

Mr. SHAYS. I would like to call this hearing. I'm going to ask you to sit down to start. I'll ask you to stand up in a second.

It's nice to welcome our witnesses and to welcome our audience and to begin this second oversight hearing on the Veterans Administration. We are pleased to have the Veterans Administration Inspector General, the General Accounting Office and two representatives, a representative of the Paralyzed Veterans of America and from the Disabled American Veterans. We appreciate the fact that all of them will be here. We'll have two panels, and our first panel is seated.

In a recent report on its restructuring plan, the VA stated that, "If the veterans health care system is to remain available viable, it must fundamentally change its approach to providing care. The need for structural change is acute."

The GAO, however, is expected to state that the veterans organization plan does not go far enough. Their plan needs clearer, more cogent focus. It needs to put less emphasis on its hospital facilities, in my judgment, and put more resources into developing a first-class outpatient system. The focus needs to be on improving the quality, not the quantity, of inpatient care and on expanding cost-effective outpatient services.

It's time for the VA to chart a new course as it moves toward the next century, and our committee looks forward to playing a role in that regard.

[The prepared statement of Hon. Christopher Shays follows:]

PREPARED STATEMENT OF HON. CHRISTOPHER SHAYS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Welcome to all our witnesses. The purpose of today's oversight hearing is to examine opportunities for improved efficiency within the Department of Veterans Affairs, with an emphasis on the department's health care system.

This is the second oversight hearing on the VA. In the first hearing held March 13, our witness was the VA Secretary, Jesse Brown. His testimony included discussion of VA's mission and his plans for streamlining the department.

To help the Subcommittee identify some of the challenges facing the VA in meeting its important mission, we are pleased to have the VA's Inspector General, the General Accounting Office (GAO), and a representative of the Paralyzed Veterans of America. We appreciate the time, interest and recommendations of each witness.

We anticipate hearing testimony about the VA plan to restructure its health care system. We need to learn why the VA lags far behind the private sector in improving the efficiency of its hospitals. We also must evaluate whether its plan would place the VA in direct, potentially destructive, competition with private sector hospitals for dwindling numbers of patients.

In a recent report on its restructuring plan, the VA stated that "if the veterans health care system is to remain viable it must fundamentally change its approach to providing care. The need for structural change is acute." The GAO, however, is expected to state that the VA reorganization plan does not go far enough. The GAO will conclude that "without intervention, use of VA hospitals will likely continue to decline to a point where VA's ability to provide quality care and support its secondary missions will be jeopardized."

Based on today's testimony, I am calling for an immediate reappraisal of the VA's strategic plan. Their plan needs a clearer, more urgent, focus—it needs to put less emphasis on its hospital facilities and put more resources into developing a first class outpatient system. The focus needs to be on improving the quality, not the quantity, of inpatient care and on expanding cost effective outpatient services.

I also believe that the VA should target those patients who are low-income veterans with service connected disabilities. They are the VA's key constituents who deserve the fullest attention and the commitment of most of its resources.

It seems to me that the VA often displays an institutional bias in favor of hospital care and facilities. Outpatient care, in the opinion of experts, is more cost effective and it is obviously the direction in which the rest of the health care world is moving.

It's time for the VA to chart a new course as it moves toward the next century and I call on the department to reevaluate its plan to restructure the VA's health system.

Mr. SHAYS. Before swearing in our witnesses, I invite the ranking member, who has just been a pleasure to work with, Mr. Towns, to make an opening statement.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Thank you for providing the committee this occasion to examine opportunities for improving program efficiencies at the Department of Veterans Affairs. I appreciate your leadership on this issue. This hearing could not be more timely or more critical. As the international community concludes its commemoration of the 50th anniversary of the end of World War II, we here at home are reminded of the tremendous debt this Nation owes to its veterans, and sometimes I think we forget it.

The Department of Veterans Affairs should embody our national commitment to honor and support our veterans, their families and their survivors. However, the VA's ability to sustain its mission of providing medical care for veterans and functioning as a safety net for veterans with low income is faced with increasing pressures. Without a doubt, this is an agency in urgent need of reform if it is to fulfill its obligation to the American veterans.

Earlier this year, VA Secretary Brown presented the agency's 1996 budget request, streamlining the reinvention priorities and efforts to correct programs and operational deficiencies. The Sec-

retary's testimony affirmed the commitment of the administration to confront the challenges to the VA.

Mr. Chairman, in light of the administration's goal to reform the VA, I am deeply concerned by the Inspector General's testimony that although major portions of the VA have been under reorganization during his 5-year tenure he has seen no significant change or improvement in the VA operations. This discouraging revelation underscores the question central to this hearing. What must be done to ensure that real and meaningful reform is carried out by this agency? I hope we can come closer to the answer here today.

Today's meeting allows the committee to consider the recommendations of the Office of Inspector General and accounting—and GAO office—as well as the views of one of the major—of two major, I should say, veteran organizations on initiatives to restructure the resources and management of the Veterans Health Administration.

We're all concerned about GAO's findings critical of the current structure of the VA health care delivery system. An April GAO report identifies several problems related to access and efficiency of care and finds that many veterans have health care needs that go unmet because of these problems.

One major factor appears to be the VA's complex eligibility requirements which limit the services veterans can get from the VA facility and prevent the VA from evolving from expensive inpatient care to less expensive outpatient care settings.

Four of the major veterans service organizations, including the organization—actually, two of the organizations represented here today have called for the Congress to reauthorize the VA to reform eligibility criteria to allow veteran patients to receive care in the most appropriate setting. This legislative action, they say, will save taxpayers $2 billion. That's B as in boy. I hope to explore the feasibility of this recommendation with all of our witnesses.

Finally, Mr. Chairman, I'm encouraged by the IG's appraisal that the organizational shift from regions to veteran integrated service network is a step in the right direction toward reform of the VA. However, the IG cautions that the VA must put in place criteria for performance measurements if the reorganization is to be successful.

The IG also raises other concerns regarding opportunities for improvement in the construction management, procurement practices and budgeting and allocation of resources. I look forward to a candid discussion of these matters.

Mr. Chairman, I thank you for the opportunity to participate; and also again may I say, even at the risk of repeating myself, I appreciate your leadership on this issue.

I yield back.

Mr. SHAYS. I thank the gentleman. It's wonderful to work with him. And we welcome Mr. Tom Davis to the hearing. We are going to be swearing in our witnesses and taking testimony.

Mr. DAVIS. No statement.

Mr. SHAYS. I ask unanimous consent that all members of the subcommittee be permitted to place any opening statements in the record and that the record remain open for 3 days for that purpose. Without objection, so ordered.

I also ask unanimous consent that our witnesses be permitted to include their written statements in the record because they will all be summarizing. Let me say that the full statements have been very helpful for our staff in preparing us for this, so I'm very grateful that you've given us in-depth comments. But for the purposes of this hearing, to be able to ask you questions, it's helpful to have you summarize.

For the record we have Stephen Trodden, who is the Inspector General, U.S. Department of Veterans Affairs, accompanied by Michael Sullivan, who is the Assistant Inspector General for Auditing. We also have David Baine, the Director of Federal Health Care Delivery Issues in the General Accounting Office, accompanied by James Linz.

And I am not sure, you're the Assistant Director?

Mr. LINZ. For Federal Health Care Delivery.

Mr. SHAYS. For Federal Health Care Delivery. OK.

STATEMENT OF STEPHEN TRODDEN, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MICHAEL SULLIVAN, ASSISTANT INSPECTOR GENERAL FOR AUDITING; AND DAVID BAINE, DIRECTOR OF FEDERAL HEALTH CARE DELIVERY ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JAMES LINZ, ASSISTANT DIRECTOR, FEDERAL HEALTH CARE DELIVERY

Mr. SHAYS. It's nice to have all of you here. If you would stand up and raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. For the record, the witnesses have all answered in the affirmative.

And, Mr. Trodden, we welcome you beginning this hearing. And thank you for being here.

Mr. TRODDEN. Thank you, Mr. Chairman, members of the committee. It is my privilege to be given this opportunity to share with you what might be called the state of VA from an IG's perspective.

As the Chair has noted, my prepared statement is admittedly lengthy, and I will not try to condense it even into a 5-minute opening statement. It was intentionally comprehensive, and I hope it has provided the committee food for thought, both in preparation for this hearing and in any subsequent deliberations.

Mr. SHAYS. I'd like to affirm that it has and gratefully received.

Mr. TRODDEN. Thank you, Mr. Chairman.

So for ease of reference to the follow-up questions of this committee, I will simply say here that my statement has three principal parts. The first segment deals with opportunities to improve programs and cut costs, the second segment deals with resource allocation issues, and the third segment deals with oversight and accountability issues.

In the first section, I deal with construction management, Worker's Compensation issues, acquisition, information resources management, affiliation issues, and what I call the stovepipe mentality in VA.

In the second section, I deal with some political and fiscal realities, resources versus workload imbalances, the staffing and utili-

zation of medical facilities, surgical program issues, physician staffing issues, and performance-based budgeting.

And in the final section, I deal with the goals and performance accountability, cost accounting, information collection and assessment, the integration of financial and operational information, performance measurements questions and also the issue of the VHA reorganization.

Mr. Chairman, this is clearly an ambitious agenda. As you permitted, I request that my entire statement be entered into the record. Mike Sullivan will help me try to address the committee's questions.

I'll only say in closing that you probably noticed that my statement is a mix of concrete VA-specific issues and issues that have a broader managerial context. If there is an overarching theme to my remarks, it is that VA and probably the U.S. Government as well is struggling to adapt to societal changes, budgetary pressures, and the requirements of law such as the Chief Financial Officers Act and the Government Performance and Results Act. And they're struggling with these things in an effort to become more cost-effective, more businesslike, more analytical, while at the same time maintaining the Department's commendable veteran focus. I encourage the Congress to maintain its push in these areas and to incentivize the Department to make progress.

One ad-lib, if the committee would permit.

Mr. SHAYS. Sure. You can have more than one ad-lib.

Mr. TRODDEN. In response to Mr. Towns' comment——

Mr. SHAYS. Could you just bring the mike down a little bit? I think it will pick up your voice better.

Mr. TRODDEN. Is that better?

Mr. SHAYS. I think so. As close as you can get to it.

Mr. TRODDEN. OK. In response to Mr. Towns' opening remarks—I'm not going to back away from my opening statement, but hearing it cold, where I talked about no progress, I want to make sure that the context of those remarks that I had in mind when I wrote them was primarily in the issue of central office vis-a-vis field management relations, the extent to which VA is an integrated system of health care, while at the same time properly delegating to the field level the implementation of health care delivery. And so, the lack of improvement that I referred to in my statement was in that area.

I do not mean to suggest that the Department hasn't made significant progress in other areas, both on their own and in response to IG recommendations. I have a number of examples that, in the questions and answers, I think I can properly give the Department credit for having made improvements in response to IG reports and IG recommendations.

My concern, when I made the more global statement, was in this entire area of central office versus field, centralized management versus decentralized policy execution, and I hope we can explore that issue further. So, with that, I'll close and permit the committee to move on.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Trodden follows:]

PREPARED STATEMENT OF STEPHEN TRODDEN, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

I am pleased to be here today to comment on opportunities for improving the management and programs of the Department of Veterans Affairs (VA). Some of these opportunities reflect situations that VA has been experiencing for years. Others have emerged more recently in response to government-wide initiatives aimed at reforming the way Federal agencies conduct business.

These are opportunities that will enable VA to improve program performance, enhance customer service, and ensure greater accountability on the part of management for achieving results. They also will enable VA to reduce costs and use available resources more efficiently.

Taking advantage of many of these opportunities will be difficult. In some cases, VA will be faced with the challenge of changing the way it has functioned for a long time. VA has already begun to take a hard look at the way it does business and, as a result, is currently in the process of reorganizing, streamlining, and reforming many of its programs and processes. VA is to be applauded for these efforts. However, even though VA has made progress in the past few of years, it is my opinion that more can and should be done.

The National Performance Review (NPR) created a challenge to reinvent the Federal government. Each manager is being challenged to become more entrepreneurial and customer driven. We are all being asked to take a hard look at what programs produce and to develop innovative proposals to enhance overall performance.

The line has been drawn between an outdated bureaucracy and modern business practices. Crossing this line will require profound and deliberate change. To achieve this change, we first must be willing to question everything we do, and ask ourselves if there is a better way. This should not be done within the confines of existing legislative and regulatory restrictions. If changes in the laws that govern programs are required to achieve excellence, then we should seek legislative changes.

We must transcend cultural attitudes if they resist change in favor of preserving the status quo. Nothing can be sacrosanct. We must be willing to put aside parochial interests and work together to develop organizations and programs that are based on quality management and sound financial principles for the common good of the veterans we serve.

While the time for change has arrived, we need not rush. It is important that this change be tempered with wisdom and experience. The course VA takes now will determine how efficient and effective it will be for years to come. Throughout my testimony, I will be commenting on some of the changes that VA is implementing, such as the reorganization of the Veterans Health Administration (VHA), and discussing other opportunities for change that VA and Congress need to consider as VA plots its course for the future.

Many of these opportunities have been identified in specific oversight work done by my office. Other opportunities reflect issues that have been developed in collaboration with VA management as part of my long-term strategic planning process. These issues are offered as areas for consideration in helping VA reinvent itself. I will discuss these opportunities in the context of the following three areas of opportunity.

I. Opportunities to Improve Programs and Cut Costs

II. Opportunities to Improve Accountability Over Budgeting and the Allocation of Resources

III. Opportunities to Improve Internal Oversight and Enhance Accountability in a Decentralized Organization

It is important to note that developing a framework for benefiting from these opportunities does not rest solely with VA or the Office of Inspector General (OIG). Congress also has an important role to play in helping VA overcome some of the legislative and political hurdles it faces with respect to implementing needed reform.

I. OPPORTUNITIES TO IMPROVE PROGRAMS AND CUT COSTS

In recent years, my office has issued many reports involving VA activities that I believe get to the heart of good management. I would like to take this opportunity to highlight specific reports and offer some observations about the relevance of these reports in a broader context. In this section, I will address opportunities to improve programs and cut costs in the following areas:

* Construction Management
* Workers Compensation
* Acquisition
* Information Resources Management
* Affiliation Related Issues

* "Stovepipe" Mentality

I will also share my thoughts concerning the need to further ingrain the "One VA" concept into the management culture of all VA components in an effort to improve services and reduce costs. It is important for VA to get away from what I label as a "stovepipe mentality" in order to more effectively address objectives and goals for solving problems that transcend component boundaries.

Construction Management:

VA's construction program has not always provided appropriate facilities at reasonable costs. During the past 5 years, my office has issued 13 audit reports identifying VA construction projects which experienced significant cost overruns, resulted in too much capacity, and provided unneeded services. These problems resulted because construction projects were not being adequately planned, administered and supervised by key personnel at central office and Veterans Affairs Medical Center (VAMC) levels.

In response to these problems, VA has reviewed its building delivery process and organization. These reviews have identified many areas where improvements could be made. For example, VA's 1992 Cost and Standards Study, Phase II identified the need for improvements in areas such as project planning, design, and management. As a result, VA has initiated organizational and process changes to improve management of the construction program.

Reviews continue to disclose management and cost overrun problems. For example, a 1993 report by the General Accounting Office found that although VA strengthened many aspects of its construction program, VA construction costs are still too high because (a) projects exceeded program needs, (b) less-costly alternatives were given inadequate consideration, and (c) certain factors that affected demand for VA health care services were not considered.

Recent OIG oversight efforts determined that construction management problems continue and that construction funds are not being managed economically and efficiently. Some of the problems noted by my office include:

* Lack of continuity with respect to construction management teams for managing and overseeing entire construction projects from start to finish.
* Poorly supported construction decisions justified by erroneous and exaggerated workload projections that result in excessive space authorizations and higher construction costs.
* Lack of controls over expenditures and the availability of multiple sources of funding for projects inhibit effective oversight over the construction program.
* An excessively long budget and planning cycle which inhibits planning, design, and cost estimation.
* Ill-defined project scope, poor or incomplete construction design, and frequent mid-course change orders for unneeded items result in cost shifting and costly contract delays.
* Divided accountability between central office and the local facility for construction projects.

A recently completed OIG audit of a major construction project at one VAMC noted several significant problems including (a) specifications and other provisions of the construction contract being treated as guidance not requirements, (b) the contract being awarded with the knowledge that the drawings and specifications were defective, and (c) failure of VA to adequately supervise and monitor the construction project. These problems contributed to significant cost overruns, improper reprogramming of funds to cover the shortage of construction funds, and inferior construction.

In an ongoing review of a construction project at another VAMC, poor planning, improper management, and lack of controls have resulted in cost overruns in excess of $15 million. If sufficient funding is not made available, the project will have to be scaled down, which will impact negatively on VA's ability to fully utilize what has already been constructed.

In my opinion, many of the problems that exist today stem from VA not fully implementing recommendations from prior studies and reviews. My office is currently conducting a review of VHA's construction management program. This review will include further evaluation of actions taken in response to VA's internal review. and include recommendations for additional opportunities for improving VA's management of its construction program.

I believe improving the management of VA's construction program, thereby exercising better oversight and control over all aspects of each construction project, is an opportunity for VA to improve Program Performance and reduce spending.

Workers Compensation:

With about 230,000 employees and a budget of $38.2 billion, there are many areas where opportunities exist to enhance program performance and cut costs. One such area is the Office of Workers Compensation Program (OWCP), also known as the Federal Employees Compensation Act (FECA) program. In VA, this program is significant both in terms of human resource costs, and medical and compensation costs. FECA costs incurred by VA through the period ending June 1994 exceeded $142 million for over 27,000 injured employees, accounting for over 8 percent of the $1.7 billion in FECA costs Government-wide.

An OIG audit of the VA FECA program disclosed that VA employees who were capable of returning to work after an on-the-job injury continued to receive FECA benefits because VA was not monitoring injured employees' fitness for duty. My office projected that about $11 million of FECA costs could be saved in FY 1995 and an estimated $194 million in future FECA costs could be avoided by returning work-capable claimants to work.

FECA program administration recently has been decentralized within VA, with program responsibilities being carried out at the local level (e.g., VAMCs). During the first quarter of FY 1995, program officials informed OIG staff that VA is now tracking OWCP cases. VA's Office of Management, in cooperation with other VA offices, has established a management information system with the capability of providing current information about each claimant. This information will come directly from the Department of Labor. As of now, this remains a pilot program at fourteen VA sites. If this program is successful, expanding it, to ensure that all claimants capable of returning to work do so, is an opportunity for VA to save millions of dollars.

The foregoing comments were made from the perspective of the VA. In a much larger context, the Congress might want to take a look at the wisdom of one Department (i.e., Labor) spending, in effect, other Department's resources.

Acquisition:

Taking advantage of VA's purchasing power is an area where there are opportunities for savings. Private sector business practices have long recognized the purchasing power of large quantity buys. Simply put, the more you buy, the better price you should receive.

Within VA, the limiting factors in achieving cost savings in this area have been two-fold. One, VA in the past has tried but never been fully successful in implementing an automated tracking system that captures how much of any one item VA is buying during the year. VA has, however, recently placed a system in operation that shows considerable promise in resolving this problem. Without reliable historical data, contracting officers have a difficult time developing solicitations for large buys since they do not know how much had been purchased and how much is needed throughout VA and the rest of the Federal government.

Secondly, the medical profession has historically been given a free hand in determining which drugs, supplies, and equipment it prefers to use. This has resulted in each facility purchasing what it wants without consideration of the economies of scale that can be realized by consolidating VHA-wide purchasing decisions.

Preserving the flexibility to purchase drugs, supplies, and equipment is advocated by VA in the name of better patient care. I fully support preserving this flexibility for individual patient cases when the difference means providing quality care. However, there is an opportunity for VA to consolidate purchases and negotiate contracts based on known or reasonable anticipated needs.

Consider pharmaceuticals, for which VA spent close to $1 billion in FY 1994. This level of expenditure provides VA with the leverage to negotiate large purchases at substantial discount. VA, however, does not always receive the best price and millions of dollars in annual cost savings are not realized.

VA relies on the Federal Supply Schedule (FSS) contracting process to purchase the bulk of its drugs, medical supplies, and medical equipment. FSS contracts give physicians and nurses a broad choice with some contractual safeguards to ensure VA receives the same or better prices than comparable customers. These safeguards, however, do not always ensure that VA receives the best price. My office recovers millions of dollars annually from contractors who are overcharging VA. During the past 2 years, my office has recovered over $28 million from post-contract award audits and investigations.

Notwithstanding the fact that this is a considerable amount of money, representing almost the OIG's entire annual appropriation, there were millions of dollars in savings that VA was unable to realize because of failure by VA contracting officers to obtain the lowest possible price. As an example, OIG audits of pharmaceutical contracts found that VA contracting officers routinely chose wholesalers as the cat-

egory of customer for comparability when negotiating the FSS price. There are, however, other groups of buyers that receive greater price discounts, such as national accounts or state and local governments.

In the past, VA has been told by the contractors that VA was not comparable to national accounts, for example, because VA could not negotiate to purchase specific quantities or dollar amounts. Part of the reason for this is that VA was unable to identify how much it needed because it did not have reliable, historical data on amounts purchased in the past. VA's automated tracking system should solve this problem and allow VA to negotiate much larger purchases than it has in the past.

In many cases, the best prices are given to customers who commit to large quantity buys. In other cases, customers who purchase full product lines are given larger discounts than those who purchase a few products. Accordingly, I believe that national VA contracts, as opposed to each VA medical facility buying for its own needs, can be negotiated at a lower price based on buying practices across the entire VA health care system with commensurate larger buys.

VA also needs to become more creative in negotiating the best possible terms. For example, VA could negotiate better pricing by using tiered pricing structures which provide larger discounts as incentives for purchasing in larger quantities.

VA needs to do a better job of identifying and purchasing more cost effective items. For example, in a recent OIG audit, it was determined that better communication among VA medical facilities about the results of drug research and which drugs are cost effective would produce about $44 million in cost savings annually. Some VAMCs identified cost effective drugs to use in their drug formularies, but had not shared this information throughout the VA medical system. Therefore, some patient treatments were more costly because the treating physicians were unaware of cost efficient substitute drugs, many of which could have been purchased in large quantities, resulting in even further savings for VA.

Developing cost effective drug formularies is not an attempt to limit the flexibility of physicians to select the most appropriate drugs for their patients. Rather, it is an attempt to identify cost effective drugs that satisfy the treatment needs of veterans that can be used throughout VHA in large quantities.

To achieve maximum concentration of VA's buying power, I believe consideration must also be given to standardization of drugs, medical supplies, and medical equipment, to the extent practicable, across the entire VA health care system. This is not to suggest that some bureaucrat in Washington should dictate to VA surgeons what sutures should be used. VA needs to track what it uses and then allow VA's surgeons and nurses to collectively settle on a limited range of products, that best meet their needs and that concentrate VA's buying power to the maximum extent possible.

The benefit of standardization and large purchases is illustrated by VA's decision to purchase I.V. solutions. VA concluded that I.V. solutions are generic, and that economies of scale could be realized by large buys of a single brand. VA solicited a competitive bid to purchase I.V. solution for all of VHA. The net effect was a savings of over $65 million during a 6-year period (1988-1993) on this item alone.

Information Resources Management:

VA's use of information resources management (IRM) is critical to controlling costs and improving the performance of VA programs.

However, consistent with VA's policy of centralized direction, and decentralized implementation, each VA organization has evolved an infrastructure to address its own IRM needs. This has resulted in fragmented and untimely policy development and systems being developed independently of one another without consideration of sharing of information.

VA automated information systems currently:

* do not provide VA management with needed information for effective decision-making,
* are not integrated,
* are difficult to use and increase the time necessary to respond to veterans' needs, and
* adversely affect the accuracy, relevancy, timeliness and completeness of VA data.

To attempt to foster communication and cooperation and to strengthen IRM efforts within VA, the Chief Information Resources Officer (CIRO) for VA has established both a Senior IRM Steering Committee and a Senior Information Resources Management Council. One of the most serious impediments to unified service delivery is the inability of VA offices to access each others' data bases or to share information of veteran status among field stations. From the veteran's perspective, this results in multiple independent contacts on issues vital to the veteran's health and

welfare, frustration in dealing with multiple service providers who appear unaware of the veteran's treatment status or situation elsewhere in VA. This results in unacceptable delays and fragmented and duplicative efforts on the part of VA in serving veterans.

As automation has progressed, difficulties associated with systems that share data and technology among VA organizations have increased. Changing needs and multiple architects have made many existing systems overly complicated and difficult to maintain. Most of these systems are aging and becoming costly to maintain.

The vast majority of VA IRM systems remain independent and serve limited, parochial interests. For example, VA currently operates four distinctly different main data centers in support of agency users. Each center provides computer operations support to specific communities throughout VA. The Under Secretaries for VHA and Veterans Benefit. Administration (VBA), and the Director for the National Cemetery System (NCS) are responsible for overseeing their own systems. These systems were developed with little consideration of interconnectability and interoperability.

In addition to the individual systems, significant IRM initiatives are currently underway within VA that highlight the critical need to accomplish the coordination and cooperation that everyone recognizes is necessary. VA is implementing a single, integrated financial management system; developing a Master Veteran Record to improve the management and delivery of services to veterans; and replacing the 25-year-old Personnel and Accounting Integrated Data System with a modern Payroll and Human Resources system.

VA decided that the emphasis on cooperation and coordination is necessary because of the long experience in VA with stovepipe systems development, lack of compatibility in information throughout VA, and lack of central oversight and decision-making authority relative to IRM issues.

Under the current VA organization, the CIRO, who is responsible for coordinating IRM functions in VA, has no ability to ensure that VA organizations adhere to the policies issued by this office or meet the standards for the development of new systems.

Under the "One VA" concept, all systems should be able to share data. Without a strongly coordinated IRM function, there is no assurance that all systems will communicate to the benefit of the veterans we serve. I recognize that there are many competing interests in VA activities. But, VA exists first to serve veterans and VA efforts should focus first on ensuring that their needs are met. In this time of reform, VA should take the opportunity to reconcile all the competing demands and chart a course which makes optimal use of available information management resources.

Affiliation Related Issues:

Most VAMCs are affiliated with medical schools, allowing interaction and interdependence in patient care, medical education, research, and sharing of resources. While VA and Congress recognize that affiliated medical schools provide significant benefits to VA, concern exists that VA's relationship with some medical schools makes it more difficult to effectively manage VAMC operations and resource allocations. I share this concern. In 1992 the OIG began a series of audits of affiliation-related issues. To date, my office has performed five audits concerning the following issues.

* Time and Attendance of Part-Time Physicians
* Resident Salary Disbursement Agreements
* Resident Work Limits Initiative
* VAMC Physician Staffing Levels
* Scarce Medical Specialist Contracts with Affiliated Medical Schools

Collectively, these audits identify opportunities to better utilize an estimated $320 million. Separately, each audit indicates an opportunity to improve program performance and cut costs. For example, the OIG audit of VHA's Resident Work Limit (RWL) Initiative demonstrated the continuing need for detailed, independent oversight of VHA activities.

For the RWL initiative, Congress provided VA a total of $219 million in fiscal years 1992-1994. VHA planned to request an additional $155 million in future years. The purpose of RWL funds was to allow VANCs to hire additional staff to achieve compliance with accreditation standards on resident physician work hours, supervision, and ancillary duties.

The OIG audit found that the RWL Initiative was a valid one, but VHA planners overestimated the need for RWL funds and VAMCs did not consistently use the funds for intended purposes. In 1991, before RWL funds were allocated, VHA surveyed the VAMCs to determine the level of compliance with accreditation standards. However, VHA planners did not examine the results of their own survey nor use

it in allocating RWL funds. OIG analysis of the survey found that VAMCs requested significantly more resources than were needed to achieve compliance. In fact, most VAMC. reported that they were already in compliance with the standards.

After receiving RWL funds, VAMCs used the funds to pay for staff positions that existed before the RWL Initiative was developed, to hire staff in clinical activities that were already in compliance with the standards, and to fill positions that were not related to resident duties. Also, VHA did not establish performance measures or controls to ensure that RWL funds were used as intended.

The OIG estimated that, of the $219 million in RWL funds, VAMCs only needed about $72 million to achieve compliance with the standards. The remaining $147 million was neither needed nor used for the RWL initiative. The OIG recommended that VHA not request additional RWL funds unless the need could be fully justified. VHA decided not to request the additional $155 million in RWL funds for the FY 1996 budget. Further, VHA has agreed to reexamine its use of RWL funds and determine any future need.

The OIG is continuing its oversight of affiliation issues. My office is beginning an audit that will further examine selected affiliation activities and their effects on how VHA allocates resources. By reviewing the operations of comparable affiliated VAMCs, the OIG will continue to identify opportunities for VA to improve its affiliation agreements and reduce costs.

Stovepipe Mentality:

During the past 5 years, my office has dedicated much of its audit resources to nationwide program reviews designed to address systemic issues. In the course of conducting these audits involving segments of all of VA's components, programs and operations, it has become apparent that each major component has developed a stovepipe mentality in its approach to planning its programs and providing services to the veteran. This stovepipe mentality has contributed to either the non-desire or the inability of each component to effectively communicate with another component to address common goals and problems for the good of the veteran.

OIG reviews of VA's strategic planning process and benefits delivery systems have shown that there is minimal horizontal communication among VA components. For example, an OIG review of VHA's strategic plan determined that VHA had not addressed VA's goal to improve the timeliness and quality of the benefit claims process—believing this to be the sole responsibility of VBA. Medical examinations, however, are within the scope of the benefit claims process. Such stovepipe thinking limits opportunities to address VA-wide goals and objectives to improve total services to veterans.

OIG reviews consistently have shown that there are many programs that would benefit from better communication and enhanced working relationships among VA components. In response to recent OIG efforts, VHA and VBA are beginning to work together to enhance services, reduce costs, and improve program results in the following areas.

* Timeliness of Compensation and Pension Claims Processing
* Validity of Systems Eligibility Data
* Accuracy of Benefit Payments
* Collection of 1st-Party Co-Payment Debts

Open, effective communication and united planning efforts among all VA components will help improve the quality and timeliness of services provided to veterans. Shared goals and objectives and joint performance measures also will help provide opportunities for VA to improve overall program performance and cut costs.

II. OPPORTUNITIES TO IMPROVE ACCOUNTABILITY OVER BUDGETING AND THE ALLOCATION OF RESOURCES

VA's budget request has grown from $29 billion in FY 1990 to almost $38 billion for FY 1995. Historically, VA has used an incremental approach to budget planning (i.e., the budget is based on funding "current services" levels of existing programs, to which adjustments, usually new and expanded programs, are added). Once a program or facility is initially established and funded, it routinely becomes part of the historical "recurring base" of the budget planning process, with little or no further justification required in subsequent budgets.

Although the historical-incremental budget planning process may be adequate in managing VA's monetary and burial benefits program, the process has made it increasingly difficult for VA to respond to the changing demographics and health care needs of veterans. Because of the limitations of historical-incremental budget planning with regard to managing the fast-changing health care environment, VA is frequently unable to: (1) identify actual program costs, (2) determine appropriate program funding levels, or (3) evaluate program performance.

VA's budget process does not provide the performance measurement capabilities needed to fully achieve the desired degree of accountability for individual and collective program results and their financial management. As a result, VAMCs report widely varying estimated costs for the same or similar programs with the same or similar workload. It is my observation that historical-incremental budget planning perpetuates these variations and the resulting inefficiencies by assuming that the reported costs are appropriate and using these costs as the basis for planning future budgets and allocating resources.

Inherent Conflict Between Political and Fiscal Reality:

VA recognizes that the mix and allocation of health care services provided by VAMCs will need to change in order to meet the needs of many veterans. The necessity for change in the way VA plans and budgets for health care has become increasingly obvious to most observers during the past several years because of VHA's inability to reallocate resources to areas of increasing demand and priority need. For example, a recent system-wide OIG health care inspection found that approximately one-third of patients housed in beds designated as acute medicine or surgery might be more appropriately managed at another level of care. The findings of this inspection make it clear that there is substantial opportunity to reallocate major resources into areas of greatest need. Correction of the inappropriate designation of acute beds itself could permit the reallocation of hundreds of millions of dollars to patient management better matched to actual needs.

Although efforts are being made to reform the budget planning process, historical-incremental budget planning continues to be the basis upon which VA's health care programs and facilities are justified and funded. This limits VHA's ability to effectively allocate resources in keeping with changing veteran demographics.

Programs also are frequently located in areas where veterans' needs are not the greatest. Once a VA presence is established, any attempt to eliminate it or downsize the activity has been met with strong political opposition. For example, the OIG audit of small, unaffiliated surgical services which recommended realigning underutilized surgical units in order to reduce costs and improve the quality of surgical care generated letters from over 60 congressional offices attempting to justify the need to maintain VA surgical presence despite the high costs or insufficient workload.

For VA to operate effectively and efficiently, it must be allowed to make management decisions that are free from excessive political pressures which may not be in the best interests of the VA, our veterans, or the American taxpayer.

Allocation of Resources Not Tied to Workloads:

One of the most difficult issues facing VHA is how to ensure the equitable distribution of budget resources to VA medical facilities. As previously mentioned, VAMCs have received funds based on their historical consumption of resources, with incremental increases for such factors as inflation and the addition of special treatment programs. However, historical-incremental budgeting has tended to reward facilities that consumed more resources, even if the care provided was not the most efficient. For example, medical centers have historically been rewarded for providing more costly inpatient care and, therefore, have had little incentive to shift to less costly outpatient care.

VHA has recently improved the management of the budget process by the development of the Resource Planning and Management (RPM) system. VHA first used RPM in the development and distribution of the FY 1994 and 1995 budgets. RPM is described as a capitated (per patient), prospective system which can be used to forecast VAMC patient care workloads and resource requirements.

While my office has not yet performed a detailed evaluation of the RPM system, I believe this system offers a more rational basis on which to allocate resources. However, it may have to be implemented more vigorously. For example, one feature of the RPM process which is intended to force high cost VAMCs to become more efficient is the unit cost outlier adjustment. In FY 1995 a total of only $20 million was reallocated from higher unit cost VAMCs to lower unit cost VAMCs. While the concept of reallocating resources from high cost to low cost facilities seems sound, I question whether these relatively small reallocations ($20 million is only .125 percent of the $16 billion medical care budget) will give VAMCs strong incentives to improve efficiencies and contain costs.

Staffing and Utilization of Medical Facilities:

I share many of the concerns expressed by members of Congress about how well VA distributes its available resources and meets the patient care needs of veterans. As the demographics and needs of the veteran population have changed in recent years, some disparities in patient care workload and staffing levels among some

VAMCs have become apparent. For example, some VAMCs that provide comparable services and treat about the same number of patients have substantially different staffing levels. In FY 1993, for example, one VAMC treated about 36,560 unique patients and had total staffing of about 1,383 FTEE. Another VAMC treated about 37,520 patients and had 2,980 FTEE. This means that for about the same number of patients, the one VAMC had more than double the staff of the other, similar VAMC. As indicated in a recent OIG audit, this is not an isolated incident. Differences in staffing levels exist throughout VA's health care system. These differences are major and require intensive exploration and explanation by VHA.

I believe that many factors have contributed to these disparities over a long period of time. Among them are VA's historical-incremental budgeting approach, the lack of comprehensive VANC operating indicators and performance measures, parochial interests that have opposed rational proposals to change specific facility missions, and the regulatory and procedural barriers that make downsizing and transfer of resources extremely difficult.

VHA is reorganizing its facilities into Veterans Integrated Service Networks (VISNs). This provides VA with the opportunity to bring about more equitable resource allocation and improved access to patient services across the nation. The concept is that the VISN Director will properly distribute resources throughout his/her network. I do wonder, however, how resources will be equitably distributed to each VISN Director.

Surgical Program Realignments:

Recent OIG audit work has shown that some VAMCs continue to operate surgical specialty programs that are not viable for either or both of two reasons. These programs are not feasible at some facilities because the cost-to-benefit ratio is inordinately high when compared to other VA facilities to which patients could be referred. Or, more importantly, they are not viable because the specialty workload is not high enough for the surgical staff to maintain a minimally acceptable skill level.

The solution to both of these conditions is to concentrate certain surgical specialty workloads at selected medical facilities. This advantage in costs and the level of surgical skill will have to be reviewed in the context of the access problems that emerge.

Surgical Summary:

My office is in the process of drafting a summary report of VHA's surgical program. The report is the culmination of 8 previous reports, and it will provide an overall assessment of surgical activity throughout VHA. It will detail the need to develop and implement a nationwide strategy that will confront declining surgical workloads and changes in the health care environment.

The draft report will challenge VHA to redefine the missions of VAMC surgical activities nationwide, and to set goals for allocating resources to these functions consistent with existing surgical activities that have demonstrated productivity and efficiency. These efforts, over time, are expected to generate millions of dollars in cost efficiencies that VHA could redirect to other high priority health care needs.

The report also will discuss opportunities to improve management information systems that monitor surgical activities, to better document the supervision provided surgical residents and anesthesia providers, and to validate justifications for minor surgical construction initiatives.

VA Medical Center Physician Staffing Levels:

VAMCs employ about 19,400 full-time equivalent employee (FTEE) staff, contract, and resident physicians with salary and benefits costs of about $1.8 billion. Physician staffing may offer an opportunity to improve resource allocation among VAMCs. For example, an ongoing OIG audit has identified significant disparities in the allocation of physician staffing among similar VAMCs. To illustrate, among 64 affiliated VAMCs, which accounted for about 76 percent of total VA physician FTEE, the ratios of patients treated to physician FTEE ranged from a low of 86:1 to a high of 191:1, which indicates that some VAMCs treat twice as many patients per Physician as other facilities.

My office has been unable to attribute the wide disparity in the allocation of physician FTEE to such factors such as (1) reported physician time spent on education and research, (2) the number of residents in training, or (3) the acuity and/or complexity of care provided. When these factors were accounted for, essentially the same VAMCs appeared in the same higher and lower ranks of relative resource allocation.

This audit may further demonstrate the need for performance measures or operational indicators. Historically, VAMCs have not had physician staffing standards or operational indicators that would help them determine the number and type of

physicians needed. I believe that this has been a contributing factor to the large differences in physician staffing ratios. I also believe that allocating resources based on historical-incremental budgeting, as opposed to performance based budgeting tied to relative workload, is a contributor to the wide disparity in allocated resources.

My office is in the process of drafting the audit report for VHA review and comment. Hopefully, they will be able to more definitively determine the rationale for the wide disparity in physician to patient staffing ratios.

Heed to Establish a Performance Based Budget Process:

Ultimately, in order to be fully effective in the way VHA plans, budgets for, and executes programs to meet the health care needs of veterans, VA will need to replace its historical-incremental approach to budgeting with a program-results oriented budgeting system. In my opinion, an integral part of this system should be the development and implementation of a cost accounting system that ensures data integrity and identifies actual costs of each individual program and relevant subsets. This will provide VA the basic management tool for facilitating development of comprehensive program budgets that reflect alternative policy and performance goals on a priority basis and at various funding levels, as well as the information systems that effectively measure program results.

VA suffers from inadequate accounting and budgeting systems. In particular, VA does not have an effective system to account for costs, particularly costs of medical care delivery. Consequently, VHA does not have accurate or reliable data on the costs of medical services, or the means to effectively compare costs among facilities. This impairs VHA's ability to manage operations and hold managers accountable for results of operations.

This condition exists because VA budget and resource allocation processes have not required an effective cost accounting system. VA has relied upon incremental budgeting, and proportional resource allocation, to fund operations. In part, this may have resulted because VA administrators were required by law to maintain a certain level of presence at all facilities, and did not have a great deal of discretion to move resources. VA management has not been motivated to develop "performance budgets," or the accounting and information systems needed to administer performance budgets.

III. OPPORTUNITIES TO IMPROVE INTERNAL OVERSIGHT AND ACCOUNTABILITY IN A DECENTRALIZED ORGANIZATION

Adequate internal oversight of VA operations, including performance measurement, is vital to VA's ability to improve results and hold managers accountable. VA is making progress in this area, but it faces significant hurdles if it is to satisfy the requirements of the Government Performance and Results Act to improve program outcome through performance measurement. While much remains to be done, I believe that VHA's reorganization is on the right track.

To improve internal oversight and accountability in a decentralized environment, VA needs to clearly articulate what it wants to accomplish, establish criteria for measuring performance, develop the necessary financial and operational systems needed to collect and report accurate and timely information, and use these systems to assess overall performance and outcomes. OIG audits indicate a need for substantial improvement in this area.

If VA is going to be successful in measuring the performance of VA programs for the purpose of improving results and holding managers accountable, the following areas need to be addressed.

* Goals and Performance Criteria
* Cost Accounting Systems
* Collecting and Assessing Information
* Integration of Financial and Operational Information Systems for Management Decision Making
* Performance Measurement
* VHA Reorganization

Goals and Criteria Development:

Establishing goals and the criteria for measuring performance against these goals are critical to determining the efficiency and effectiveness of VA activities. The performance measurement process, required by the GPRA, is dependent upon clearly articulated goals for each program, and performance measurements which disclose the results (outcomes and outputs) achieved and how well the program is meeting the intended objectives (impact).

Performance criteria need to disclose, in an objective, quantifiable, and measurable form, the extent to which programs are achieving their missions, goals, and ob-

jectives. Program managers should be able to use these measures to assess the efficiency and effectiveness of their programs, to design actions to correct problems, and to demonstrate program achievement.

Recent OIG reviews of VHA's, VBA's and NCS's strategic plans found that the achievement of most program goals and objectives could not be measured because criteria for performance measurements have not been established or were not specific or quantifiable enough to measure accomplishment. VA managers have the opportunity to improve criteria for measuring program efficiency and effectiveness by developing more specific and quantifiable performance criteria.

VA has taken the position that "absolute" criteria do not always exist and, in some cases, are difficult or even impossible to develop. This is where "relative" criteria have a role. Relative criteria-setting often is referred to as "outlier analysis," "most efficient organization analysis," or "gap analysis." In all cases, the procedure is to take a particular indicator of performance, such as ratio of workload versus costs among units with similar missions, and display the individual units in order of cost.

Applied to VA organizational units, one could measure, for example, how much it costs one medical center to perform a surgical operation versus another medical center's cost for the same operation. If the range of costs is, for example, $2000 per operation to $7000 per operation, one can question whether the medical center near the high end of the cost is efficient. Thus, the universe of organizational units and how they are displayed on a particular variable create the "measuring stick" of their relationship to one another. It also is important to ensure that the efficient units are effective. This could be done by a similar ranking of the medical centers by, for example, surgical outcomes.

By using such relative measures, it is possible to evaluate any group of organizational units on a variety of factors. Relative measures have the advantage of not requiring vast amounts of research and testing in their development. They do not require experimentation or use of "control" groups. Relative measures also avoid disagreements over their appropriateness to the units being measured, because it is the performance of those units themselves compared to others with which they are measured. Examples of this type of analysis will be included in the OIG draft reports on the VHA surgical program and on VHA physician staffing.

If VA is going to be successful at measuring program performance and holding managers accountable for achieving goals and objectives in programs where absolute criteria cannot be developed, consideration must be given to establishing relative criteria as a means for assessing performance and improving VA operations.

Soon after my appointment as Inspector General, I met with the principal VA managers to determine what complaints they had with the OIG, and what they wanted or expected from us. One complaint frequently articulated was that IG auditors did not have the background to competently evaluate the results of professional activities. In particular, they questioned the criteria on which our judgments rested. To this I replied, "Tell us what you believe is good service. Tell us your goals. Provide us your criteria and performance measures, and we will evaluate the results of operations against those criteria and standards, and provide you with results on how well you are doing."

VA recognizes that it has to meet the requirements for performance measures as established by GPRA, and it is working to establish quantified goals and performance measures. This, however, is only one aspect of assessing overall performance and holding managers accountable. Having reliable financial and cost accounting systems is equally important.

Cost Accounting Systems:

All aspects of VA operations are impacted by cost accounting which measures costs against predetermined goals. Recently, the need for a system to measure and evaluate costs has received greater emphasis as a result of the CFO Act, GPRA, and NPR. In today's climate of fiscal restraint, the pressure to become more cost effective is greater than ever. Accomplishing this, however, requires the ability to evaluate the costs to perform services.

Currently, VA lacks the necessary cost accounting systems to perform this requirement. For example, recent OIG audits have identified VHA cost reporting system limitations. VHA's current cost reporting system cannot generate meaningful summary reports relating to budget objectives, work units, or outputs without significant manual intervention.

With VA's recent development and implementation of the Financial Management System, VA is starting the process of developing the basis for recording and tracking costs (expenses) to match with output. My office has recently begun a review to evaluate cost accounting within the VA.

Collecting and Assessing Information:

Archaic reporting and management information systems also impede oversight. Simply put, VA management does not have timely, relevant, reliable, program results information. The information that is available is frequently inaccurate and incomplete, and is process rather than results oriented.

There are two sound reasons why reports of any kind ought to be prepared by field staff for submission to higher level authorities. First, is to monitor compliance with policy. The second is to gather data to assess performance for management decision making. However, my office has determined that required reports prepared by field staff for submission to VA central office are often not used for any purpose. Evidence of this has been demonstrated in several OIG reports involving surgery-related issues.

OIG work noted that VA central office (VACO) officials took no action and, at times, did not even inquire when some medical centers failed to submit required reports. In some cases, officials were not even aware that required reports had not been submitted. In other cases, reports that clearly indicated out-of-line conditions generated no inquiry from VACO staff. This suggests that the reports were either of no real value to VACO officials, or the officials were not prepared to act on the conditions which might have been revealed in them. Audits and healthcare inspection reports indicate that this condition is widespread in VA operations.

Integration of Financial and Operational Information Systems for Management Decision Making:

Systems that integrate financial, operational, budget, and performance information, and provide timely and meaningful information to managers, are essential for reinventing government; that is, changing government processes to make them work better. I fully support this concept and have committed a significant amount of audit resources to help achieve these objectives.

Much of this work has already produced improvements in the reliability of financial information in VA, as evidenced by the results of four audits of VA's Consolidated Financial Statements. VA also is making progress in developing performance measures. However, much still needs to be done to shift the focus of performance measurement from program inputs to program results in order to better determine how well programs are meeting VA goals.

I believe that performance measurement and integration of financial and operational information systems should ultimately provide a "report card" answering the question of how well VA is doing. VA and Congress cannot only be satisfied with a good set of books. VA management ultimately is responsible for establishing goals, objectives, and performance measures that tie to Congressional objectives, and for developing the systems for measuring how well VA performs.

As I have stated in earlier testimony before the House Committee on Government Operations, Subcommittee on Legislation and National Security, the OIG found little evidence suggesting that program managers used VA's financial statements to manage their programs. The systems used to produce these financial statements need to be integrated with program and performance information to be of any real value. My office has worked diligently with VA's financial managers to ensure financial statement accuracy, but it is critical that the program managers complete the next step—i.e., incorporate the financial statements and supporting information into the management decision making process.

The last two OIG audits of VA's Consolidated Financial Statements determined that VA had made a significant effort in identifying and presenting performance measures in VA management's overview that accompanies the financial statements. However, while numerous measures were included, the financial statement overview generally focused on operating statistics concerning programs.

Performance Measurement:

The CFO is working with VA management and has several actions underway in conjunction with the GPRA that, when completed, should help measure program performance in relation to VA goals and objectives. Actions underway include developing a system for measuring performance throughout VA by shifting the focus of performance measurement from program inputs to program results.

VA is a long way from achieving the ultimate goal of using performance measurement as a tool for improving the efficiency, effectiveness and economy of VA's overall effort. Ultimately, VA should have reliable data that indicate whether it had a good year or a bad year. While the NPR, GPRA and CFO are aimed at improving results, VA's consolidated financial statement should be the vehicle for communicating the true impact and accomplishments of the VA. VA is moving in the right direc-

tion, but Congress should keep pressing all Departments and Agencies to produce financial statements that reflect overall mission performance.

VHA Reorganization:

As addressed in an OIG report on the implementation of VHA's strategic plan and performance measurements, the degree of achievement of VHA's goals and objectives could not be effectively measured because of the lack of specific performance criteria. As a consequence, oversight of the achievement of program goals and objectives could not be performed, making it difficult to hold field managers accountable for effectively managing and utilizing resources. However, the recent reorganization of VA's health care system provides opportunities to improve internal oversight and accountability over the field. For example, by tying the performance elements of medical center director performance appraisals to VISN goals, objectives, and customer standards, VHA will serve as a good example of the progress that parts of VA are making with performance measurement and accountability.

VHA's reorganization marks an era of reform for VA. The change from a system having substantial central office control over the daily operations of medical facilities, to the concept of organizational leadership by national headquarters is widely supported. Also supported is the change to VHA program oversight of such fundamental end products as quality and timely patient care. VHA's success in achieving this change, however, will depend on the development of criteria for performance measurement.

The change from regions to VISNs should result in better coordination between headquarters and the field, and help facilitate the integration of administrative, clinical, academic and research staff within a network area. This is designed to improve patient care and program results. However, the relationships, or processes, between medical centers, VISNs, and headquarters have not yet been well defined. Issues such as the level of authority VISNs will have over medical centers within their jurisdiction, and the degree of autonomy VAMC directors will have with respect to how they use allocated resources, are unclear. Before the VHA reorganization is implemented, roles and responsibilities should be clearly delineated.

In my opinion, an important part of the VHA reorganization plan is the development of system-wide health care policies and practice parameters by which patient care outcomes can be measured. While I expect the concept of medical practice parameters to face some opposition from VHA's clinical establishment, I have been a strong and vocal advocate for some form of quantifiable measures by which the OIG, VA, and the Congress can use to assess the quality of patient care and other VA provided health services.

Required performance measurement to improve results and enhance service is a cornerstone of VHA's reorganization plan. For example, VHA plans to develop performance measures which allow comparison of the results of medical center operations with private sector counterparts. This assumes, of course, that the private sector is making similar efforts in performance measurement. Modernizing and developing relevant management information systems that provide uniformity in the data collection necessary for oversight and monitoring are also being planned.

VHA's reorganization is a step in the right direction, but it does not solve all its problems, nor all of VA's problems. Many of the concerns that I have raised throughout my testimony, dealing with issues such as construction management, budgeting and allocation of resources, acquisition practices, and performance measurement, continue to be opportunities for improvement.

During the 5 years that I have been Inspector General, I have seen major portions of VA that have been under constant reorganization, with no significant change or improvement in VA operations. The VHA reorganization plan is an opportunity for change and improvement. Now, it is only a plan. As VHA strives to implement the plan, assessments, feedback, and adjustments will be needed to refine and improve operations. To this end, my office is dedicated to conducting independent and objective oversight aimed at helping VHA, and VA, fulfill its mission in the most effective, efficient, and economical way possible.

Thank you for the opportunity to present this comprehensive over-view of VA operations to the Committee. I will attempt to answer the Committee's questions.

Mr. SHAYS. Before I call on Mr. Baine, I just wonder if you would just give the committee a little bit more detail. Usually, we have to work the other way and ask people who testify to conclude their statements. But I wish if you could just give us a little bit more meat in terms of what you feel in those three areas, which is the

area that our committee should focus on the more, and maybe just make some comments on at least one of those three areas.

Mr. TRODDEN. OK. The central theme that I would suggest for the committee's consideration, Mr. Chairman, are the issues that surround the Government Performance and Results Act, the CFO Act, and the whole set of issues of what it is that's expected of the Federal Government and in this case the Department of Veterans Affairs in the way of producing an annual report.

I have my own visions here, and I would love the opportunity to share that with the committee, but at the moment I don't know that they're anything more than my visions or my interpretation of what the Congress had in mind when they passed the CFO Act and GPRA. But I would envision, for example, that, ultimately, the Department of Veterans Affairs would be producing an annual statement that would not only show a set of balanced books and records from a financial standpoint but would also be describing in meaningful performance terms whether VA had a good year or a bad year.

In the prior year, for example, did VA deliver more services to veterans, more effectively, with higher quality, than the year before? Or did they not?

And in order to produce such a document, I think there needs to be great clarity of the public policy of the United States with regard to what the Department of Veterans Affairs exists to do on the one hand, and then, second, given that clarity, I think it's then incumbent on the Department to come back to the Congress with meaningful performance measures that would describe how well VA is executing the public policy of the United States.

So I think there's room for a lot of improvement in the clarity of what the charter is; the expectation level of the Congress and the American people for VA; to whom should we be providing benefits, what, when, where and how. And then there's room, considerable room in my mind, for VA to come back to the Congress and pose meaningful performance measures that describe how well that mission has been executed.

Now I have in mind, maybe not in my tenure but before I leave this earth at least, to see an audited financial statement that would be as meaningful, for example, to the Secretary of Veterans Affairs as the annual statement of profitability is to the chairman of General Motors or any other corporate entity that you choose to pick. I don't think we're there yet, and I would like to see us move in that direction.

Mr. SHAYS. That's a fairly serious indictment, if we don't know what our mission is.

Mr. TRODDEN. I don't think it's unique to VA, Mr. Chairman. I think there's a lot of agencies that now, given the passage of GPRA and given the passage of the CFO Act, are struggling with just those very questions, things that have been presumed for years and years and now one is forced to articulate.

Mr. SHAYS. Well, we'll get into that in the questions. I guess we could see the same thing with Members of Congress, in making sure we know what our mission is.

Mr. SHAYS. Mr. Baine.

Mr. BAINE. Good morning, Mr. Chairman and members of the subcommittee.

Mr. SHAYS. Could I also—I'm sorry to interrupt you. I'd like to acknowledge for the record that we are joined by Connie Morella, who represents a good part of the districts that most of the people in Washington live in. It's nice to have her join us.

Would you have any statement you'd like to make?

Mrs. MORELLA. No, thank you.

Mr. SHAYS. Thank you, Mr. Baine.

Mr. BAINE. Mr. Chairman, thank you for inviting us today to discuss the future direction of the VA health care system.

Mr. SHAYS. I'm going to ask you to talk a little louder. And really try to energize us here.

Mr. BAINE. My comments this morning will focus on actions needed to improve the efficiency of VA hospitals, challenges that threaten the long-term viability of the VA health care system and options for restructuring the system.

Our prepared statement discusses a series of actions needed to improve the efficiency of VA hospitals. I will limit my comments this morning to two long-standing myths about the VA health care system: That VA's eligibility provisions prevent it from shifting much of its inpatient workload to outpatient settings, and that VA's central office, micromanages its medical centers.

The Congress amended VA's eligibility provisions over 20 years ago to specifically authorize VA to provide ambulatory care to any veteran, regardless of income or other factors, when that care would obviate the need for hospital care. Thus, hospital care for cataract surgery, for example, would appear to be obviated if VA provided the care on an outpatient basis. Nevertheless, most cataract surgery in VA is still done on an inpatient basis. VA management has been slow to take advantage of the flexibility Congress gave it.

For example, VA's methods of allocating resources to its medical centers have historically been based on inpatient workload, creating incentives for medical center directors to provide care on an inpatient rather than an outpatient basis. VA's recently implemented resource planning methodology shows some promise in overcoming this incentive.

The second myth is that VA central office micromanages its medical centers. VA operates not as a centrally managed health care system but as individual medical centers competing with each other to provide as wide a range of services as possible. Medical center directors' performances are often judged largely on the basis of what new facilities and equipment they can bring to the center. Little thought is given to the availability of services and equipment at nearby centers or in the private sector.

Our work repeatedly finds that VA central office lacks much of the system-wide information that it needs to effectively monitor the performance of its medical centers, ensure that corrective actions are taken when problems are identified, and identify and disseminate information on innovative or best practices.

VA's plans to reorganize its health facilities into veterans integrated service networks, mentioned by Mr. Towns, are an impor-

tant step toward getting the organization of the Veterans Health Administration in shape.

I'd like to now turn to several challenges that threaten the long-term viability of the direct care system. Clearly, VA is at a crossroads, regardless of how successful it is in improving the efficiency of its own system.

I would briefly like to highlight four challenges: First, over the last 25 years, workload in VA's hospitals has dropped by over 50 percent, and further declines are likely.

Second, VA needs to find resources to meet the special care needs of veterans such as treatment for posttraumatic stress disorder and substance abuse.

Third, VA needs to find the resources it needs to meet the growing demand for long-term care services.

And, finally, VA needs to find ways to make access to outpatient care more equitable. Veterans' ability to obtain needed health care services frequently depends on where they live and to which facility they go.

I'd like to now turn to some options for restructuring the health care system. First, some VA hospitals could be closed or services consolidated.

VA and the private sector have reacted very differently to the declining inpatient workload. For example, hundreds of private hospitals have closed over the last 5 years, but no VA hospitals have closed because of declining workload. In fact, VA plans to add hospitals in five States in the next 2 or 3 years.

Another option for restructuring the health care system would be to retarget resources. About 15 percent of the veterans using VA's medical centers in 1991 were nonservice-connected veterans with incomes of $20,000 or more. VA could use these resources to target the special care needs of veterans and strengthen its ability to fulfill its safety net mission.

The third option that could be considered is eligibility reform. While eligibility reform would be needed if the Congress wants VA to provide a uniform set of benefits to all veterans, such an expansion would fundamentally change the veterans health care system and has significant implications for both cost and access to care.

Our written statement discusses several potential options for paying for expanded eligibility. One option for increasing the work load at VA hospitals, if that's the desire of the policymakers, would be to expand VA's authority to treat nonveterans. Expanding the government's role in providing care to nonveterans could, however, jeopardize the fiscal viability of private sector hospitals.

Finally, one option for meeting the increased demand for nursing home care with available funds is to increase cost sharing. In fiscal year 1994, VA provided nursing home care to about 31,000 veterans at a cost of over $1.5 billion. VA offsets less than one-tenth of 1 percent of its costs through copayments. VA could have recovered hundreds of millions of dollars by adopting the copayment practices used by State veterans' homes and by establishing an estate recovery program patterned after those established by many States under their Medicaid programs.

In conclusion, Mr. Chairman, the veterans health care system, we believe, is clearly at a crossroads.

Mr. SHAYS. We believe it's what? I'm sorry?

Mr. BAINE. Is clearly at a crossroad. Many important issues need to be resolved in determining the future of the health care system and, more importantly, the future of veterans health benefits. Decisions regarding how these and other issues play out will have far-reaching effects on veterans, taxpayers and private health providers.

We'll be happy to take your questions.

[The prepared statement of Mr. Baine follows:]

PREPARED STATEMENT OF DAVID BAINE, DIRECTOR OF FEDERAL HEALTH CARE DELIVERY ISSUES, GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the future direction of the Department of Veterans Affairs (VA) health care program. VA, with a $16 billion health care budget, faces increasing pressures to contain or reduce health care spending as part of government wide efforts to reduce the budget deficit. It also faces increasing challenges from a rapidly changing health care marketplace. We welcome this hearing as an important step in analyzing the challenges VA faces and exploring options for improving the VA health care system.

My comments this morning will focus both on actions needed immediately to improve the efficiency of VA hospitals and challenges that threaten the long-term viability of the VA health care system. Finally, I will discuss some options for restructuring the VA health care system to respond to those challenges.

During the past several years, we conducted a series of reviews focusing on the relationships between the VA health care system and other public and private health benefits programs and the effects changes in those programs could have on the future of the VA health care system. Similarly, we conducted a series of reviews to identify ways to improve the efficiency and effectiveness of current VA programs. My comments this morning are based primarily on the results of those reviews.[1]

In summary, our work clearly demonstrates that VA lags far behind the private sector in improving the efficiency of its hospitals. Over the last 5 to 10 years we have identified a series of management problems limiting VA's ability to (1) improve the operational efficiency and effectiveness of its hospitals and (2) shift more of its inpatient care to less costly ambulatory settings. Although VA is planning a major reorganization and other initiatives to improve its management capabilities, we remain concerned that some of the actions may not go far enough.

Even if it improves the efficiency of its hospitals, VA is at a crossroad in the evolution of its health care system. The average daily work load in its hospitals dropped about 56 percent during the last 25 years, and further decreases are likely. At the same time, however, demand for outpatient care, nursing home care, and certain specialized services is expanding, taxing VA's ability to meet veterans' needs.

Decisions made over the next few years about VA's role in health care will have significant implications for veterans, taxpayers, and private health care providers. For example, eligibility for VA care could be expanded or VA could be authorized to treat more nonveterans to increase its hospital work load. Such restructuring would, however, involve a fundamental change in VA's health care mission and would increasingly place VA in direct competition with private sector hospitals for dwindling numbers of patients. On the other hand, changes could be made so that VA services supplement rather than unnecessarily duplicate health care coverage under other programs. Regardless, VA would need to establish priorities for how its limited resources would be targeted.

In the final analysis, a complete reevaluation of the VA health care system appears needed. Absent such an effort, use of VA hospitals will likely continue to decline to a point where VA's ability to provide quality care and support its secondary missions will be jeopardized.

BACKGROUND

The VA health care system was established in 1930, primarily to provide for the rehabilitation and continuing care of veterans injured during wartime service. VA developed its health care system as a direct delivery system with the government owning and operating its own health care facilities. It grew into the nation's largest

[1] A list of related GAO testimonies and reports is in appendix I.

direct delivery system. For fiscal year 1996, VA is seeking an appropriation of about $17.3 billion to maintain and operate 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries. VA facilities are expected to provide inpatient hospital care to 930,000 patients, nursing home care to 35,000 patients, and domiciliary care to 18,700 patients. In addition, VA outpatient clinics are expected to handle 25.3 million outpatient visits.

Over the last 65 years, VA has seen a significant evolution in its missions. In the 1940s, a medical education mission was added to strengthen the quality of care in VA facilities and help train the nation's health care professionals. In the 1960s, its health care mission was expanded with the addition of a nursing home benefit. And in the early 1980s, a military backup mission was added.

The type of veterans served has also undergone an inevitable evolution. VA has gradually shifted from a system primarily providing treatment for service-connected disabilities incurred in wartime to a system increasingly focused on the treatment of low income veterans with medical conditions unrelated to military service. Similarly, VA once treated an almost exclusively male veteran population but is now striving to meet the privacy and health care needs of increasing numbers of women veterans. Finally, the growth of private and public health benefits programs has given veterans additional health care options, placing VA facilities in direct competition with private sector providers.

ACTIONS NEEDED TO IMPROVE THE EFFICIENCY OF VA HOSPITALS

Because VA is not subject to many of the cost-containment pressures, such as the Medicare prospective payment system, exerted on private sector hospitals in the last 10 years, it lags far behind the private sector in efforts to improve the efficiency of its hospitals. For example, VA continues to perform most cataract surgery on an inpatient basis years after the private sector has shifted such surgery to an outpatient basis. Similarly, VA's lengths of stay continue to be significantly longer than those in the private sector.[2]

VA's complex eligibility and entitlement provisions are frequently cited as a primary reason why VA cannot move more care out of hospitals and into ambulatory care settings. However, our work has pointed to management inefficiencies, not eligibility provisions, as preventing VA from shifting much of its current hospital work load to ambulatory care settings.

VA's eligibility provisions were amended in 1973 to specifically authorize the provision of ambulatory care to any veteran—regardless of income or other factors—when that care would obviate the need for hospital care. The eligibility provisions would, for example, allow VA to perform cataract surgery on an outpatient basis to obviate the need for inpatient care.

Our work over the past 5 to 10 years has identified a series of recurring management problems limiting VA's ability to improve both the efficiency of its health care system and services to veterans. Specifically, VA lacks

—oversight procedures to effectively assess the operations of its medical centers,

—systems to shift significant resources between medical centers to provide consistent access to VA care,

—information systems capable of effectively coordinating patient care between VA facilities and

—a corporate culture that values economy and efficiency.

VA has a number of initiatives to address these problems and strengthen management while further decentralizing control.

Central Office Oversight

VA's central office lacks much of the system wide information that it needs to effectively (1) monitor the performance of its medical centers, (2) ensure that corrective actions are taken when problems are identified, and (3) identify and disseminate information on innovative programs developed by its medical centers. For example, VA did not know

—How many veterans are denied health care services because of a lack of resources and what types of veterans are being denied care?

—Which VA facilities have excess capacities that they are able to sell to the Department of Defense or the private sector?[3]

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[2] An unpublished VA study reported the average length of stay in VA hospitals to be 10.6 days in 1991 compared with 6.8 days in private sector hospitals.

[3] VA medical centers are authorized to enter into affiliation agreements with nearby medical schools. Through these agreements, VA centers and medical schools may share excess services as a means of improving the efficiency of operations. This can be done through joint acquisition

—How long veterans wait to see a doctor when they go to a VA medical center without a scheduled appointment and how long they have to wait for an appointment for specialty care?

—How many VA medical centers have mammography equipment?

—What controls VA medical centers have over the distribution of controlled substances?

In each case, VA's central office was unable to provide the data, and special surveys of its medical centers were required to obtain basic performance information.

With a decentralized management structure, managers in VA's central office should have systems to monitor field facilities to ensure that veterans receive high-quality services. In cases where the central office has monitored field facilities' operations, it has made some progress in ensuring that policies were properly implemented and problems were corrected. For example, system wide improvements resulted when the central office became actively involved in ensuring that medical facilities properly validated the credentials of their physicians and controlled inventories of addictive prescription drugs. But monitoring is the exception rather than the rule. Frequently, VA officials indicate that they lack sufficient resources to monitor field facilities' operations.

Even when monitoring occurs, VA has not held medical center directors accountable for ensuring that policies are implemented and corrective actions taken. For example, problems in improving the thoroughness of women veterans' examinations persist more than 10 years after they were first identified. VA's central office required medical centers to submit corrective action plans for improving the thoroughness of the examinations, but even when medical centers submitted inadequate plans, the central office did not follow through to notify medical centers of its findings.

Finally, VA's central office should be serving as an information exchange, identifying and evaluating locally developed programs and methods and disseminating best practices to other medical centers. For example, in our most recent report on women veterans' health care, we noted that several medical centers had developed innovative approaches to address the long-standing problem of inadequate physical examinations.[4] We recommended that VA identify and disseminate information on best practices, but when we followed up 2 years later, no action had been taken.[5] VA officials said they were not sure what we meant by "best practices."

Resource Allocation

VA's methods of allocating resources to its medical centers have historically been based on inpatient work load, creating incentives for medical center directors to provide care on an inpatient rather than outpatient basis. The incomes and service connected status of veterans using the facilities are not considered in making the allocations.

VA could reduce inconsistencies in veterans' access to care by better matching medical centers' resources to the volume and demographic makeup of eligible veterans requesting services at each center. In effect, VA would be shifting some resources from medical centers that have sufficient resources and, therefore, do not ration care. Such resource shifts could mean, for example, that some higher-income veterans at those medical centers might not obtain care in the future. But the shift could also mean that some veterans with lower incomes who had not received care at other medical centers might receive care in the future.

From a veteran's perspective, VA's development of a strategy to deal with resource shortfalls on a more equitable basis system wide seems preferable. We recommended in 1993 that VA modify its system for allocating resources to its medical centers so that veterans with similar economic status or medical conditions would, to the extent practical, be provided more consistent access to outpatient care.[6]

Although VA created a new resource allocation system, the Resource Planning Methodology (RPM), like its predecessor, the Resource Allocation Methodology (RAM), places limits on the amount of resources that can be shifted between medical centers. Less than 2 percent of resources has been shifted between medical centers under VA's resource allocation methods. More importantly, RPM allocates resources based on prior work load without any consideration of the incomes or service-con-

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of equipment or contracts that require one party to reimburse the other for costs of services shared. In addition, VA can enter into sharing agreements with military health care facilities.

[4] VA Health Care for Women: Despite Progress, Improvements Needed (GA)/HRD-92-23. Jan. 23, 1992).

[5] VA Health Care for Women: In Need of Continued Attention (GA)/T-HEHS-94-114, Mar. 9, 1994).

[6] VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

nected status of that work load. We are currently reviewing RPM to determine why it does not shift more resources between medical centers.

Information Systems

Major improvements in both the quality of VA's services and the efficiency with which they are provided depend on VA managers' ability to get the right information at the right time. As we pointed out during last year's health reform debate, without accurate and complete cost and utilization data, VA managers cannot effectively make such decisions as when to contract for services rather than provide them directly and how to set prices for services it sells to other providers or how to bill insurers for care provided to privately insured veterans.[7]

Accurate utilization data also are essential in monitoring patient care both to help ensure quality and to prevent abuse. For example, a recent study by VA researchers identified 35 veterans who had been admitted to VA hospitals 2,268 times over a 5-year period at an estimated cost to taxpayers of $6.5 million. The researchers noted that VA doctors cannot easily tell when patients are moving from hospital to hospital because VA medical centers do not have a centralized patient information system.

VA is in the process of implementing a new Decision Support System (DSS) that uses commercially available software. This system can provide data on patterns of care and patient outcomes as well as their resource and cost implications. While DSS has the potential to significantly improve VA's ability to manage its health care operation, the ultimate usefulness of the system will depend not on the software but on the completeness and accuracy of the data going into the system. One longstanding problem with VA's information and financial systems is that medical centers frequently enter incomplete or inaccurate data or both. We are currently assessing VA's efforts to implement DSS including efforts to improve the reliability of data going into DSS.

VA Culture

VA operates not as a centrally managed health care system but as individual medical centers competing with each other to provide as wide a range of services as possible. Medical center directors' performance is generally judged by what new facilities, services, and equipment they bring to the medical center. Little thought is given to the availability of services and equipment at nearby VA facilities or in the private sector.

To address this problem, VA plans to reorganize its health care facilities into geographic networks known as Veterans Integrated Service Networks (VISN) to trim unnecessary management layers, consolidate redundant medical services, and use available community resources. Two important parts of the reorganization of VA facilities into 22 VISNs are plans to establish performance measures and hold VISN directors and medical center directors accountable for implementation of policy directives.

Because of the current lack of effective central office oversight of medical center operations, we view the establishment of VISNs as an important step by VA in increasing oversight of medical center operations, holding medical center directors accountable for implementation of policy directives, and taking corrective actions on problems identified.

CHALLENGES THREATENING THE FUTURE VIABILITY OF VA'S HEALTH CARE SYSTEM

Although actions to improve the efficiency of VA's hospitals are an important first step in addressing current operational problems, VA faces many other major challenges in a rapidly changing health care marketplace. For example:

—A continuing decline in patient work load threatens the economic viability of VA hospitals.

—Veterans have unequal access to health care services because of complex VA eligibility requirements, limited outpatient facilities, and uneven distribution of resources.

—Needs of special care populations are not always met.

—An aging veteran population has an increasing need for nursing home and other long-term care services.

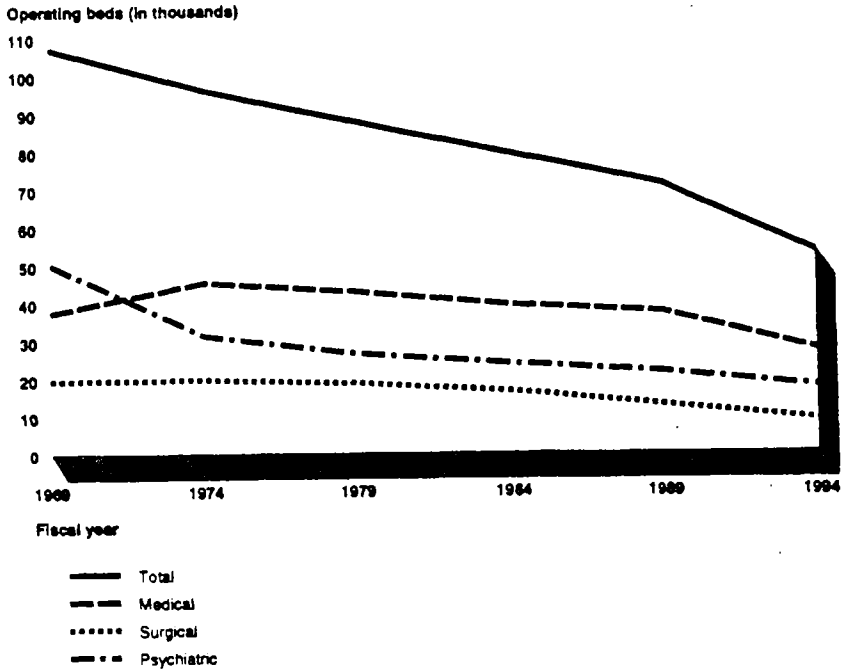
VA Hospital Usage Declining

VA has experienced a dramatic decline in its hospital work load. Over the past 25 years, the average daily work load in VA hospitals dropped by about 56 percent

[7] Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

(from 91,878 in 1969 to 39,953 in 1994). VA reduced its operating beds by about 50 percent, closing or converting to other uses about 50,000 hospital beds. The decline in psychiatric beds was most pronounced, from about 50,000 in 1969 to about 17,300 beds in 1994. (See fig. 1.)

Figure 1: Operating Beds in VA Hospitals (1969-94)



insert figure 1 here

A number of factors could lead to a continued decline in VA hospital work load. For example:

—The number of veterans with health insurance coverage is expected to increase, which will likely decrease demand for VA acute hospital care. Almost all veterans become eligible for Medicare when they turn 65 years old, even if they were employed in jobs that did not provide health insurance.

—The nature of insurance coverage is changing. For example, increased enrollment in health maintenance organizations (HMO)—from 9 million in 1982 to 50 million in 1994—is likely to reduce the use of VA hospitals. Veterans with fee-for-service public or private health insurance have a financial incentive to use VA hospitals to avoid copayments and deductibles. This financial incentive is largely eliminated when they join HMOs because there is little or no cost sharing. Proposals to expand Medicare beneficiaries' enrollment in HMOs could thus further decrease the use of VA hospitals.

—The declining veteran population will lead to significant declines in VA acute hospitalization even as the acute care needs of the surviving veterans increase. The veteran population is estimated to decline by one-half over the next 50 years. The downsizing of the military will likely make the decline even more dramatic. With fewer new veterans entering the system, the veteran population will decline more rapidly, and the percentage of veterans 65 years old and having Medicare coverage will increase. In addition, many veterans leave the VA system when they become Medicare-eligible.

—VA hospitals too often serve patients whose care could be more efficiently provided in alternative settings. The major veterans service organizations noted in their 1996 Independent Budget that a recent study indicated that VA could

reduce its hospital inpatient work load by up to 44 percent if it treated patients in more appropriate settings.

VA's Under Secretary for Health recently testified that it will not be that many years before acute care hospitals become primarily intensive care units taking care of only the sickest and most complicated patients, having switched all other medical care to other settings, including ambulatory care settings, hospices, and extended care facilities.[8]

Needs of Special Care Populations Are Not Always Met

Although demand for VA acute hospital care is declining, the health care needs of veterans needing specialized services are not always met because of space and resource limits in specialized treatment programs. For example:

—Specialized VA post-traumatic stress disorder programs are operating at or beyond capacity, and waiting lists exist particularly for inpatient treatment.

—A sufficient number of beds are not available to care for homeless veterans. VA has only 11 beds available in the San Francisco area to meet the needs of an estimated 2,000 to 3,300 homeless veterans.

—VA substance abuse programs are near capacity.

Increased Demand for Nursing Home Care

As the nation's large World War II and Korean War veteran populations age, their health care needs are increasingly shifting from acute hospital care toward nursing home and other long-term care services.

Old age is often accompanied by the development of chronic health problems, such as heart disease, arthritis, and other ailments. These problems, important causes of disability among the elderly population, often result in the need for nursing home care or other long-term care services.

About 32 percent of veterans are 65 years old or older, with the fastest growing group of veterans being those 85 years old or older. This older group raises concerns because the need for nursing home and other long-term care services increases with the age of the beneficiary population. Over 50 percent of those over 85 years old are in need of nursing home care compared with about 13 percent of those 65 to 69 years old.

VA has set a goal of meeting the nursing home needs of 16 percent of veterans needing such care. Between 1969 and 1994, the average daily work load of VA-supported nursing home patients more than tripled (from 9,030 to 33,405). With the veteran population continuing to age rapidly, VA faces a significant challenge in trying to meet increasing demand for nursing home care.

Uneven Access to Outpatient Care

Veterans' ability to obtain needed health care services from VA frequently depends on where they live and which VA facility they go to. VA spends resources providing services to high-income insured veterans, who have no service-connected disabilities, while low-income uninsured veterans have needs that are not being met. About 191,000 low-income uninsured veterans with no apparent health care options indicated in a 1987 VA survey that they had never used VA health care, in part, because they were not aware that they were eligible.

Although not the primary reason for VA being slow to shift care from hospital to outpatient settings, the complexity of VA eligibility rules affects VA's efficient delivery of health care to veterans.

Any person who served on active duty in the uniformed services for the minimum amount of time specified by law and who was discharged, released, or retired under other than dishonorable conditions is eligible for at least some VA health care benefits. VA uses a complex priority system based on such factors as the presence and extent of any service-connected disability, the incomes of veterans with nonservice-connected disabilities, and the type and purpose of care needed, to determine which veterans receive care within available resources.

In general, VA provides cost-free priority medical care to veterans who have (1) service-connected disabilities; (2) a special status, such as being a former prisoner of war or a World War I veteran; or (3) incomes below a specified level (mandatory care category). If space and resources are available after caring for these veterans, VA provides care to other veterans; that is, those veterans with nonservice-connected disabilities and incomes above the specified level (discretionary care category).

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[8] Statement of Dr. Kenneth W. Kizer, Under Secretary for Health, VA, before the Subcommittee on Hospitals and Health Care, House Committee on Veterans' Affairs, April 6, 1995.

Only those veterans with service-connected disabilities rated at 50 percent or more—about 450,000 veterans—are entitled to comprehensive outpatient services. VA's eligibility rules impede the provision of efficient health care to other veterans in that they may not be eligible for preventive services or treatment of medical conditions until such conditions, if left untreated, warrant hospital care or specialized outpatient treatment. This makes it difficult for VA to consistently apply the eligibility rules. As a result, eligibility for treatment depends greatly on what outpatient clinic the veterans visit.

Although considerable numbers of veterans have migrated to the Western states, there has been little shift in VA resources and facilities. As a result, facilities in the Eastern states are more likely to have adequate resources to treat all veterans seeking care than facilities in Western states, that frequently are forced to ration care to some or all higher-income veterans as well as many veterans with lower incomes.

Using a questionnaire, we obtained information from VA medical centers on their rationing decisions. The medical centers' varying rationing practices resulted in significant inconsistencies in veterans' access to care both among and within the centers. For example, higher-income nonservice-connected veterans could receive care at 40 medical centers that did not ration care, while 22 other medical centers rationed care even to veterans with service-connected disabilities. Some centers that rationed care by either medical service or medical condition turned away lower-income veterans who needed certain types of services while caring for higher-income veterans who needed other types of services.[9]

Finally, VA does not provide veterans access to outpatient care comparable to what they would get under other public or private health benefits programs. Veterans must generally travel to one of VA's 376 outpatient clinics to obtain routine outpatient treatment. Frequently veterans must travel long distances to obtain outpatient care. For example, veterans in Charlotte, North Carolina, must travel about 50 miles to the nearest VA outpatient clinic. Under other public and private health benefits programs, however, beneficiaries generally have access to a broad range of providers within a few miles of their homes.

OPTIONS FOR RESTRUCTURING THE VA HEALTH CARE SYSTEM

Because of the major challenges facing the VA health care system, VA and the Congress are at an important crossroad in the evolution of the system. A major restructuring of the system appears warranted. Options for such a restructuring might include

—consolidating hospital services or converting hospital beds to other uses,

—retargeting VA resources to better meet the health care needs of VA's current target populations,

—expanding eligibility to transform VA into a comprehensive health care system competing with private sector providers,

—expanding care for nonveterans,

—strengthening cost sharing for nursing home care, and

—expanding use of private nursing home providers.

Consolidating Hospital Services

VA and the private sector have reacted very differently to declining inpatient work load. In the private sector, hundreds of hospitals have closed over the last 5 years; more than 10,000 beds were taken out of service in 1994 alone.[10] VA, however, has not closed any hospitals because of declining utilization.[11] In fact, VA plans to add new hospitals in Florida, Nevada, Hawaii, Alaska, and California as part of joint ventures with the Department of Defense.[12]

To survive in such a competitive environment, private sector hospitals have increasingly (1) merged into hospital systems; (2) expanded horizontally to include such related health care facilities as nursing homes, ambulatory surgery centers, and home health agencies; (3) joined forces with HMOs to ensure a steady stream

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[9] VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993)

[10] Statement of William J. Schuler, President and Chief Executive Officer, Portsmouth Regional Hospital, before the House Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, April 6, 1995.

[11] Two VA hospitals, in Martinez and Sepulveda, California, were closed because of structural problems. VA plans to replace the Martinez hospital, but does not plan to replace the Sepulveda hospital.

[12] The Air Force recently withdrew from the planned joint venture in Brevard County, Florida.

of patients; and (4) formed alliances with other hospitals to share high-cost services and equipment to prevent costly duplication.

Similar changes are needed in the VA system if it is to become more efficient and capable of competing with private sector hospitals. VA's recently announced plan to reorganize its medical centers into 22 VISNs is, among other things, an attempt to strengthen planning on a network rather than facility basis. In addition, VA envisions consolidating high-cost services in fewer facilities.

Although these are goals that we strongly support, VA's early efforts at network planning have not been successful. We recently reported that VA's central office had not given adequate guidance to its regional offices and medical centers on how to change VA's facility-by-facility construction planning process into an integrated network planning process. As a result, VA overstated its need to increase its extended care capacity. Although our report was issued in December 1994, VA has not taken a position on our recommendations that it revise its strategic planning guidance to better support networkwide rather than facility-by-facility planning.[13]

If VA has difficulty in changing its construction planning to a network basis, VA—however well-intentioned its plans may be—will find it even more difficult to make important decisions about consolidating services and closing underused facilities. One option may be to establish an independent panel, similar to the military base closure commission, to recommend changes.

Special Care Needs of Veterans Should Be Better Targeted

Another option for restructuring the VA health care system would be to retarget resources used to provide care for higher-income nonservice-connected veterans toward service-connected and lower-income veterans whose health care needs are not being met.

About 15 percent (319,000) of the 2.2 million veterans using VA medical centers in 1991 were nonservice-connected veterans with incomes of $20,000 or more. About 11 percent (91,520) of the single nonservice-connected veterans (832,000) and 57 percent (227,430) of the married nonservice-connected veterans (399,000) using VA medical centers in 1991 had incomes of $20,000 or more. Among married nonservice-connected veterans using VA medical centers, 21 percent (84,000) had incomes of $40,000 or more.

VA could use those resources to target the special care needs of veterans and strengthen its ability to fulfill its safety-net mission. For example, the resources could be used to

—conduct outreach to medically underserved populations, such as homeless veterans;

—expand programs that address special care needs; or

—expand services for lower-income, uninsured veterans.

Expanding Eligibility for Veterans

While eligibility reform would be needed if the Congress wants VA to provide a uniform set of benefits to all veterans, such an expansion would fundamentally change VA's health care mission and has significant implications for cost and access to care. Currently, veterans' entitlement to care, even for service-connected veterans, is limited to those services that can be provided within available space and resources.

Keeping the resource constraints while broadening the entitlement to services could result in shifting VA resources away from providing services to service-connected and lower-income nonservice-connected veterans in order to provide a wider range of services to higher-income nonservice-connected veterans. In other words, it might decrease services available to service-connected veterans.

On the other hand, eligibility reform that would remove the space and resources constraints would essentially turn VA into an open-ended entitlement program like Medicare. Removing the resource constraints and expanding VA entitlement to free comprehensive health care services to all veterans currently eligible for free care (about 9 to 11 million veterans), as VA proposed last year, could add billions of dollars to VA's health care budget. The cost would depend on the number of veterans taking advantage of such expanded eligibility and the extent to which changes are made in the VA system to make care more accessible to veterans.

One option for limiting the cost of eligibility expansion is the use of cost sharing to offset the costs of the expanded benefits. For example, VA might be authorized to provide veterans any available health care service without-changing existing eligibility for free care. In other words, veterans could purchase, or use their private

[13] VA Health Care: Inadequate Planning in the Chesapeake Network (GAO/HEHS-95-6, Dec. 22, 1994).

insurance to purchase, additional health care services from VA. Such a change would not, however, significantly strengthen VA's safety-net role because lower-income uninsured veterans would likely be unable to pay for many additional health care services even if VA were authorized to provide them.

Another option would be to expand eligibility to create a uniform benefit package but narrow the scope of services included in the package. In other words, some veterans would receive a narrower range of free services while others would receive additional benefits. This approach, however, would essentially take some benefits away from service-connected veterans with the greatest disabilities and give additional benefits to service-connected veterans with lesser disabilities and to nonservice-connected veterans.

A third option for paying for eligibility expansions would be to authorize VA to recover from Medicare the costs of services VA facilities provide to Medicare-eligible veterans. Allowing VA to retain recoveries from Medicare without an offset against VA's appropriation, however, would create strong incentives for VA facilities to shift their priorities toward providing care to higher-income veterans with Medicare coverage. More importantly, VA facilities would essentially receive duplicate payments for care provided to higher-income Medicare beneficiaries. Rather than improve the efficiency of the VA system, allowing VA to keep recoveries from Medicare could make the system less efficient by increasing resources available without a commensurate increase in work load. It could also significantly increase the overall costs of the VA system.

Finally, authorizing VA recoveries from Medicare could further jeopardize the solvency of the Medicare trust fund and increase overall federal health care costs regardless of whether VA is allowed to keep all or a portion of the recoveries. This is because such an action would essentially transfer funds between federal agencies while adding administrative costs.

Expanding Care for Nonveterans

One option for increasing the work load of VA hospitals would be to expand VA's authority to provide care to veterans' dependents or other nonveterans. Currently, VA has limited authority to treat nonveterans, primarily providing such services through sharing agreements with military facilities and its medical school affiliates.

Allowing VA facilities to treat more nonveterans could increase use of VA hospitals and broaden VA's patient mix, strengthening VA's medical education and research missions. Without better systems for determining the cost of care, however, such an approach could result in the use of funds appropriated for veterans health care being used to pay for care for nonveterans. For example, we recently reported that the Albuquerque, New Mexico, VA medical center was selling lithotripsy services to nonveterans at prices well below cost.[14]

In addition, VA would be expanding the areas in which it is in direct competition with private sector hospitals in the surrounding communities. Essentially, every nonveteran brought into a VA hospital is a patient taken away from a private sector hospital. Thus, expanding the government's role in providing care to nonveterans could further jeopardize the fiscal viability of private sector hospitals.

Recovering VA Costs for Providing Nursing Home Care

VA has a goal of providing nursing home care to 16 percent of veterans needing such care. VA could serve more veterans with available funds by (1) adopting the copayment practices used by state veterans homes and (2) establishing an estate recovery program patterned after those operated by increasing numbers of state Medicaid programs.

In fiscal year 1994, VA provided nursing home care to about 31,000 veterans in VA facilities, 29,000 in contract community facilities, and 18,000 in state veterans' homes at a combined federal cost of over $1.5 billion.

All veterans with a medical need for nursing home care are eligible to receive VA-supported care to the extent that space and resources are available. No veteran, however, is currently entitled to nursing home care.

Unlike Medicaid and most state veterans homes, the VA nursing home program has no spend-down requirements and minimal cost sharing. Only higher-income nonservice-connected veterans contribute toward the cost of their care, making copayments averaging $12 a day.

In fiscal year 1990, such copayments offset less than one-tenth of 1 percent of VA's cost to provide nursing home care in VA and community facilities. In comparison, eight states that charge for care offset from 4 to 43 percent of state veterans'

[14] VA Health Care: Albuquerque Medical Center Not Recovering Full Costs of Lithotripsy Services (GAO/HEHS-95-19, Dec. 28, 1994).

home operating costs through copayments. If VA had offset similar percentages, its yearly recoveries would have been between $43 million and $464 million depending on which state copayment provisions were adopted.[15]

VA could also offset a significant portion of its nursing home and domiciliary costs if it had the same authority states were given to operate estate recovery programs. Estate recovery is a process through which a government agency recovers the costs of services provided to a beneficiary by filing a legal claim against the beneficiary's estate. We estimated that estate recovery programs recover 68 percent of the Medicaid nursing home benefits paid for recipients who owned homes in the six states studied.[16]

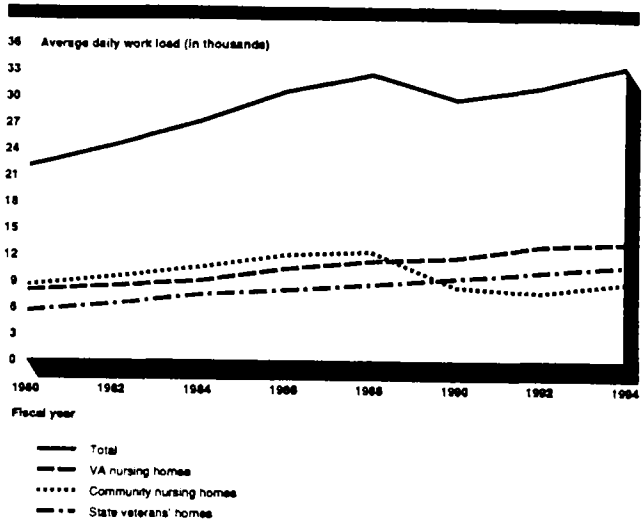
The potential for recovering nursing home costs through estate recoveries may be greater for veterans than for Medicaid recipients. This is because (1) home ownership—the primary asset of most elderly persons—is significantly higher among elderly veterans than among Medicaid nursing home recipients and (2) veterans living in VA facilities generally contribute much less of their incomes toward the cost of their care than do Medicaid recipients, allowing veterans to build bigger estates.[17]

Expanding Use of Private Nursing Homes

Finally, VA does not make effective use of lower-cost community nursing homes as an alternative to construction and operation of VA nursing homes. Since the early 1980s, we have repeatedly urged VA to increase its use of community nursing homes because (1) VA's costs of supporting patients in community nursing homes (about $106 a day in fiscal year 1994) are significantly lower than the costs of operating VA nursing homes (about $207 a day) and (2) VA could avoid the costs of constructing nursing homes (about $6 to 19 million for a 120-bed nursing home).

As shown in figure 2, however, VA has significantly decreased its use of community nursing homes since 1988, with a comparable increase in care provided in more costly VA nursing home care units.

Figure 2: Average Daily Work Load of VA-Supported Nursing Home Care, By Source of Care (1969-94)



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[15] VA Health Care: Offsetting Long-Term Care Costs Adopting State Copayment Practices (GAO/HRD-92-96, Aug. 12, 1992).

[16] Medicaid: Recoveries From Nursing Home Residents' Estates Could Offset Program Costs (GAO/HRD-89-56, Mar. 7, 1989).

[17] VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (GAO/HRD-93-68, July 27, 1993).

CONCLUSIONS

The VA health care system is at a crossroad—particularly in view of the dramatic changes occurring throughout the nation's health care system. These changes raise many important questions concerning the system:

—Should VA hospitals be opened to veterans' dependents or other non-veterans as a way of preserving the system?

—Should veterans be given additional incentives to use VA facilities?

—Should some of VA's acute care hospitals be closed, converted to other uses, or transferred to states or local communities?

—Should additional VA hospitals be constructed when use of existing inpatient hospital capacity is declining both in VA and in the private sector?

Decisions regarding these and other questions will have far-reaching effects on veterans, taxpayers, and private providers. We believe that attention is needed to position VA to ensure that veterans receive high-quality health care in the most cost efficient manner, regardless of whether that care is provided through VA facilities or through arrangements with private sector providers.

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or other Members of the Subcommittee may have.

Mr. SHAYS. We have an opportunity with three Members to really get into some key issues here, and so I'd like to begin the questions and just ask to start with—do the Inspector General's and the GAO's office work closely with each other in a lot of different departments?

Mr. TRODDEN. We work closely, particularly, Mr. Chairman, in the area of coordination of work and attempts to understand what each other is doing and to——

Mr. SHAYS. Not duplicating?

Mr. TRODDEN [continuing]. Not duplicate. We don't work particularly close together in terms of outcome. We're both independent agencies.

Mr. SHAYS. You both come to your own conclusions, but you just make sure you're not duplicating efforts and you'll read the report of the other and try to learn from that and so on.

Mr. TRODDEN. Correct.

Mr. SHAYS. What areas do you both agree on the most? Mr. Trodden is the VA program at a crossroads in your judgment?

Mr. TRODDEN. Yes, I think VA is at a crossroads, and I think VA agrees that it's at a crossroads.

Mr. SHAYS. I don't believe any administration can turn something around in, you know, 100 days or even 2 years. So our comments are not intended to reflect on this administration versus the past administration.

This is a major challenge for Members of Congress. Sometimes we like to think we're objective about it, but veterans carry a lot of clout, and sometimes we may not always speak as candidly as we need to speak. I hope we can have a candid dialog here.

Being at the crossroads means what? Put it as succinctly as you can, what being at a crossroads means.

Mr. BAINE. To us, Mr. Chairman, I believe——

Mr. SHAYS. A little louder. I'm sorry. A little louder.

Mr. BAINE. Our characterization of VA being at a crossroad means that the system, the veterans health care system, has a long way to go to catch up to the mainstream of American medicine.

The veterans health care system is largely hospital based. It's deals with episodes of care, rather than dealing with treatment of the whole person, if you will. It has incentives still in place to re-

tain and maintain the inpatient focus of the care it provides. That's got to change. It's just got to change.

The rest of American medicine is going to largely ambulatory care, largely managed care, with case managers for individual patients. There are places, pockets around the VA health care system, where that is being started. It's not widespread, and I think it's going to be a long time before that becomes the norm.

Mr. SHAYS. That strikes me as an indictment of two things. It's an indictment that we're not getting the best service we can, and we're paying a lot more for the service than we should be paying.

Mr. BAINE. I believe that's correct.

Mr. SHAYS. It sounds to me like you're describing a system not quite in the dark ages but way far behind the rest of the medical programs around the country.

Mr. Trodden, do you agree with that comment?

Mr. TRODDEN. I'm going to make a distinction, Mr. Chairman. When I say VA is at a crossroads, it's not exactly in the same context with what Mr. Baine's just said.

Mr. SHAYS. You're not deserting him here, are you?

Mr. BAINE. It wouldn't be the first time.

Mr. TRODDEN. I'm going to draw a different distinction, Mr. Chairman.

Mr. SHAYS. Please be candid.

Mr. TRODDEN. That's what I'm trying to be. I really do view that the Inspector General's Act and the way it's written, both specifically and in its overall thrust, establishes that I am not a policymaker. So I want to make that clear to start with. I think it's entirely proper for the GAO to recommend to the Congress policy changes.

And when the GAO talks about maybe VA ought to retrench and do the things that it does best and not necessarily be a full service medical system, that's entirely proper for the GAO to recommend and for the Congress to consider. I have no view on that. Obviously, the——

Mr. SHAYS. What do you mean, you have no view on that?

Mr. TRODDEN. Well, let me finish it. I think it is the—I know it is the administration policy to oppose that. My crossroads is that I think VA——

Mr. SHAYS. But be clear on this one part. You are an independent agency. What the administration has as a policy has nothing to do with what you're about?

Mr. TRODDEN. Correct. That is correct, sir. And whether that's their policy or my policy, you're right, I have every right to be independent, and I am independent.

Mr. SHAYS. OK.

Mr. TRODDEN. But I am not a policymaker.

Mr. SHAYS. Fine. I am asking you a particular question, though. Do you think it's at a crossroads?

Mr. TRODDEN. I think it's at a crossroads, but the crossroads that I envision is a slightly different one. I think VA is at a crossroads in terms of coming to grips with its resource allocation in such a way that it can maintain its viability. Whatever its charter is from the Congress to VA, in terms of what veterans get treated with what range of services, I think VA is very much at a crossroads in

adopting what I'll call modern business practices, if you will, to assure itself and the Congress that whatever resources it gets are optimally employed to do its mission.

Mr. SHAYS. What does it say to you, though, when you see a 50 percent drop in the number of people demanding the service in the last 25 years? What does it say in terms of whether we should put more focus on outpatient rather than inpatient? Does it say that we as a committee should be looking at reducing the number of VA facilities? We're talking about efficiency; we're talking about service. How would you weigh in on those issues?

Mr. TRODDEN. I would weigh in that those are clearly the issues that should be on the table, that a reasonable set of performance and cost measures that VA might provide that would illustrate—for example, if you have got 10,071 medical centers and a declining enrollment and excess capacity, I would think that a reasonable set of performance measures, unit cost measures, for example, would draw attention to the hospitals that have got a problem with regard to their capacity versus their clientele.

Mr. SHAYS. And you would contend that, based on the system we have now, we don't really highlight——

Mr. TRODDEN. Correct.

Mr. SHAYS. And so some hospitals run more efficiently than others, some have greater demand than others?

Mr. TRODDEN. Correct. And I don't see a great deal of visibility into what I'll call the core of VA as to why those issues exist. For example, as I addressed in my statement, the VA has adopted an RPM system of deploying its resources. The concept is that VA will move resources from what VA calls its high-unit cost outliers to its low-unit cost outliers, a concept that seems to have some sense in it to me.

However, if, without the knowledge of what's in that base and why that high-unit cost hospital is, in fact, a high-unit cost hospital, you could be doing damage to veteran patients there.

Mr. SHAYS. You could, but I think it doesn't take a rocket scientist to know that if you don't have the demand for the service and you still have the facility that the appropriation cost is going to go up significantly.

Let me just ask if there isn't a significant disincentive to go to outpatient services if you've got a facility that's totally underutilized?

Mr. BAINE. Mr. Chairman, I don't think there's any question that there's a disincentive to go headlong into an ambulatory care setting, if you have a facility that has to be maintained.

And I think Steve is right when he mentioned the new resource allocation model. The resource allocation model, like its predecessor, makes some sense. The fact of the matter is that, as a result of that model and its predecessor, less than 2 percent of VA's resources were moved around the system. And part of the reason for that was that the VA and the Congress, I believe, thought it had to maintain the base. It had to maintain the 171 medical centers around the country. And that costs a lot of money. And, therefore, a large portion of the $16 billion or $17 billion that the Congress appropriates for veterans health care goes to support that base.

Mr. SHAYS. Have either of you done studies that would determine that you could provide a better service to veterans by letting them go to their own local hospital?

Mr. BAINE. We have done some work with regard to polling veterans. Polling is not the right word—we've had focus groups.

Mr. SHAYS. Surveys.

Mr. BAINE. Surveys. And there is a fair amount of sentiment, that a large portion of veterans would rather go for their normal care to their private providers near where they live. As a matter of fact, I think you'll find that most veterans—most of the 26 to 27 million veterans—do just that, because they have private insurance or they're covered by Medicare or some other kind of insurance coverage, which permits them to go to their private providers. And then they will come to VA for the things that are not well covered under the Medicare program or their private health insurance.

Mr. SHAYS. My time has run out, but, Mr. Trodden, did you want to comment to that?

Mr. TRODDEN. No. A short answer would be I haven't done anything directly on that question, Mr. Chairman, but we did do a review a couple years ago of eight small surgical units. And we found—our concern was not primarily cost, although that was a big factor, but also our concern was volume of activity that would keep surgical skills at a level needed to maintain proficiency. And we issued a report that said that those eight surgical units ought to be considered for what we called consolidation. And the hue and cry, particularly on this side of the government, was substantial. My——

Mr. SHAYS. This side being Congress?

Mr. TRODDEN. This side being Congress, yes, sir.

Mr. SHAYS. You speak in tongues sometimes.

Mr. TRODDEN. I'm sorry, sir.

Mr. SHAYS. You're almost as bad as Alan Greenspan.

Mr. TRODDEN. I'll be direct. The Congress' reaction was quite vocal. You want me to be more colloquial, I'm saying they called my Deputy IG out to the west and keelhauled him. And the question was——

Mr. SHAYS. OK, that's fair, that's fair.

Mr. TRODDEN. Do you want—and the question was, do you want this pointy-headed bureaucrat from Washington closing your hospital?

Now I submit the most important power in Washington is the power to frame the question. And the question, in my opinion, more appropriately would be, if you're only going to have your gallbladder snatched out once in your life, do you want to have it done down the block by an outfit that does it a couple of times a month or would you be willing to travel 100 miles to an outfit that does it 20 times a day? I think you might get a different answer to that question, depending on how the question is framed.

Mr. SHAYS. Let me call on Mr. Towns.

And I appreciate your more direct comment. I have a sense that we're afraid to ask the question because we may not like the answer and that we may need to be asking some questions. I don't mean in this room, but I mean these broader questions that both of you hinted at.

Mr. Towns, I've gone through two cycles; and you're welcome, as well as the other Members, to do the same.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me begin by sort of saying to Mr. Trodden that your written statement is about as powerful as I have seen since I've been in the Congress, and that's something like 13 years. And I just wanted to share that with you.

You know—however, you know, in some of your comments, though, you seem to sort of back away from some of the things that are said here. So I just want to make certain that——

Mr. TRODDEN. I hope not, Mr. Chairman.

Mr. SHAYS. That he wrote it?

Mr. TOWNS. Well, no, I just want to make certain that we clearly understand. I like what I'm reading over here.

Mr. TRODDEN. I do not intend to back away from the statement, Mr. Towns, other than that one sentence that I commented on in my opening remarks. I did have a context for that that was different than you received it. I wanted to be sure that I was clear on that.

Mr. SHAYS. Did you say that Congressmen take things out of context?

Mr. TRODDEN. No comment.

Mr. TOWNS. Let me just put it this way. You say your concerns about the VA's ability to effect reform in the past were mostly focused on its decentralization of operations to the field. Is this correct? Decentralization is a fundamental aspect of the vision approach. Are you saying that the VA may not be able to enact vision? Is that what you're saying? I want to make certain that's clear. I don't like to do this, but——

Mr. TRODDEN. No, that's fine, Mr. Towns. What I'm trying to say—and I agree with Mr. Baine here. He says that one of the premises of the VISN reorganization is that central office has micromanaged the field. And my reaction to that is I'm not in favor of micromanagement, but I haven't seen micromanagement. I haven't seen a heck of a lot of management, much less micromanagement.

Now, the history of the central office role would be that they will put out policy, they will react properly to problems, for example, that the GAO raises or that my office raises, and they will put out policy that looks like it's well targeted to address the problem that we identified.

What I don't see and haven't seen in the past is a lot of management follow-up to make sure that that policy is, in fact, implemented. And the great history, the common theme of my 5 years here, has been to revisit problems that we thought we had fixed, only to find that they hadn't been fixed. So that's what I mean by the absence of management.

What the field seems to mean by micromanagement is that central office has spent their whole time deciding who gets what promotion or what director gets moved from hospital A to hospital B, and that's perceived by the field as micromanagement. And it well may be.

But in terms of management, absolutely insisting on certain fundamental principles that have to be implemented in the field and

then bringing somebody up short when they don't carry them through, I haven't seen a lot of that. So I'm encouraged by Dr. Kizer's approach where he says he is going to establish performance measures for those directors of his VISN networks, and he's going to hold them accountable in contract terms to those performance measures.

My only reservation to that is I've heard good things before and I'm now hearing good things again, but at least he's the first Chief Medical Director, in my experience, to be signing up to the proposition of performance measures for health care. I think that's a very, very important step.

Second, I recently took a briefing from the Chief Medical Director with regard to some work he's doing in the area of patient satisfaction, a very impressive piece of work. I was particularly impressed that it looks like it's logically developed.

I was more impressed with the conclusion that it came to where it said that, in the first go-round, some 65,000 responses from veterans who had been discharged from VA facilities rated their satisfaction, if you will, some 10 points lower than a comparable group discharged from private-sector hospitals. The fact that they came to that conclusion and made that statement gave them quite a bit of credibility, in my opinion, and some power in their instrument. So I'm encouraged that he's moving in that direction.

He also acknowledges that patient satisfaction is one thing and objective measures of quality of care are another, and that both are important even if they're not correlated. In other words, even if a patient is satisfied with his treatment, it may or may not mean that quality care was delivered, and he's going to try to do both.

So I think anything that I can do and anything that the Congress can do to support Dr. Kizer in those two endeavors would be money and effort very well spent.

Mr. TOWNS. All right. Let me move along. Let me just ask you one other question here real quick.

In your testimony you said we must transcend cultural attitudes if they resist change in favor of preserving the status quo. Nothing can be sacrosanct. We must be willing to put aside parochial interests and work together to develop organizations and programs that are based on quality management and sound financial principles for the common good of the veterans we serve. A great statement, and I agree with it.

In general, though, in terms of how has the VA responded to your recommendations in the past, is the culture in place to ensure your recommendations are carried out?

Mr. TRODDEN. The general reaction in the past, the first part of your question, Mr. Towns, has been to satisfy the IG. In other words, in the IG Act there's a provision for resolution. If I end up disagreeing with the manager, there's a process by which we take it to the Secretary and get resolution.

Sometimes I wish they would disagree with me more, because what they tend to do is agree, agree with the problem, prescribe a solution which is designed sometimes I think to make us all go away happy, without any real, long-term corrective action envisioned.

So I can't fault the reaction to the report. It's, generally, you've got a legitimate problem. We're going to make this change. My concern is on the implementation, of that and in holding their feet to the fire to make it happen.

Now one last thing—I know this is a long answer. I think Dr. Kizer needs all the help he can get with the policies that he's briefed to this committee on his reorganization. Because what he said and what he's going to be able to make happen are two different things. And I think he's got a culture at the hospital level that's going to resist that change. At least they've resisted me in the past.

I've been preaching performance measures and criteria for evaluating these facilities now for 5 years. VA's culture has been very resistant to that. I have no reason to believe, other than the fact that Dr. Kizer has got line clout and I don't, that they're going to be more receptive to him than to me. So anything the Congress can do and this committee can do to undergird his effort in those areas, I would fully support.

Mr. TOWNS. This is a very quick answer, and I want to have one question for Mr. Baine before my time runs out.

Mr. SHAYS. You've got time.

Mr. TOWNS. OK, thank you, Mr. Chairman.

You indicated that you were not a policymaker.

Mr. TRODDEN. Yes, sir.

Mr. TOWNS. And, however, in reading your statement, you indicated very clearly that legislation might be needed. Are you saying if you were a policymaker you would suggest some legislation? Make sure I understand this. We've been on break, so I might be a little slow this morning.

Mr. TRODDEN. No, I—let me see if I can straighten that out.

Mr. TOWNS. OK. Thank you.

Mr. TRODDEN. I am not a policymaker. I think the Congress should, for example, take to heart the questions that GAO raised and decide what it is that VA is supposed to be delivering. I think the Congress should get behind performance measures. These things are not very clear.

As I think you've probably been through, if you read the eligibility rules, the Secretary and everybody else is in favor of eligibility reform, I would submit if for no other reason than that VA eligibility rules read like a Wall Street lawyer might have written them. They're very complex. I have to turn to Mike Sullivan on my left every time this question comes up, who's eligible for what, in and of itself would argue for some clarity.

VA has educational programs. Is their purpose to get the vet a job or is it to get him a course of study? Before VA can come back with performance measures and how well it's doing, I'm suggesting that the charge from the Congress to the Department could stand quite a bit of clarity.

Mr. TOWNS. All right. Thank you very much, Mr. Trodden.

Mr. Baine, eligibility for certain health care services is currently linked to receipt of hospital care in VA facilities. Isn't access to comprehensive outpatient services a critical factor in reducing costs?

Mr. BAINE. I certainly believe it is, Congressman Towns. I—in listening to Mr. Trodden—I want to point out one thing. I'm not a policymaker either. But, I think the move to turn VA into a primarily outpatient, an ambulatory care system, is very, very important.

If VA is to remain a viable system for the foreseeable future it has got to turn this boat around, and it could use the help of the Congress in doing that.

Mr. TOWNS. I know you indicated very clearly that you are not a policymaker, but it won't stop this question from coming to you as well.

Mr. BAINE. OK.

Mr. TOWNS. Is legislation likely to be necessary to restructure the veterans health benefit programs?

Mr. BAINE. I'm sorry. Could you——

Mr. TOWNS. Is legislation likely to be necessary to restructure the veterans health benefit programs? Will we need legislation to do that?

Mr. BAINE. The VA can do some things with eligibility through providing guidance to their medical centers out of central office and so forth, but I believe that if eligibility reform takes the form of changing the benefits or making people entitled to care who are not now entitled to care on an outpatient basis, that legislation would be needed, yes, sir.

Mr. TOWNS. Thank you very much, Mr. Chairman. I yield back.

Mr. SHAYS. Mr. Chrysler wanted to ask some questions, but he is testifying at another hearing, and I just think that what we will do is do each 5 minutes more.

We could spend a great deal of time with each of you. Your statements are both excellent, and your comments are helpful as well.

But the picture I get is a system in which we are dealing with a very important and sensitive group. We are dealing with our veterans, and so I think there is a built-in caution to say things so carefully that no one takes offense politically and so on. But what I see is a system of facilities located where there was workload in years past. Some of these areas may not have as many veterans. Then we have newer areas. Obviously, people have shifted. There has not been that kind of adjustment in population with our facilities.

We are seeing in the private sector private hospitals become more competitive and some actually being closed down, and I am struck with these realities. One is, we can expand who is covered in a veterans' facility to have it not just be those who have lack of financial resources and those who have illnesses or injuries that are related to their responsibilities in the service. We can invite families to be part of these facilities. We can include people in the private sector to use them. And then, as you point out, Mr. Baine, then we are directly competing with the private hospitals.

But I guess my question is, how is it conceivable that we can, in the years to come, have viable, competitive, cost-effective hospitals if we don't close some of them down and we don't increase the patient need in others? I just don't know how we can do it. So, if we make no changes, each of you tell me what happens to the

system. If we continue as we are going, what happens to the system?

Mr. BAINE. In my opinion, Mr. Chairman, if the system remains as it is, given the decline in veteran population and a number of other factors, I believe that the system will wither away by itself over some period of time.

Mr. SHAYS. But by doing it that way, Members of Congress don't have to make a more direct——

Mr. BAINE. That is true.

Mr. SHAYS. In other words, you allow the patient, in a sense, to die.

Mr. BAINE. That's my own personal opinion. I think that the trends that we have seen over the last 25 years are headed in that direction.

One other comment I would like to make in response to your opening comment——

Mr. SHAYS. Sure.

Mr. BAINE. I am fond of saying that it is entirely possible to preserve and perhaps enhance the veterans health benefit without necessarily preserving the hospital system, the health care system as it is today. This has been done, as you may be aware, in some other countries where the veterans health benefit has been enhanced and veterans have priority over other citizens in the private sector.

Mr. SHAYS. Yes.

Mr. BAINE. If the Congress and if the policymakers, to use Mr. Town's phrase, were to decide that that's the way to go, this would provide VA an opportunity to do the things that it does probably better than anybody in this country, for example, treatment of spinal cord injury, posttraumatic stress disorder, mental health, drug and alcohol abuse, and blind rehabilitation.

Mr. SHAYS. Your point being that there is a greater area of expertise here and so on?

Mr. BAINE. Yes, yes. And these are all services that are provided by some medical centers around the country. In my view, resources could be shifted to pay increasing attention to those kinds of services, and for the acute care needs of veterans, perhaps make greater use of the private sector.

Mr. SHAYS. Mr. Trodden, what happens to the system if we allow it to continue the way it is? You pointed out changes you suggest we make to highlight efficiencies of hospitals and so on—or the lack of efficiencies. But, if we make no changes, what happens to the system 5, 10, 15 years from now?

Mr. TRODDEN. I think the system is in trouble if no changes are made. I think there is probably agreement on that score. For example, I think there is agreement from the Secretary, from the Chief Medical Director on down, that the thrust of modern medicine is away from inpatient treatment and toward outpatient treatment.

So, if nothing else, we have a set of eligibility rules right now that make it tougher for a veteran, eligibility-wise, to get outpatient coverage than it does to have him admitted to the hospital. That makes little sense to me. So, if nothing else, it would seem to me that would have to change.

Mr. SHAYS. Mr. Towns.

Mr. TOWNS. Yes. Thank you very much, Mr. Chairman.

Mr. Trodden, you have indicated that the VA fails to realize millions of dollars in savings in its procurement activities. Does anything in the VHA reorganization plan address this problem? If not, how should the plan be amended?

Mr. TRODDEN. It's not specifically, I don't believe Mr. Towns, discussed in VHA's reorganization plan. However, there is an initiative under way that is designed to deal with the issue that I raised.

The fundamental problem in VA's past has been they haven't known—I know this sounds silly, but you asked me to be blunt—they haven't known what they were buying. They haven't known it in quantities. And so this is where VA, in my opinion, has to deal with the question, is it a system or isn't it? Is it 172 separate hospitals or is it a major buying force?

Typically, in the past, VA would negotiate with, say, a pharmaceutical company for a line of pharmaceuticals under FSS, Federal Supply Schedule contracting procedures, which basically sets a price for the drug under the premise of: If I buy any, what would you charge me? And the answer, of course, is, oh, if you buy any, I will charge you 10 bucks a pill. Whereas—again, the power to frame the question.

If VA were saying, I need to buy 10 zillion tons of this particular pharmaceutical, what price would you charge me, the answer might well be, if you agree to purchase in that bulk, I will agree to charge you $3 a pill. And it has been the inability of VA in the past to commit to those quantity purchases because the central buying authority hasn't always known what the history of requirements have been that's caused the kind of contracting they talk about.

They now have a system under way that's designed to capture the quantity buys that VA is making. I'm hopeful that should that pay off, as advertised, VA will be able to do more bulk buying, like the IV example that I have in my prepared statement.

Mr. TOWNS. Mr. Trodden, you indicated that millions in Federal Employees Compensation Act costs could be saved or avoided by returning work-capable claimants to work. Are the VA pilot programs a useful attempt to correct this problem? Will the VISN program approach actually present additional concerns?

Mr. TRODDEN. No, I don't think VISNS will bring me more concerns, Mr. Towns, because the VISN concept is that the VISN director won't be so much hospital focused in the future, at least that's the way the rhetoric goes. He'll be patient focused, and he'll be looking at the needs of serving the veteran patients in his network. And since he is only going to have a limited amount of resources I hope that he will be even more incentivized to not spend them on people who are capable of working.

The second thing that VA has already done, and which to me makes great sense and I hope it proves out, the tab, the bill for these folks who were off on worker's comp and couldn't work, used to be centrally funded. So if the hospital had a number of workers who were on the worker's comp rolls, they weren't feeling the price, they weren't feeling the pain in their budgets of having these workers on the worker's comp rolls. That was centrally funded.

VA has reversed that now. Mark Catlett, the Assistant Secretary for Management—the Chief Financial Officer has reversed that, and now each individual hospital has to pay the freight for the hospital employee who's off on worker's comp.

When we did an audit, we found a number of employees whose doctor was saying that their original problem, assuming it to have been valid, has now been solved, the employee is ready to come back to work, and we weren't bringing them back to work. It is as simple as that.

And I am now hoping that with the price tag being shifted to the hospital director or, in the advent of reorganization, to the VISN director, that's a money winner, and they'll grab those employees and bring them back to work.

The last issue I raised in my statement I think is beyond me, but I did commend it for the committee's consideration, and that is the phrase I used in there that one might question the wisdom of having one agency of government spending another agency of government's money. And by that I mean the Department of Labor is the one that adjudicates whether or not a VA employee is, in fact, disabled. If Labor says he or she is, VA pays the price.

And everything I addressed to you earlier had to do with getting rehabilitated employees back to work. The question I am now raising is the judgment call of whether that employee was disabled in the first place, and I think the Department of Labor is probably incentivized to compensate people for injuries. God knows, there are some of them who warrant it, need it and deserve it. There are others of them, though, that I question; and I wonder if Labor is going to be making that call whether or not Labor ought to be paying the freight. Just a question I raise.

It does seem like, in this area of incentives, it might be worth looking into the question of whether one agency of government ought to make the decision because of the price tag and have it endure to the detriment of another agency.

Mr. TOWNS. We wouldn't have any dollar figures on this, would we, as to how much money we are really talking about? Do you have any idea?

Mr. BAINE. I do not, sir. I can check around in our office and see if I could find some, but I do not know.

Mr. TRODDEN. I will take just a real rough stab at this, Mr. Towns. We had a figure, I think it was $194 million, VA alone. Now, admittedly, VA is the second or third, depending on how you count, largest employer in government. But if VA has got the potential for $194 million——

Mr. TOWNS. So it exists in all the agencies?

Mr. TRODDEN. I would expect that it exists in substantial terms throughout the Federal Government, yes, sir.

Mr. TOWNS. Thank you very, very much.

Mr. SHAYS. I would like to thank all of you for testifying.

I don't know, Mr. Souder, if you want to join in right now.

Let me say to you that, Mr. Linz or Mr. Sullivan, you have been very loyal participants here. If you had any comment you want to make, any observations—sometimes those who don't say anything end up having the most insightful comments. Do you have any comment that you would like to make?

Mr. SULLIVAN. I don't at this time, sir.

Mr. SHAYS. That was very insightful—or wise.

Mr. LINZ. The only thing I would add is that I really think the Congress and VA have some very tough choices to make because of the decline in VA hospital utilization.

Mr. SHAYS. Yes.

Mr. LINZ. Should actions be taken to admit nonveterans or to admit veterans' dependents to try to prop up the hospitals? Or should you start moving toward transferring the veteran's acute care program toward the private sector and focusing on the specialized services?

Mr. SHAYS. These are major issues, and you have duly warned us, I think, of the need to address this, and, you know, as policy decisionmakers, it is our decision, but I am happy you have raised these policy questions for our concern.

This has been a very helpful hearing and enjoyable as well. I would like to request that someone from each of your offices stay to listen to our last panel. It won't be as long.

John Bollinger, deputy executive director of the Paralyzed Veterans of America. We have also invited on short notice David Gorman, the deputy national legislative director of Disabled American Vets. And they have had the opportunity to hear your comments, and they might have some responses to that. And so if someone—either all of you or some of you could stay, it would be very helpful.

Mr. TRODDEN. I will be able to stay myself, Mr. Chairman, at least until 12:30; and if it goes beyond that, I will leave somebody here.

Mr. SHAYS. Thank you very much. I really appreciate it. And we'll call our second panel. And, again, thank you all for your testimony and your contribution.

We were, during part of this hearing, joined by Mr. Chrysler and Mr. Souder as well, for the record.

And we also are joined by Frank Buxton from the American Legion, and it is wonderful to have you here as well. I am happy you came to the hearing. We are inviting you on short notice, and I just think it is very appropriate that you all be participants.

And we are also joined by Douglas Vollmer, is that correct? So we have accounted for everyone.

Mr. Fuller. And, Mr. Fuller, you are with——

Mr. FULLER. Paralyzed Veterans of America.

STATEMENT OF JOHN BOLLINGER, DEPUTY EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ACCOMPANIED BY DOUGLAS VOLLMER, ASSOCIATE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA; AND RICHARD B. FULLER, DIRECTOR OF HEALTH POLICY PROGRAM DEVELOPMENT, PARALYZED VETERANS OF AMERICA; AND DAVID GORMAN, DISABLED AMERICAN VETERANS; AND FRANK BUXTON, AMERICAN LEGION

Mr. SHAYS. Let me tell you all that we need to swear you in.

Mr. Bollinger, I am not expecting you to stand up, but I thank you all for your service to your country and you all honor us by

being here, and we want to do the right thing by you and our country, and we look forward to your testimony.

At this time, if all of you would raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. For the record, all five gentlemen have responded in the affirmative and are under oath.

Let me be clear, we are going to have testimony then from three different individuals. We are going to start with you, Mr. Bollinger. You were our invited guest, and with some warning, and everyone else is an invited guest on short notice. And, Mr. Bollinger, we are delighted to have you here and welcome our testimony.

Mr. BOLLINGER. Thank you very much, Mr. Chairman, and thank you for inviting this expanded panel here on short notice. I don't feel quite as guilty about focusing my comments on a specialized service.

Mr. SHAYS. We are happy that we have at least resolved that, because you certainly were eager to have others participate and so we are happy that they have.

Mr. BOLLINGER. Before I comment on the restructuring of VA and Secretary Brown and Dr. Kizer's plan, I want to take just a moment to tell you about the stake that PVA members and paralyzed veterans have in this issue.

Health care delivery is something that we depend on every single day of our lives from the first moment of injury and for the rest of our lives. Our ability to obtain quality acute care, rehabilitation, sustaining care, long-term care will dictate the quality of our lives.

Interdisciplinary medical care is a lifelong need for PVA's members. Prosthetic equipment, neurologists, urologists, plastic surgeons, adaptive devices, all those things are a part of our daily lives. So our stake in the restructuring of VA is very high.

VA's unique expertise in the specialized area of spinal cord injury is something that we depend on very heavily, so it is with this point of view that I share our thoughts on VA's future with you today.

As you consider the restructuring of VA, there are several areas that I would like to stress today that I think are most important both in terms of the costs to our country and in terms of the provision of quality health care, and these areas are specialized services, entitlement reform and funding and health care practice guidelines or parameters.

As you know, specialized services include such care as spinal cord injury medicine, blind rehab and PTSD. These are areas where VA has over the years developed a unique expertise. And as the April 1995 GAO report testifies, these special services fill a void in the private sector's medical care system. And we know very well that in the case of spinal cord injury, and with the exception of a few model centers that exist, VA's the only game in town for most paralyzed veterans. And even with some of the shortcomings VA has, VA provides the most comprehensive interdisciplinary care that we desperately need.

It must be understood that in order to fulfill the missions discussed in GAO's report, the specialized services and the safety net mission that they mention, these services can't exist independently, and that's where we differ from the GAO's report.

Specialized services are not easily distinguishable from acute care services, and they can't exist in a vacuum. VA can only provide high-quality specialized services to veterans with a solid acute care infrastructure in place. SCI medicine relies on a highly integrated approach to care delivery which simply couldn't take place if the VA only operated SCI centers, and the same is true of other specialized services.

The second area I would like to stress is that of eligibility reform, and I am sure you know and it has been discussed this morning already that the current system is confusing, at the very least. And as we have said many times before, it results in bad economics and bad medicine. Patients ineligible for lower cost outpatient care must now wait until they are sick enough to be admitted for expensive inpatient care.

And we are not policymakers either, but we strongly believe that Congress should enact legislation which would reform eligibility for health care in order that eligible veterans are able to obtain the full spectrum of care. This will result in a more efficient approach and will surely result in healthier patients.

We strongly believe that eligibility reform is essential to successful allocation of resources within VA. And until VA physicians can make treatment decisions without referring to arcane criteria which now control veterans' access to different VA health care settings, the benefits of a decentralized management system as articulated in VA's current plan can only be partially realized.

Mr. Trodden has stated in the IG's report that the most important part—one of the most important part of VA's reorganization plan is the development of system-wide health care policies and practice parameters, and we believe very strongly that he is correct there. We believe such parameters or guidelines are essential to ensure accountability as VA begins to reorganize in these VISNs and across the country in the specific hospitals.

I would like to close with a few general observations about VA's reorganization plan.

Basically, we see it as a good first step; and we congratulate the Secretary and Dr. Kizer for their foresight. But we are concerned about a few things. And, again, I am being a little parochial here, but the reorganizational plan is silent about how spinal cord injury services would be protected. Spinal cord injury medicine is high cost and labor intensive, and we are concerned that SCI medicine would be extremely vulnerable to dollar-driven decisions made by local directors.

The plan is also silent on the specifics of SCI medicine and the future configuration of those services. VA should outline in greater detail the management structure that must preserve the quality of VA's specialized services, including blind rehab, PTSD, homelessness issues and spinal cord injury.

And, third, the VA's reorganization plan does not address the issue of eligibility reform.

Finally, there is no doubt that VA will be a much different place 10 or 15 years from now. More than likely, it will be smaller; and more than likely it will be treating dependents and possibly others who could benefit from its expertise in areas like spinal cord injury medicine.

One thing is certain. We believe it's a national resource, and we believe very strongly that it's very much worth preserving.

And that concludes my statement. Thank you.

Mr. SHAYS. Thank you very much, Mr. Bollinger.

[The prepared statement of Mr. Bollinger follows:]

PREPARED STATEMENT OF JOHN BOLLINGER, DEPUTY EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Chairman Shays, Ranking Minority Member Towns and Members of the Subcommittee, on behalf of the Paralyzed Veterans of America (PVA), I wish to thank you for this opportunity to present testimony today regarding the Veterans Health Administration's (VHA) Reorganization Proposal. PVA commends the Secretary of the Department of Veterans Affairs (VA) Jesse Brown and the Under Secretary for Health Dr. Kenneth W. Kizer for submitting a progressive reorganization plan for VA's health care system. Moreover, PVA would like to praise Dr. Kizer's leadership of VHA and his courage for undertaking the daunting task of realigning VHA's health care delivery system.

Paralyzed Veterans of America (PVA) is a Congressionally chartered veterans' service organization all of whose members have experienced catastrophic spinal cord dysfunction (SCD). Since our founding nearly fifty years ago, immediately following World War II, our members have relied upon the VA health care system for the full range of health care. The extensive and continuous medical and rehabilitative care requirements of SCD individuals encompass the broad range of medical specialties the VA offers and VA in addressing the needs of SCD veterans has developed a unique system of SCD services, many of which have no counterparts in the private sector. This system of care consists of acute, sustaining and long-term care services which address the lifetime needs of veterans with spinal cord injury or dysfunction.

Because of the broad spectrum of health care services PVA's members require we, as an organization, have historically focused much of our energy in working to ensure that the VA health care system meets these requirements. Through studies, research and continual monitoring of service provision PVA addresses the health care needs of our membership. For this reason we are pleased to present our views regarding the reorganization of the VA health care system.

PVA views the VHA's plan as a step in the right direction, one that will change the veterans' health care system to a more patient centered and efficient program. To that end, PVA extends its experience and expertise to this Subcommittee and to the VHA to assist in anyway in the realignment of the veterans' health care system to meet the health care needs of all its users, including those veterans with spinal cord dysfunction (SCD).

Mr. Chairman, PVA supports this effort by the VA to streamline its management structure and enhance the efficiency of the veterans health care system. However, in doing so, we must make certain that VA does not lose sight of the VA's primary health care mission. The VA has historically focused on addressing those medical requirements of veterans which are noticeably prevalent in the veteran population and related to their military service. For PVA's members those services have been provided by the VA'S system of spinal cord injury/dysfunction care. For other veterans the VA has created unique programs focusing on many specialized areas of need such as, amputee care, blind rehabilitation, long term care and PTSD and mental health care. As the VA's restructuring moves forward it is extremely important that these core, specialized services are given special consideration. It is essential that these specialized services are recognized as being the cornerstone of VA's health care mission. The reorganized VA must maintain and enhance these specialized services which will to allow VA to retain its unique role in meeting the health care needs of veterans.

PVA, along with three other national veterans, service organizations, develops an Independent Budget each year which provides Congress a counterpart to the Administration's budget request for VA programs. This document also provides particular recommendations our organizations have for managing VA resources. For many years, the Independent Budget has called for the same type of decentralized management evident in the Under Secretary's " Vision for Change." The Independent Budget's greatest call over its nine years of publication, however, has been for eligibility reform. Such reform would allow VA practitioners to make the most appropriate clinical decisions regarding treatment of their patients, regardless of that veteran patient's eligibility classification. We believe that eligibility reform is essential to successful allocation of resources within VA and one that is missing from the reorganization plan. It is one thing for VA to reorganize and decentralize its adminis-

trative structure, improving efficiency at the source. But these management improvements are meaningless unless eligibility reform gives the system a rational health care product to provide. Until physicians can make treatment and placement decisions without referring to the arcane criteria that now control veterans' access to different VA health care settings, the benefits of a decentralized management can only be partially realized.

Veterans Integrated Service Networks

VHA's reorganization proposal would restructure VHA's field operations and its central office management. VHA's field operations would be restructured around the concept of Veterans Integrated Service Networks (VISN). Under this concept, VHA's current field operations (four regional field management offices) will be replaced by 22 Veterans Integrated Service Networks nationwide. A director will manage each VISN area. The VISN directors will be responsible for ensuring the full range of services, including specialized services and programs for disabled veterans. VISN directors will report directly to the Office of the Under Secretary. According to the proposal, VISNs will focus on (1) integrating acute and long term inpatient and ambulatory services, and (2) achieving the greatest possible health care value for the allocated resources provided.

We support the reconfiguration of VHA's field operations because it vests in the VISN directors the authority and flexibility needed to operate VA medical facilities in the context of a rapidly evolving health care system. VISN directors will be tasked with developing and implementing VISN budgets, consolidating and/or realigning functions, and contracting with non-VA providers for medical and non-medical services. Under this proposal, the directors will be able to tailor health care operations to correspond with local needs. VISN directors will be afforded greater latitude in responding to state health care reform initiatives. Moreover, PVA recognizes that the success of VISNs will be intrinsically tied to the individual directors. They will be responsible for ensuring the continuity of medical services within the VISN framework and the viability of specialized programs.

While PVA supports the enhanced authority and flexibility the reorganization plan will give VISN directors, we are concerned about the implications this new authority will have on SCD medicine. For example, a VISN director may view SCD medicine as a high cost, labor intensive program and may decide to cut services. In such an environment, SCD medicine would be extremely vulnerable to budget and program manipulation at the local and VISN level. We strongly recommend that protections be implemented to safeguard SCD medicine and to ensure continuity of services provided to SCD veterans within VISNs.

Mr. Chairman, we realize you have had the opportunity to hear testimony from the General Accounting Office on their assessment of the Under Secretary's plan. We have also had the chance to review their work. Over the years, PVA has worked with GAO, sharing much of our analyses and opinions with them. We believe they often offer constructive suggestions for necessary VA change. However, in the case of the document we reviewed, "VA Health Care: Retargeting Needed to Better Meet Veterans, Changing Needs" GAO only seemed to hear half of the message we tried so hard to relay in Strategy 2000, Phase II: Meeting the Special Health Care Needs of America's Veterans. The half they clearly understood was the fact that veterans rely upon the specialized services they receive in the VA health care system and that these VA services fill a void that exists in the private sector's medical care system. They also point to the waiting times and queues these services sometimes have. We fully agree and suggest that VA correct these problems with program capacity that exacerbates waiting times for these services, such as post-traumatic stress disorder treatment and blind rehabilitation, that veterans desperately need. The part that didn't seem to get through to the GAO was the fact that these services cannot exist independently. They cannot be teased out of the rest of the totality of the VA health care system. The very benefit of VA's spinal cord injury centers is their integrated approach to delivering spinal cord medicine.

"Specialized" services are not easily distinguishable from "acute care" services. They cannot operate interdependently without them. We promote a joint emphasis on specialized services and the need to enhance acute care services and implement managed care in the Independent Budget and Strategy 2000: Phase II. VA can only provide high-quality specialized services to veterans with a solid acute care infrastructure in place. Specialized services consistently rely on online support from "acute care" providers. For instance, Spinal Cord Injury medicine relies on an interdisciplinary approach to delivering care-care is coordinated among cardiologists, urologists, neurologists, dermatologists, mental health professionals, rehabilitative specialists, and many other clinicians. This highly integrated approach to care deliv-

ery could not take place if VA only operated a Spinal Cord Injury center in a more "sub-acute" care arrangement. The same is true of many other specialized services.

Veterans offer unique challenges to the VA medical care system. VA health care users, as a group, are older, and often exhibit co-morbidities upon arrival at VA health care facilities. A veteran receiving care from an amputee clinic team, for example, may need access to a diabetes management clinic, to social services, and to cardiological services all of which may be considered "acute care" services. Bolstering acute care systems is consistent with enhancing specialized services. The two operate together, not in isolation from one another.

We also are concerned with the general timbre of the GAO report which suggests that any VA effort to improve veterans, access to VA medical services or provide them with a broader continuum of acute care services is needlessly duplicative and fosters a "competitive" atmosphere, shifting costs to VA. As we have asserted, VA needs a sound acute care system in place to support its specialized services. Supporting the acute care infrastructure necessitates a "critical mass" of veteran users, that is a certain number of veterans must use services to keep staff skilled and practiced in the provision of care and to ensure cost-effective care delivery. The types of enhancements the Independent Budget and PVA's Strategy 2000, Phase II address are the needs for VA to create this "critical mass". This will allow VA to operate services more efficiently for the veterans it now serves and more cost effectively for the American taxpayer. PVA views these enhancements, not primarily as an effort for VA to compete for more users, but as a necessary adjustment to delivering care more efficiently to those it serves. We have also suggested that VA medical centers be used to fill identified voids in the health care continuum, for example, VA might be called upon to deliver care to dependents or beneficiaries of its sharing partners in rural communities where VA is the sole provider. We believe that these types of arrangements are beneficial to all.

The structure and function of VHA's central office will also be significantly altered. Central Office's emphasis will change from control of processes to monitoring of outcomes. In short, central office will no longer micro-manage field operations. Instead, central office will focus on developing system-wide polices and practice parameters.

VHA's reorganization proposal for field operations and central office management is intended to produce tangible improvements in the quality and efficiency of care provided to veterans. PVA supports the following goals promulgated in the reorganization proposal: (1) decentralized central office; (2) increased accountability at the delivery level; (3) a stream-lined veterans health care system; and (4) greater efficiency. In fact, PVA has advocated and urged change in these areas for quite some time. PVA's study, Strategy 2000 Phase II: Meeting the Special Health Care Needs of America's Veterans, discussed in detail the need to restructure the VA health care system. The study also advanced the need to safeguard VA's specialized services and programs for disabled veterans .

Implications for Provision of Care to Veterans with Spinal Cord Dysfunction

PVA believes the VHA's reorganization proposal is one of many steps that must be taken to carry the VHA into a new and vigorous future. PVA is also cognizant of the fact that a misstep along the way could have disastrous implications for disabled veterans. VA needs to clearly demonstrate that it has the commitment and capabilities to adjust to the changing health care environment. In particular special care must be taken to nurture and protect those services developed to meet the unique needs of veterans with SCD and other veterans requiring VA's specialized services.

VA's spinal cord injury/dysfunction care system affords veterans access to a complex, comprehensive mix of health care services not readily available in the private sector. Providing all aspects of necessary medical and rehabilitative services, the VA integrates acute, sustaining and long-term services for veterans who experience spinal cord dysfunction. The VA's SCI system brings together the range of medical specialties necessary to address the lifetime requirements of veterans with SCD.

PVA is concerned about the quality and viability of SCD medicine as described in the reorganization plan. To illustrate, VHA does not provide sufficient clarity as to how the new central office and VISNs will interact to adequately assure quality performance and outcomes for specialized services, most notably, care for veterans with SCD. Without system-wide performance indicators, clinical practice guidelines, and treatment outcome measures, central office and VISNs cannot ensure the proper resources and quality of care for effective SCD medicine. In addition, VHA's proposal does not state whether there will be designated coordinators or personnel to monitor the conduct and quality of SCD medicine and other specialized services at the local and VISN level. PVA's membership depends heavily on the unique and

specialized services of VA's SCD medicine program. VHA's realignment must be implemented in a manner that will not compromise the SCD medicine program.

The reorganization proposal is remarkably silent on the specifics of SCD medicine and its future configuration. For example, some VISNs will have several Spinal Cord Injury Centers (SCI) while others will have none. The reorganization proposal does not provide information on how services to SCD veterans will be arranged in VISNs without an SCI Center. PVA recommends that VHA create an inter-VISN referral mechanism to ensure the appropriate provision of care to SCD veterans in VISNs without SCD centers. We recommend that VHA thoroughly review the operation of SCD medicine within the VISN scenario to ensure that SCD veterans have access to VA's SCD services regardless of where they live.

If the VHA is to preserve the unique quality and integrity of SCD medicine, as well as other specialized programs, then VHA must outline in greater detail a management structure that will ensure system-wide integrity in the context of decentralized administration. To ensure this end, PVA recommends an organization that would:

- Protect the resources essential to sustain strong specialized services programs
- Develop clinical practice guidelines for specialized programs and develop standards of care;
- Monitor performance and quality; and
- Enforce the coordination of funding, policy, standards, and quality assessment to ensure the dependable access and high quality care for veterans within the service network.

Funding for Specialized Services:

PVA recommends that resources for specialized services, including SCD medicine, should be protected and maintained to ensure the integrity of these specialized services.

The current VA system of allocating resources to individual medical centers with spinal cord injury centers has proven inadequate in appropriately recognizing the costs associated with SCD care. The current Resource Planning and Management (RPM) model does not fully account for all services provided veterans with SCD. For example, the cases of outpatient care and long term care reimbursements do not reflect the resource utilization frequently required. It is incumbent upon VA to ensure that the proposed changes in managerial structure are matched with accompanying changes in their resource allocation methodology assuring that individual centers are not penalized for the provision of SCD care.

Clinical Practice Guidelines for SCD Medicine:

To demonstrate our faith and commitment to the creation of such standards to improve our members health care, PVA has embarked on an extensive study process with other concerned parties, including practitioners, payers and consumers. Together, this group will develop numerous practice parameters for conditions either caused by or highly associated with spinal cord injury or disease. PVA's goal is to ensure that these guidelines improve the quality of health care for both veterans using VA medical care centers for spinal cord injury care and for all Americans with spinal cord dysfunction regardless of where they receive care. This process is particularly critical as VA begins its reorganization where the central office's role will shift from management to leadership. The field will have more of a role in assessing the requisite resources and proper protocols for treating veterans with spinal cord injury and disease. We want to assure our members that all VA medical centers, with or without spinal cord injury centers have access to these guidelines which could literally save our members' lives.

Monitor Performance and Quality:

PVA recommends that VHA designate specific personnel or coordinators to monitor the conduct and quality of SCD medicine and other specialized services at the VISN and local level.

We also recommend that responsibility for these functions should reside in the Office of Patient Care Services. In addition, all specialized programs should be represented in a Specialized Services Unit within the Office of Patient Care Services.

PVA also recommends that VA establish a mechanism that ensures consumer involvement in the reorganized system. Consumers and non-VA experts must be afforded the opportunity to provide the Under Secretary with a broad view of how VHA compares with and compliments similar services outside VA. This will give the Under Secretary independent assessments of how the new management structures are affecting service and how veterans with special needs perceive VHA.

Again PVA applauds Secretary Jesse Brown and Under Secretary for Health Kenneth W. Kizer for their guidance and foresight in taking the first steps toward restructuring the VA health care system. And while the need for structural change is acute, the cure for VA's long term success and viability will depend on the following: eligibility reform; maintenance of VA's core mission of providing specialized services; guaranteed funding for the provision of health care services; and retention of non-appropriated funds (e.g., third party reimbursements and Medicare payments). These changes will provide the VA health care system with the instruments and incentives it needs to deliver efficient and quality health care to our nation's veterans.

Mr. Chairman PVA will support the reorganization of VHA. We will assist in the process in any way we can to ensure the quality of VHA's program for spinal cord injury and dysfunction, so vital to our members' well being, is sustained. PVA will also insist on excellence in other specialized services for blinded veterans, for veterans in need of prostheses, for those in need of special mental health services such PTSD. Like us, these veterans depend on VHA for service that cannot be matched by other federal programs or private sector providers.

Thank you for this opportunity to testify. We look forward to continuing to work with you and this Subcommittee in the future.

Mr. SHAYS. I am going to ask now David Gorman to make some comments. And I realize that this is an issue that is very familiar to you, but you haven't had much time to prepare your statement, and thank you for your comments.

Mr. GORMAN. Thank you, Mr. Chairman. I think that short notice is better than no notice at all.

I want to really say how we appreciate being asked to participate. I think oftentimes sometimes policymakers and others in professions and disciplines sit around a table and make decisions, and oftentimes the voice of the consumers and the patients are often left out. And that's really what we are.

The organization I work for, the Disabled American Veterans, is comprised of 1.1 million members, all wartime, service-connected, disabled veterans. That's who I speak for today, and that's who I think most of us place the priority on where VA services should be dealt, and that's with the service-connected veteran.

I am going to try to, therefore, speak in the tongue that you so eloquently said that sometimes government officials do speak in, and we have certainly heard some of that. But I think what has really been brought to the table in the last 2 years, 2 years plus now, has really been a concerted effort to try to look at this system that nobody can make any sense out of. They don't know if heads are up or tails are down when they look at the VA health care system and try to do something constructive with it.

I think Dr. Kizer, in the short tenure he has been with VA, maybe 6 months or so now, has come in from the outside and looked at a system that really has been institutionalized since World War II. And he sits at a table and says, why am I doing this? I shouldn't be doing this kind of thing. I am the Chief Executive Officer of the health care system. I shouldn't be signing off on these kinds of things. I want to run the system. And I believe it is a system.

So I think we are all looking at his efforts that have been brought to the table in a positive vein, and I think this reorganization plan of restructuring simultaneously the field operations of VA and the central office structure are compatible, they need to go forward, and the DAV is supportive of those.

They do not however, as some people think, contain an element of eligibility reform. But I think with the reorganization, the VA is going to be allowed and permitted to do certain things in the field without eligibility reform, as Mr. Baine alludes to. Some of those, if permitted, they are going to be allowed to open up additional points of access where veterans don't have to drive, whether it be 20 miles or 200 miles, to go to a VA hospital, this big brick building set up on the hill that people look to the VA as to get their health care.

The issue of demand and workload was brought up, and I think somebody used the figure over the last 50 years or 20 years or 25 years, the demand for VA care has diminished by, I think, 50 percent. I am not aware of that figure being accurate.

It may be that the occupancy rates of VA facilities have decreased by somewhere—I don't think to that level, but maybe approaching that level. And some of that I think is suppressed demand. I mean the VA just doesn't operate. They are moving away from the bed-based model as they should, but the eligibility rules do come into play. Resources come into play. If you can't fund personnel to staff beds in a VA medical facility, then you are not going to be able to place patients in those beds. That's where the occupancy rate falls in.

The eligibility rules are such that no one can make sense of them. For instance, if you break your leg in front of a VA hospital, they can carry you in, fix it, set it and put a cast on it, but you can't get crutches to go out of the facility. The eligibility rules say——

Mr. SHAYS. Do what? I'm sorry.

Mr. GORMAN. Crutches. You have to hop out with a cast on your leg. That doesn't make sense to us, and I don't think it makes sense to many people, but that's the way the rules have been designed over the years, with no ill intent.

I think that a lot of people, veterans' organizations, have come to the table. Members of Congress have listened and have compassionately listened and try to do the right thing by building in certain eligibility requirements, maybe some expansion of care, some special programs. And it's just gone topsy-turvy, and what we have ended up with is this morass today that we are trying to look at and deal with.

The other—Dr. Kizer once described in a couple of settings what he views hospitals to be in the future, and he views them to be nothing more, at least in the VA, as giant intensive-care units. So I think that speaks to the mentality of where VA would like to go. And that is, you shouldn't be in a hospital. You should be receiving care in an ambulatory care setting in the community as contemporary medicine is being practiced in the private sector.

The one other comment I would make, because I don't know what your time is——

Mr. SHAYS. Since you introduced that, the ranking member needs to leave shortly after 12, and I want to make sure he is able to introduce some questions, but we will be here for a little longer.

Mr. GORMAN. Then I would make the flat statement that as a user of VA services and some specialized services over the last 25 years since I have been out of the service, I do not want to get all

of my health care in the private sector. I want to be able to continue to go to where I know I can get quality health care delivered in a manner that I need it and from people who know how to deliver what I need, and that's in the VA medical facility.

Mr. SHAYS. Thank you very much, Mr. Gorman.

Mr. Buxton, would you have some very brief comments? And then we will let the ranking member ask some questions.

Mr. BUXTON. Thank you, Mr. Chairman, for inviting me to come up to the table. The American Legion is pleased that you did that.

I think the strongest feeling that the American Legion has right now is being a staunch advocate for eligibility reform in the VA. We don't think that the dollars that are appropriated for VA health care for service-connected and poor veterans should be forced to be expended for the care for nonservice-connected veterans.

We know that VA can collect from third-party payers, but we also know that they are not allowed to keep those dollars; and, as a result, there is a major leak in the funding for VA, because a lot of dollars are expended for taking care of nonservice-connected veterans. Medicare subvention to the VA would be an important way to sustain the VA as well. We should look at VA appropriations in terms of service-connected and poor and look at other dollars for nonservice-connected veterans.

I would like to take exception to the earlier remarks that the VA is operating in the dark ages. That was a pretty general statement. However, we don't believe that is true.

Mr. SHAYS. Attributed more to me than those who testified. It was a question, but attributed to me.

Mr. BUXTON. The VA health care delivery is, in many cases, more specialized and of better quality than some delivered in the private sector. I can speak to that because I worked in the private sector health care for 40 years. I think the Joint Commission reports will substantiate that VA does deliver good care.

Mr. SHAYS. I do need to interrupt you for this point. Nobody was saying that they weren't delivering good care. I think the issue is, are we modernized? Are we responding to the same kinds of challenges that modern hospitals in the private sector are responding to? And I think that, clearly, we could agree that they aren't keeping abreast that way.

Mr. BUXTON. Thank you. Actually, a move to the care in the most appropriate setting. There has been a lot of discussion this morning of moving to outpatient care.

Mr. SHAYS. Right.

Mr. BUXTON. Outpatient care isn't necessarily the preferred mode in many cases, as you know. So we would prefer to say, move it to the most appropriate care setting.

In regard to micromanagement, yes, the VA is micromanaged——

Mr. SHAYS. I am going to do this. I am going to allow you to make some comments after. Mr. Towns, you want to just ask a few questions? And then I will get back to you.

Mr. TOWNS. Thank you very much, Mr. Chairman, and I appreciate your consideration because I do have to leave.

Mr. Bollinger—and being a veteran myself, I am concerned that veterans may have health care needs unique to certain regions

and—well, I can sort of name maybe tuberculosis in some areas of the country is a real problem. In other areas, it's not much of a problem. Posttraumatic stress disorder in some areas more than others. Will the VISN approach be able to respond to these regional-specific kinds of needs?

Mr. BOLLINGER. I think it will. Because, with this approach, the VISN director will, obviously, have a number of VA hospitals within his geographic district. And, even now, if you look across the country, there are hospitals that are—that excel in certain deliverables, whether it be cardiology or whether it be psychiatric care or whatever.

I think that via the VISN system that they will be able to have a better handle on how to provide those kinds of services.

Mr. TOWNS. Mr. Chairman, what I would like to get permission to do is submit some questions for the record.

Mr. SHAYS. Sure.

Mr. TOWNS. I appreciate that.

Mr. SHAYS. Happy to do that.

[The information referred to follows:]

June 8, 1995

John Bollinger
Deputy Executive Director
Paralyzed Veterans of America
801 Eighteenth Street N.W.
Washington, D.C. 20006

DEAR MR. BOLLINGER:

Enclosed are three questions Congressman Edolphus Towns, the Ranking Member of the subcommittee, was unable to pose to you during the hearing. Congressman Towns would like you to review these questions and submit your answers to the subcommittee so they can be included in the final record of the hearing.

I apologize for the late notification of this request and hope that you would be able to provide the subcommittee your responses by June 22. Should you have any difficulty meeting this deadline, please contact Kate Hickey of the subcommittee. She can be reached at 202/225-2548.

Thank you for your time and attention to this matter.

Sincerely,

CHRISOPHER SHAYS
Chairman

QUESTIONS FOR JOHN BOLLINGER

1. While you clearly support the agency's plan, you appear doubtful that the VA will maintain and enhance specialized services. You testify that the V.A. needs to demonstrate that it has the commitment and capabilities to adjust to the changing health care environment.

—Is there specific reason for your concern?

—Do you believe the culture in place to ensure your concerns are addressed? What needs to change in order for the department to effect real progress?

—With the exception of the health care system, how would you prioritize needed reforms? Are any of these reforms underway?

—Can you provide any insight of how we might frame our consideration of VA's reform initiatives to address your concerns?

—What other participants should we include this discussion?

2. Mr. Bollinger, in a recent report, GAO found that the VA health care system does not adequately address veterans health care needs.

—What is your assessment of GAO's findings? Will the reorganization correct these problems?

—Are there other health issues outside the VISN plan that will require reform? What action is the V.A. taking on these matters?

3. Among other things, your plan calls for removing regulations that limit access by most veterans to out-patient care and force VA hospitals to treat them in more expensive in-patient settings.

—Isn't access to comprehensive outpatient services a critical factor in reducing costs?

—Will eligibility requirements change under the VISN approach?

—Is legislation likely to be necessary to restructure the veterans health benefits program?

NOTE.—At the time of printing, Mr. Bollinger had not supplied the subcommittee with the answers to Mr. Towns' questions.

Mr. TOWNS. And let me thank all of you for your testimony. And I think you have expressed some real concerns that I have that I think that it's important that we keep the structure but I think that we need in some areas to improve it in a lot of ways. And I think that, in order to do that, we might have to get involved in some additional legislation in order to make it address some of those problems.

As I listened to the statement made by Mr. Gorman in terms of you go in and you get all the needs and all of a sudden you need crutches to walk out, I think that within itself is sort of ridiculous. And, at the same time, this is going on in the United States of America. I mean, I think that that's just sort of really wild.

So I think these are the kinds of things that we need to take a very serious look at and begin to address them to see in terms of what we might be able to do to move these things out of the way to provide the kind of quality care that is actually needed.

So I want to let you know that I sign on to do what is required here to make certain that it works, and I think that—I gather from you that there is support across the board that these facilities should continue and that, where necessary, should be upgraded, you know, not eliminated. I guess that's the general feeling that I get from all of you.

So, Mr. Chairman, thank you very, very much. I look forward to working with you.

Mr. SHAYS. I thank the gentleman, and we will be respectful of the fact that there is no minority member in this chamber now.

Mr. Buxton, if you wanted to just conclude. Your comments were helpful and happy to have you conclude.

Mr. BUXTON. All right, Mr. Chairman. I just want to comment on the issue of micromanagement very briefly.

There is micromanagement. Title 38, Congress and the central office of VA do micromanage what happens in the field. Nobody knows any better what happens in the field than the people that are in the field, and we support Dr. Kizer's ideas about moving responsibility.

However, moving the accompanying accountability to the field, we think is also very important. We want to reinforce our position that we think that eligibility reform would help the VA a great deal in expanding their population, bringing money in and therefore relying less on appropriations.

The special missions I think have been discussed this morning: VA, PTSD, spinal cord dysfunction, blind rehab, and prosthetics. Those are types of special missions cannot be delivered in the private sector with the quality and with the compassion that they are delivered in the VA.

I just want to put some support in for the research and education functions of the VA. Many, many of our doctors in this country re-

ceive part of their education in the VA, and that adds a great deal to the quality of health care universally, not just in the VA.

Thank you very much, Mr. Chairman.

Mr. SHAYS. I thank you.

And what I am going to do is I am going to start with questions. And Mr. Vollmer and Mr. Fuller, please feel free to comment. If you wanted to make just a brief comment now, I would be happy to hear it. Otherwise, we will start with the questions.

The only way I can really learn is to just be very up front and very open with you, and I might say something that you can take offense with, but I will learn better this way.

The way my mind works, we have a certain number of veterans that we have said qualify for assistance, those who have injuries, service related, and those who do not have financial resources. We have eliminated the use of these facilities by other people, basically. Am I pretty generally on target?

Now, I hear the word eligibility, and what that says to me is, Mr. Gorman, you are making a comment that maybe some of the reduction in the demand for services may be related to who we say is eligible and who isn't. We have an interesting issue. Do we try to maintain all of the hospitals? And, if so, at what level do we maintain them? And if in the process of trying to maintain all of them, do we cripple too many of them in the sense that we are not going to allocate the resource?

I mean, as a policymaker, this is what I am wrestling with. And the challenge that we are going to have on this side is that we don't want to offend any veteran, especially someone like myself, who was a Peace Corps volunteer when my friends were in Vietnam. And so, you know, the temptation for all of us on this side of the desk is to simply back away and just let the system evolve somehow.

I don't think we have the resources to maintain all the hospitals at the condition they need to be, and so maybe you all could explain something to me. I don't understand why a veteran would want to travel 1½ hours to a veterans' hospital to get a service that they could get as well in their own local hospital. And I wonder why we don't have a veterans' card that entitles you to go to any hospital you want and get the best service and that you be first in line.

So tell me why—what scares you about that kind of system that would enable the veteran to go to the hospital nearest with the card and get the service they want?

Mr. GORMAN. If I could just make a couple comments. I know Mr. Fuller would want to get in with more of the specifics.

Mr. SHAYS. Sure.

Mr. GORMAN. First of all, I am a Vietnam veteran, a combat veteran. I take no offense at anybody who is not a veteran. I think we all did what we did.

The point that I would make is that we do have, I believe, a commitment to honor. And the commitment to honor—we are going to the 50th anniversary of the end of World War II and we are going through all these ceremonies, and I think we saw this at the height of the Gulf war when our young men and women came home victorious. It was a celebration, but it was a short-lived celebration,

and we seemed to get back into the same mode of forgetting. The farther away from conflicts we get, the more we forget; and I think that's human nature.

Mr. SHAYS. So is part of the concern that if you have a hospital that is for a veteran, you know there is going to be veteran services, and your concern is that 10 years down the way, the veteran will not get unique and special service, that they will be forgotten? Is that where you are coming to?

Mr. GORMAN. That's one of the points. I think in order to get those special services, the unique services that have been mentioned oftentimes today—the spinal cord injury, the blind rehab, the PTSD—you need to have with that a complement of acute care services. You can't operate a hospital in a vacuum.

There is no one who can convince me—I have received care in both VA—many VAs, in the private sector, and I am not convinced yet that I can get first-class care—that VA isn't first-class care, No. 1.

A veteran probably wouldn't want to drive or travel X number of miles to go to a VA oftentimes when he can get care or she can get care in the local community. However, veterans have some sense to them, whether it is a fraternalistic type thing or whether it is just a patriotic thing or whether it is where they can go to be with their peers, their colleagues.

VAs mean an awful lot to an awful lot of people for reasons that I can't explain, even for VA employees. There are many, many employees in the VA health care system who could be making, if it was strictly a financial and economic reason, more money on the outside, but yet for their own reasons, all valid, they have stuck with the system.

Mr. SHAYS. I am getting the gist of your comment, and it is very helpful. We have other Members here who haven't had a chance to ask questions, and I am going to come back.

Mr. Souder, be happy to have you.

Mr. SOUDER. I am interested in the same question. So——

Mr. SHAYS. Well, let's just all pursue it.

Mr. SOUDER [continuing]. In the sense of, I get the feeling—how widespread do you feel that that is about—your comments about it, in effect, being somewhat fraternalistic in addition to just medically driven? Because in northeast Indiana, we have a veterans' hospital in Fort Wayne as well as down in Marion, but many people will travel—have to travel quite a ways whereas they could get that service elsewhere.

My feeling is—from a lot of veterans is that they don't feel that way, yet others feel intensely that way. And it is very confusing to me, not being a veteran myself, even though my father was and my uncle and others, why some feel that way so strongly and others would rather have the card where they could go to their local hospital or to a regular hospital. What would explain the division?

Mr. FULLER. It depends on where you are, who you are, what services you need, what your health conditions are and that type of thing, Congressman.

But I think what we are talking about here is the commitment of the Federal Government to meet a requirement that those who served in the defense of this Nation expect. I think there is a cer-

tain feeling within the veterans' community that the VA health care system is our system. But, apart from that, we know it is the responsibility of the Federal Government, and not Kaiser Permanente, to be able to monitor the quality of the care, the types of services, the amount of services that the government is paying for in this situation.

So, without VA hospitals we would be setting up an entirely different type of bureaucracy in order to be able to monitor what kind of services these individuals would be getting from the HMO around the corner versus being able to go to VA hospitals where we know what the services are, what the medications are, what the amounts are and what you need and expect.

There was a comment made earlier by the GAO about a study they did last year on the experience of other countries that had identifiable veterans health care systems and how they dissolved or integrated those systems into other health service systems over a period of time.

It is very easy to attempt to make comparisons that Finland did it this way and they got rid of their VA hospitals, and if we could do the same thing here everybody would be very happy. Canada, as well, had an identifiable VA health care system which gradually shrank and eroded away and is just about completely gone at this point.

But if you try to compare the United States with Finland and Canada, in each instance, these countries had some other system for the veterans to go to. Finland is a socialist country. It had a universal health care system. Canada had a universal health care system. And so there was a support structure there that they could still put their veterans into and monitor.

The Congress, last year, made the decision we are not going to go that route. Our fear right now is that if you started to give veterans vouchers or mainstream them here or there, it is going to be impossible. You are going to have even more of a helter-skelter type of eligibility system than you have right now.

Mr. SOUDER. Does anybody else have a comment?

Do you have a comment on that?

Mr. BUXTON. I just wanted to comment on Dr. Kizer's plan for VISNs for the future for the VA, would definitely move the health care closer to the veterans by means of a system of community-based clinics which would put the health care closer and the veteran wouldn't have to travel all those miles. But we certainly wouldn't object——

Mr. SHAYS. If the gentleman would just suspend a second. Would the gentleman mind yielding to this?

Mr. SOUDER. Fine.

Mr. SHAYS. I don't see the Veterans Administration really moving forward with out-based clinics. I don't see it happening. And so maybe you could address that as well.

The hospitals are underutilized so there is an incentive to utilize the hospitals. The hospitals are in certain parts of certain States, and so people have to travel there.

Mr. BUXTON. I think the private sector, Mr. Chairman, has learned their lesson about centralized health care delivery and that

they know you have to bring health care to the patient, and our veteran patients have to have the health care brought to them.

That's not to say that that would diminish the value of the hospital as tertiary care delivery and specialized care delivery hospitals. The integration that's planned of the various hospitals, and mission changes—are certainly acceptable. But the VA system hospital has got to stay intact for the very reasons that we heard here earlier.

Mr. FULLER. Mr. Chairman, if I just could interrupt 1 second——

Mr. SHAYS. This won't be off your time.

Mr. FULLER [continuing]. And add something to that.

We can be very critical of the VA in not being able to practice medicine in a contemporary fashion where outpatient care is the rule of the game. The problem is not necessarily the VA's. It is not the VA's at all.

The Congress itself has developed the eligibility criteria which specifically prohibits VA from providing care in the most efficient and effective way. Convoluted byzantine eligibility criteria require VA to provide care on an inpatient basis, whereas providing it on an outpatient would be much more practical, much more cost effective and much more applicable to the needs of the veteran.

And, at the same time, we have another example, which has just arisen in the Congress in the past several weeks. Despite restructive eligibility criteria, VA has been out there trying to become innovative on its own. Apart from what the Congress has said you shall not do, it has been out there attempting to set up outpatient clinics; going to mayor so and so in such and such a city, saying give me some space; going to the veterans' associations, give me some materials to open a clinic.

From what we understand the Appropriations Committee here in the House at least decided that they can't let this happen. Because, they say if you open every clinic more people are going to come, and it is going to cost more money to care for them.

So the Congress, again, is prohibiting the VA from practicing medicine in the most efficient and effective way. The only way we are going to be able to solve this is to pass legislation requiring eligibility reform.

Mr. SHAYS. Let me get back to Mr. Souder.

Mr. SOUDER. We have a couple core premises we are trying to deal with. One is that we don't have money and that we have been running a deficit that no organization other than the Federal Government could have been allowed to do.

Second, we have contracts with all kinds of people who—they were basically false contracts. In other words, you were promised all kinds of things. All types of people in America were promised all types of things. The government didn't have the means to deliver it, and they should have never made the offer in the first place. Nevertheless, particularly those who have serious injury—I mean, you were put at risk by your government, and we have an obligation to follow through, and that what I kind of understood you to be saying earlier, Mr. Fuller—and I want to see if the others feel this way, too, because it is the general impression that I have gotten, and the chairman was kind of addressing this a minute ago—is that, logically, in an economic system when we have

underutilized hospitals all over, when what you see in northeast Indiana is a—the major hospitals in Fort Wayne, increasingly, the regional hospitals getting hooked up where they send the acute care in, that you would have a similar system where veterans could tap into that and if they—one hospital in Fort Wayne is a burn center, another one more specializes in heart, rather than trying to cover everything out of one unit, and it doesn't make a lot of economic sense.

But underneath it there is a political problem. And that is, as long as there is an accountability, you see your clout there and you are concerned, particularly if veterans become a decreasing percentage of the population, that if we merge it, that you won't have as much clout in the sense of being able, you said, to monitor. But monitor, in effect, what you are saying is you feel the government is going to be more fair to veterans than the medical system, which presumes that if you feel politicians are going to be more responsive and not cut your budget, that means you feel you have leverage over those politicians that you might not in another system. Is that really kind of a common feeling among veterans' groups?

Mr. FULLER. I don't think we are talking about clout, Congressman. I think what we are talking about is insuring that veterans get the best care. And if you have veterans going to every doctor and every clinic and every hospital in this country, you are not going to be able to identify whether the actual laws that the Congress has written regarding what veteran gets what and where they get it and how much they get are being followed.

Mr. SOUDER. You are saying part of that is because they view you as their primary client. So in addition to the political—the people at the hospital view the veterans differently.

Mr. FULLER. We have always looked at the Congress to make the laws. The Congress designed a system that said that the Federal Government was responsible for taking care of the health care of the Nation's veterans. If that's the case, then it is the responsibility of the Federal Government to be able to monitor whether the provision of that care is adequate whether or not you have someone in a VA nursing home or a private sector nursing home someplace, how are you going to be able to monitor the quality of that care if everyone is just given a ticket and told to go off and just get what you need?

Mr. SOUDER. Isn't it true that we would monitor it the same way we do now? In other words, in effect monitoring, because quite frankly, none of us really follow it that closely. There is an agency designated to make sure that you are cared for. Now, if you have cards and you are not getting the care and you feel that discrimination, politically that is going to come back up through the Veterans Administration and back through us through the political system to address as well, is that not true?

Mr. VOLLMER. If I could build upon your whole question, first of all, you reference the fact that there is excess capacity in VA hospitals. There is excess capacity in civilian hospitals, too. And I think some of the things that we are seeing, both in VA and in the——

Mr. SOUDER. I meant that in all the hospitals.

Mr. VOLLMER. Right. There is an evolving approach to dealing with how we deliver medicine in this country.

But, beyond that, I think, collectively, the veterans' organizations represented here certainly agree that there are better ways to utilize resources at times, not so much competing with the private sector for patients, but kind of creating a partnership in establishing certain sharing agreements, when you look at a situation where VA is capable of providing exceptional services and has some additional capacity, through a sharing agreement where perhaps private-sector facilities have some other resources that could benefit veteran patients, that this could be established.

I think one of the things we have to look at, too, is I think we have all collectively agreed, is that the VA—when we say we want to preserve the VA system, it doesn't have to look in 10 years exactly like it looks today. But I think veterans have come to rely upon it, both for their health care and it has been put in place and for 50 years, veterans—certain veterans have been told that's the way the government is taking care of your needs.

And there is an innate concern that, suddenly, when somebody is saying that, you know, we are going to give you a card and tear down the building that we have been sending you to for the last 50 years—I have a neighbor that every Saturday morning leans over the fence and tells me what great care he got at the VA this time, and he has been going there since he was injured in Korea in 1952.

And so to change the way 26 million people have been given assurances by the government for the last 50 years is certainly going to cause a lot of dislocation on their part and consternation.

Mr. SOUDER. If I may make a brief comment, too, that in Fort Wayne they have moved heavily to outpatient services and are doing much like what the general trend is, unlike the Marion hospital which tends to be more long-term care. So we are seeing some changes in the system, too.

Thank you, Mr. Chairman.

Mr. GORMAN. Mr. Chairman, I don't think we got to your original question, or the one that you raised, too, and that is about the closure of VA hospitals. And I think you both asked that question, maybe in different ways.

I don't think any of us sitting here today are saying that—what we are talking about is a better way and more efficient way to deliver VA health care, and implicit in that is looking at how the VA does it and where they do it.

If there is a hospital—I don't think any of us will sit up here—if there is a VA hospital that is providing minimal care or inferior, substandard care, that we would sit up here and try to defend that system or that hospital. We certainly wouldn't want to do that because that is not delivering quality care to veterans.

So I think we have to look at mission changes in VA hospitals, what they're doing, how they are doing it and where they are doing it. All we are trying to get to is the best possible service for veterans in the most efficient way.

And I think in the independent budget, which I think Mr. Towns referenced earlier, and he mentioned the figure of $2 billion, the inappropriate ways that VA is providing care right now to patients

because they want to take care of them, they are sick, they are in need; in order for them to take care of them, they have to put them in this expensive hospital system.

If you change that venue of care, that's where the figure that we are generating of $2 billion can be actually saved and redirected to bolster up the rest of the system.

Mr. SHAYS. Thank the gentleman.

Mr. Davis.

Mr. DAVIS. Mr. Souder was talking about the trust in the medical community of politicians—I really think there is a certain distrust about any change that comes from us that's cost driven, even though it may result in a better, more efficient system.

It seems to me, in talking to some of the veterans in my district, that some of them would like the flexibility sometimes to maybe go into private-sector care as opposed to veterans' care. But when you are driven into it by a regulation, I think there is understandably a certain suspicion. And I think we need to continue this dialog and work through the money issues on our side and the efficiency and quality issues from yours. I think there is room for both. I appreciate very much your testimony today.

I wanted to get back to the eligibility issue, if I could, on eligibility reform and ask two questions: First, what kind of changes might you suggest in that? But, second, what is the backup now? If there is a question of eligibility and you are going to—and there are appeals, we have heard testimony before that the appeals process for all kinds of veterans' benefits is significantly backlogged. Can any of you talk about that experience or things we might do to remedy that?

Mr. GORMAN. The backlog of claims or the alternative to medical care?

Mr. DAVIS. Both.

Mr. SHAYS. The claims probably.

Mr. DAVIS. Claims is where I think the huge backlog is.

Mr. GORMAN. There is a lot of practice and I think some of this—and I am not sure I can speak as expertly to it as others could, but I think there is a lot of things with the advent of the Court of Veterans Appeals that has been placed on the system. They have directed the VA to, in essence, comply with the law, which, in many cases when the Board of Veterans Appeals was the only remedy, they would just sometimes, by fiat, make a decision and they weren't accountable to anybody.

And accountability comes into play again. The court now has made them comply with certain things, and they've set certain practice—certain precedents that they have to comply with. That has caused a tremendous amount of the work being done both at the VA regional offices across the country and the Board of Veterans Appeals to be done much more meticulously, much more time-consuming. There's a duty of assist the veteran now that the court has placed on the VA that was never there before.

So all of these things come into play to really add an extremely long period of time.

Mr. DAVIS. There are a lot of unintended consequences to that, because of the backlogs that are created, people not getting an answer.

Mr. GORMAN. Very much so. Very much so. Maybe Frank can say. I know it's well over a thousand days from the——

Mr. BUXTON. The time for claims adjudication is getting better. It's slowly but surely getting better. There still is a backlog. There was a blue ribbon commission on veterans claims, which came out with a series of recommendations, and those recommendations are slowly being put in place.

I would just quickly comment on ability of a veteran to receive medical care and then appealing that. That is not the most common claim we would see, of course, and many of those particular appeals are handled at the VA medical center level.

And in regard to Indiana, I was just in Indianapolis 2 days ago, and the Indianapolis Veterans Hospital is seeing all veterans that appear at the door. They are being given care whether they're discretionary or not.

So I believe that—I'm not sure that there's so much of a barrier that it has to go to the claims process. Although there are some claims for veterans health care that are before the claims adjudicators.

Mr. DAVIS. OK. All right. I thank you all very much. I'll yield back.

Mr. SHAYS. Mr. Buxton, how are they able to service someone who doesn't meet the criteria? I mean what—do we have flexibility that medical directors have and so on?

Mr. BUXTON. The medical directors at the hospital can do that. Getting back to the old adage that we've all said at one point or another, the health care of the VA is resource driven. If you've got an astute director who manages his resources well, he can take veterans into the system.

Mr. SHAYS. I know there's an army adage that says somehow there's a way to get around the bureaucracy.

Mr. BUXTON. Well, we think the language is the difference in Title 38 between shall and may.

Mr. SHAYS. Mr. Bollinger, you're kind of the leader of this group, even if you don't want to be.

Mr. BOLLINGER. I agree.

Mr. SHAYS. But you're the leader here. Is there anything that you would have liked us to have asked that we didn't? Is there any comment here that was made that you disagree with or would like to emphasize?

Mr. BOLLINGER. Well, I would echo one thing Dave said, Mr. Gorman said, about again—and a couple of you raised the question about closing VA hospitals and that sort of thing. I think that all of us would agree that the VA is going to be a different place down the road sometime. And none of us are saying that 171 hospitals exist today and, by God, 171 hospitals are going to exist 10 or 15 years from now.

I think over time we've got to, you know, based on veteran demographics, based on the needs and so on and, obviously, the different kinds of specialties that the VA needs to be involved in, changes have got to be made to accommodate the veterans who need the system and perhaps dependents and others as well. That may be one approach. And we're certainly willing to sit down at the table and talk about that.

I would emphasize the need for eligibility reform, and I would emphasize that specialized services are indeed the cornerstone of the VA system. They have been for years. And the specialized services and the safety net mission that VA has developed over the years are going to be—have to be what the VA is all about in the future.

And we appreciate this opportunity to tell you our views and concerns, and we sure hope to work with you as we help the VA with their future plans.

Mr. SHAYS. Well, we look forward to working with all of you; and your testimony has been very valuable and very helpful.

And we thank you for coming, Mr. Bollinger, and for allowing us to invite others to participate in what is truly a very important issue; and the sooner we address it as a team effort, the better it will be for all of us.

And I just want to emphasize that your point about specialized services is coming through loud and clear; and I think that all of us here recognize the value of the veterans facilities and the need to have them continue and to provide the services that you all have a need for and totally deserve.

And I'd conclude by thanking you for serving your country in the military and continuing to serve your country in the capacities you're doing now. I will adjourn this meeting and thank you all for being here.

[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

[Additional information submitted for the record is as follows. Due to high printing costs, this information can be found in subcommittee files.]

Appendix 1.—Selected Section of Dr. Kizer's reorganization plan for the VHA "Vision for Change, A Plan to Restructure the Veterans Health Administration."

Appendix 2.—Selected Sections of the VA Inspector General's Five Year Strategic Plan (FY 1995—FY 1999).

Appendix 3.—Selected Sections of the February 6, 1995 Inspector General Report No. 5R1–A19–026, "Review of the Implementation of VHA's Strategic Plan and Performance Measurements."

Appendix 4.—Selected Sections of the PVA's "Strategy 2000 Phase II: Meeting the Special Health Care Needs of American Veterans."

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